Worcestershire NHS
Acute Hospitals NHS Trust

There will be a meeting of the **Worcestershire Acute Hospitals NHS Trust Board** on **Wednesday 6 July 2016**
at 12:00 in **Charles Hastings Education Centre, Worcestershire Royal Hospital, Worcester**

John Burbeck
Interim Chairman

Please take papers as read

AGENDA

1	**Welcome and apologies for absence**	Interim Chairman	
2	**Listening in Action**	Director of Communications/LIA lead	
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.*		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **8 June 2016** as a true and accurate record of discussions.*	Interim Chairman	**Enc A**
6	**Matters Arising**	Interim Chairman	**Enc B**
7	**Questions from the Public** *Questions relating to items on the agenda only should be provided in advance to the kimara.sharpe@nhs.net by 12 noon on Tuesday 5 July 2016.* ***Please note change of email address***		
8	**Chairman's Update Report** *For information*	Chairman	**Enc C1**
9	**Chief Executive's Report** *For assurance*	Interim Chief Executive	**Enc C2** ***To follow***
	STRATEGY **Board Assurance Framework**		
10.1	**Future of Acute Hospital Services in Worcestershire** *For assurance*	Interim CEO	**Enc D1**
	QUALITY AND PATIENT SAFETY **Board Assurance Framework 2790, 2902, 3038, 2895**		
10.1	**Quality Governance Committee report** *For assurance*	Committee Chair	**Enc E1**
10.2	**Patient Care Improvement Plan** *For approval*	Director of Planning and Development	**Enc E2**

WORKFORCE Board Assurance Framework 2678, 2894, 2893			
11.1	**Workforce Assurance Group report** *For assurance*	Committee Chair	**Enc F1**
11.2	**Nursing and Midwifery Workforce** *For noting*	Interim CNO	**Enc F2**
11.3	**Medical workforce** *For assurance*	Interim CMO	**Enc F3**
11.4	**Medical revalidation** *For assurance/approval*	Interim CMO	**Enc F4**
FINANCE AND PERFORMANCE Board Assurance Framework 2888, 2668			
12.1	**Finance and Performance Committee** *For assurance*	Committee Chair	**Enc G1** ***To follow (mtg 30-6-16)***
12.2	**Integrated Performance Report** *For assurance*	Director of Planning and Development	**Enc G2**
12.3	**Financial Performance Report** *For assurance*	Interim Director of Finance	**Enc G3**
GOVERNANCE AND COMMITTEE REPORTS Board Assurance Framework 2888, 2668			
13.1	**Board Assurance Framework** *For assurance*	Interim CNO	**Enc H1**
13.2	**Organ Donation –annual report** *For assurance*	Acting Chief Medical Officer	**Enc H2**
13.3	**Safeguarding Annual report** *For assurance*	Interim CNO	**Enc H3**
15	**Any Other Business**		
	Date of Next Meeting The next public Trust Board meeting will be held on **Wednesday, 7 September 2016, Charles Hastings Education Centre, Worcestershire Royal Hospital, Worcester**		

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 8 JUNE AT 09:30 HOURS

Present:

Interim Chairman of the Trust:	John Burbeck	
Board members: (voting)	Stephen Howarth	Non-Executive Director
	Rab McEwan	Interim Chief Operating Officer
	Bryan McGinity	Non-Executive Director
	Andrew Short	Acting Chief Medical Officer
	Andrew Sleigh	Non-Executive Director
	Jan Stevens	Interim Chief Nursing Officer
	Chris Tidman	Interim Chief Executive
Board members: (non-voting)	Denise Harnin	Director of HR & Organisational Development
	Sarah Smith	Director of Planning and Development
	Marie-Noelle Orzel	Improvement Director
	Lisa Thomson	Director of Communications
	Lynne Todd	Board Advisor
	Bill Tunnicliffe	Associate Non-Executive Director
In attendance:	Kimara Sharpe	Company Secretary (minutes)
	Haq Khan	Deputy Director of Finance
Public Gallery:	Press	0
	Public	6
Apologies:	Stewart Messer	Chief Operating Officer
	Rob Cooper	Interim Director of Finance
	Paul Crawford	Patient Representative
	Alan Harrison	Non-Executive Director

44/16 **WELCOME**

The Interim Chairman welcomed members of the public to the meeting. He also welcomed Dr Andrew Short to his first meeting as Acting Chief Medical Officer.

45/16 **PATIENT STORY**

Ms Stevens introduced SC to share his mother-in-law's experience of being an inpatient at both the Alexandra Hospital and Worcestershire Royal.

SC thanked the board for giving him the opportunity to describe his experience and to hopefully ensure that there was learning from it. His mother-in-law, J was admitted to the Alexandra Hospital after experiencing inability to walk. She had, up until that time, been fit and healthy. The diagnosis was a fracture of the thigh bone. After a series of investigations, a further diagnosis of metastatic lung cancer was made.

SC complimented the staff who were all friendly and kind and he stated that the basic care was good.

However, he was critical of the three discharges that J had, two from the Alexandra Hospital and one from Worcestershire Royal. The common theme relating to all the discharges was the lack of communication with her principle carer, her daughter, who lived two hours away. J's second admission was made when she arrived at the Alexandra Hospital having fallen, but had sustained no injury. Unfortunately J was moved four times whilst an inpatient, the last time at 1am. SC asked why the Trust did not have a policy which meant that patients were not moved at night. In preparation for this discharge, social care was not contacted until 11 days into the hospital admission.

The third admission was due to a possible spinal cord compression. Whilst J was referred to University Coventry and Warwick, the decision was made not to give active treatment. For this discharge, no member of staff spoke to the daughter who had arranged for her mother to be cared for at her home and had contacted various services such as her GP and MacMillan nurses. J was discharged and died very peacefully a short time later at her daughter's home.

SC went onto say that he fully understood the pressures that the NHS is under however he felt that his mother-in-law had not received the care and compassion required and had not been treated holistically.

In relation to her diagnosis, J had been seen by the oncology team, but then was not seen again for 30 working days. Her daughter was not spoken to, despite it being known that she was her principle carer.

In conclusion, SC stated that the experience was as the family would have wanted.

Ms Stevens thanked SC for sharing his story and apologised for the experience he had received. She was pleased that SC was going to work with the Trust to ensure that changes are embedded.

Mr Tidman committed to sharing the story with all staff. He was clear that the Trust failed in ensuring that J was seen as a whole person.

SC stated that he was speaking to senior nurses in the next week and at a discharge seminar in two weeks. He was passionate about wanting to help improve the Trust.

Mr Sleigh reflected that the NHS tends to treat illnesses rather than the person. He turned to the discharge process and asked whether the process should be reviewed. Ms Stevens confirmed that she was reviewing the whole discharge process. She also stated that the Trust was looking at moves at night which were unacceptable.

Mr Burbeck thanked SC for his story. He committed to ensuring that the Trust improved the care given.

Resolved: that
The Board

- Noted the content of the story

46/16 **ANY OTHER BUSINESS**

No other items of business were raised.

47/16 **DECLARATIONS OF INTERESTS**

Resolved that
The following declarations of interest be entered on the Register:

- Alan Harrison
  - Deputy Chair and Senior Independent Director – South Warwickshire NHS FT
  - Chairman – Fry Housing Trust
  - Director – The Albatross Theatre Project
  - Magistrate – HMCS
- Andrew Short – none
- Jan Stevens – Ambassador for the Prince's trust (volunteer role)

48/16 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 4 MAY 2016**
Resolved: that

- The Minutes of the public meeting held on 4 May 2016 be confirmed as a correct record and be signed.

48/16/1 **MATTERS ARISING/ACTION SCHEDULE**
The Company Secretary confirmed that all the actions had been completed or not yet due.

49/16 **QUESTIONS FROM MEMBERS OF THE PUBLIC**
Mr Bryn Griffiths asked the following two questions:

- *With reference to the report on the STP planning foot prints, can the public please be provided with a copy of the April submission for the local STP and the emerging priorities and proposals and/or the gap analysis?*
- *The report on the agenda says: "The Herefordshire and Worcestershire STP in particular demonstrated good collaborative working including all the respective NHS organisations, HealthWatch and the local authorities; however, it also stood out terms of the scale of the financial challenge." Please may we be informed in summary of the extent of the financial challenge in terms of both money and timescale?*

Ms Smith explained that the Trust's policy was not to publish draft documents. The documents will be published in due course. She stated that the financial information was already in the public domain and had been published on April 22.

There followed a discussion about the necessity to change the way healthcare is delivered and concentrate more on preventative work in order to meet the financial challenges.

50/16 **Interim Chairman's Report**
Mr Burbeck reported that Alan Harrison would be joining the Trust as a Non-Executive Director until the end of November. He was currently deputy Chair at South Warwickshire FT.

Resolved: that
The Board

- Noted the report

51/16 **Interim Chief Executive's Report**
Mr Tidman was pleased to report on the Listening into Action work, which was giving confidence and belief to the staff that they can make a difference. It was launched on 12 May with staff from all areas of the Trust. He agreed to bring the LiA team to the

Trust Board next month to demonstrate the commitment and changes taking place.

He then reported that the West Midlands Clinical Senate has completed its review and he has been informed verbally that the model will be endorsed. He was hopeful that public consultation by the CCGs could commence in the Autumn. However, he stated that the Trust was mindful of the continued fragile nature of some services at the Alexandra Hospital.

The building work at Worcestershire Royal continued with the modules being lifted into place in the previous week. The expanded ED should be open in July.

Mrs Todd was pleased to hear about the Listening in Action work. She asked who was responsible for the GP Unit at Kidderminster. Mr Tidman stated that the CCG had given notice that they wished to reprovide the service and he welcomed the opportunity that local people would be given to state how the service should be provided in the future. He was clear that the CCG was responsible.

Mr Sleigh asked when the report on the mock inspection would be published. Ms Stevens stated that the inspection highlighted some areas for further work, but she was pleased with the result. The Executive Management Team would consider the report and it would be presented to the Quality Governance Committee in July.

Mr Burbeck asked what the communication was for the positive news in relation to Listening into Action. Mrs Thomson confirmed she was using a variety of multimedia outlets including video which has proved very successful at the latest recruitment day.

Resolved: that
The Board,

- Received the assurance within the report
- Noted that a petition in relation to the GP unit at Kidderminster had been received.

52/16 **STRATEGY**

52/16/1 **Trust Control Plan and Priorities for 2016/17**

Ms Smith presented the report. She stated that the document would provide a basis for the communication with staff on the 12 month priorities. Mr Burbeck thanked her for the report which was clear and unambiguous.

Ms Smith agreed to include the 2 week wait as a measure, following a comment from Mr McGinity. She also confirmed that she was working with Mrs Thomson on the communications plan which would involve a leaflet for all staff and a poster campaign.

Mr Howarth asked what the timescale was for the vision and strategy for medicine. Ms Smith confirmed that a draft should be available in 3 months.

Mrs Thomson confirmed to Mr Sleigh that she would be developing communication tools in plain English.

Resolved: that
The Board:-

- Received the Trust Plan for 2016/17, presented as a control plan with an associated performance framework

52/16/2 **Sustainability and Transformation Plan - update**

Ms Smith gave the update in respect of the local plan. She was pleased that the

process was now more iterative and she highlighted the need to develop radical solutions to the complex challenges. The deadline of 30 June had been revised.

Mr Burbeck reported that he had attended the leaders' briefing. He was pleased to see the maturing relationships between the various strategic partners including the third sector.

Mr Tidman advised that the next steps were to ensure that clinicians from all services developed the radical models of care. He confirmed that work was commencing now. He also confirmed that the work would be coproduced with communities. Mr Sleigh emphasised the necessity for analytical and financial expertise to be available for the work required.

Mr Tidman confirmed to Mr McGinity that Mr Burbeck and he had started a dialogue with South Worcestershire about holding a board to board meeting to discuss the commitment for the way forward.

Resolved: that
The Board:-

- Reviewed the progress with the local Sustainability and Transformation Plan

53/16 QUALITY AND PATIENT SAFETY

53/16/1 Quality Governance Committee

The Chair of the Committee, Dr Bill Tunnicliffe presented the report from the Quality Governance Committee (Enclosure E1) and highlighted the key points. Dr Tunnicliffe highlighted the discussion held about the patients waiting for treatment and assured members that harm reviews were being undertaken. He went onto report that whilst HSMR was improving slowly, SHMI was not. Work was taking place with primary care to understand the reasons for this as it will relate to the 30 days post operative period. He also expressed his concern about the uptake of health and safety training and engagement with divisions.

He went onto report on the medicine deep dive and was pleased that the number of open incidents was reducing. Trajectories for getting back on track were presented. A Mortality lead has been appointed for the division and he was hopeful that an improvement would be shown.

Mr McGinity asked for more information in relation to health and safety. Dr Tunnicliffe explained that the divisions have been requested to provide more assurance within their reports to the Committee. Ms Stevens stated that the work with Oxford as the buddy Trust would strengthen divisional governance and review the gaps in assurance. All areas would then be performance managed.

Resolved: that
The Board

- Receive assurance about the implementation of the CQUIN on antimicrobial prescribing
- Note the deep dive report into Medicine division
- Note the report

53/16/2 Quality Account

Ms Stevens thanked HealthWatch for their commentary.

Resolved: that

The Board

- **Approved the Quality Account for 2015/16**
- **Approved the addition of the HealthWatch statement and the External Audit opinion when received**

53/16/3 **Patient Care Improvement Plan**

Ms Smith spoke to the circulated paper which was the latest published version, March 2016. She stated that the report identified the challenged faced by the Trust. She was pleased that extra resources had now been identified to support the programmes as requested by the Strategy and Transformation Committee.

She confirmed that the Improvement Board would be reviewing the progress sat the next meeting in June and she would review the report to the Trust Board.

She was pleased with the improvement shown in urgent care and patient flow. There has been a reduction in length of stay for over 75 year olds as well as the time to initial assessment.

Mrs Todd asked whether the trajectories for avoidable mortality were unrealistic. Mrs Smith confirmed that this would be addressed by the Improvement Board.

Ms Stevens emphasised the importance of staff engagement to improve services and not just capture numbers. Ms Orzel advised that benchmarking was imperative.

Mr Sleigh asked for greater assurance on the achievement of the programmes. He was critical that the frailty work stream concentrated on patients over the age of 75 when many stranded patients were in fact below this age. He also expressed a desire for the work stream to be called patients with comorbidities. Ms Orzel confirmed that the Trust was using the national definition of stranded patients.

Mr McGinity acknowledged the complex work. He wondered how staff were fully engaged in the work programmes. Ms Smith reminded members that there was publicity planned around the control plan and that each programme would have a one page summary. The communications on successes were also critical.

Resolved: that
The Board

- Received the latest published PCIP report and to support the further actions described to ensure that satisfactory progress is being made.

54/16 WORKFORCE

54/16/1 **Workforce Assurance Group**

Mr Burbeck, Chair of the WAG presented the report (enclosure F1). He reported good progress in recruitment and was pleased that there were clear plans for each medical vacancy. The cost of agency staff was reducing but it was clear that controls are not as tight as they need to be. WAG was assured of the processes involved in the performance management of divisions in this area of work.

Mr McGinity expressed his concern that staff turnover was worsening. He asked for the website to be reviewed in respect of recruitment. Mrs Harnin agreed and stated that a deep dive report into retention would be considered by WAG.

Dr Short confirmed to Mr McGinity that the job plans would be finalised by the end of June. He stated that it was a priority for him to ensure that all consultants had a job

plan for 2016/17 in a timely fashion and that the plans would be on the intranet.

Resolved: that
The Board

- Received assurance on the controls in place to manage nurse agency spend
- Received assurance on the processes in place for medical recruitment
- Noted the position with respect to the introduction of the junior doctors contract
- Noted that the Committee considered the Nursing and Midwifery report and the assurance that this gives
- Noted the assurance in respect of the BAF risks

54/16/2 **Nursing and Midwifery Workforce**

Ms J Stevens, presented the report (enclosure F2). She reported that the recent recruitment day had been a success and that the Trust had run two return to practice campaigns with Health Education England focussing on newly qualified nurses. She was adamant that the Trust needed to improve the offer to staff in respect of career progression. She was very impressed with the calibre of health care assistants and was delighted with the two events taken place in respect of the new band 4 roles.

Mr McEwan stated that at the recent induction session, he had observed that staff were now being recruited due to the training opportunities offered.

Resolved that
The Board received assurance in relation to

- Nursing and Midwifery Workforce metrics and associated actions
- Safe Staffing Status

55/16 **FINANCE AND PERFORMANCE**

55/16/1 **Finance and Performance Committee Report**

Mr Sleigh, Committee Chair, presented the report from the Finance and Performance Committee held on 27 May 2016 (enclosure G1) and highlighted the main points. Mr Sleigh was pleased that the control total had been met. He was also complimentary about the performance management regime now in place.

He expressed concern about the need to deliver £24m savings and requested a cross divisional approach to this.

Resolved that:-
The Board

- Noted the achievement of the planned outturn deficit for 2015/2016.
- Noted that Divisions have plans that deliver much of the planned £24m savings in this financial year, but that focus and cross-Divisional approach will be necessary to reach the target.
- Noted that financial performance in Month 1 was close to budget, but reflected increased cost savings offset by reduced revenue, and that several key performance measures were below target for the month.

55/16/2 **Annual Accounts and Letter of Representation**

Mr H Khan, Deputy Director of Finance, presented the report which had been circulated as enclosure G1. He confirmed that the Audit and Assurance Committee had approved the accounts and the letter of representation on behalf of the Board at its meeting on 1 June. The accounts had been submitted to the Department of Health as required.

Mr Tidman expressed his thanks to the Finance Team in what had been a challenging year.

Resolved that:-
The Board

- Received the Annual Accounts and Annual Audit Letter which were approved by the Audit and Assurance Committee at its meeting on 1 June 2016

55/16/3 **Integrated Performance Report**

Ms Smith presented the report. She reminded members that the Quality Governance Committee and the Finance and Performance Committee scrutinise the respective performance. She stated that the Trust needed to recover its performance and that a significant amount of work was required.

Mr McEwan presented the performance in relation to cancer and RTT. He explained that there had been an increase in referrals to the trust in March and April. The junior doctor strike had also increased the backlog as 7 days' work had been lost during February and March. An added challenge was the Trust's change of policy on paying for additional work outside of core hours.

In respect of the two week standard, 39.4% of people were seen in April within this standard, with the national target being 93%. Whilst this was very disappointing, there were clear signs of improvement. The early June performance was 57.43% which he was hopeful would increase to 75-80% by the end of the month. There were 932 patients who were not seen within the standard in April, and of those, 748 patients did not have cancer. 69 have cancer and are being treated and 115 have an unconfirmed diagnosis.

For those patients with breast symptoms, 111 breaches were not cancer one had cancer and is now being treated. He was hopeful that June 2 week breast performance would be 60%.

He assured members that the backlog has now been cleared. There are currently 195 patients waiting for an appointment and five have waited over two weeks. About 100 are waiting under six days.

Mr McEwan then turned to the controls in place. The daily escalation lists ensure there is the right capacity to ensure that all cancer referrals are seen within 2 weeks. Some patients choose to wait longer than 2 weeks and this factor remains an issue. Cross divisional remedial action is in place. He confirmed that a detailed report would be going to QGC at the next meeting on the harm reviews. All patients who had experienced a delay have a clinically led harm review. No harm has been identified.

He confirmed that he was working with the CCGs to ensure that GPs are aware of the challenges and that they will re-refer patients they are worried about. Individual patients have been contacted by cancer nurse specialists.

Mr McEwan then turned to the 62 day cancer standard: He was hopeful that from July onwards, 85% would be achievable. The current backlog was that 122 patients had an unconfirmed diagnosis and a number of these were waiting for endoscopy. The Trust is using the independent sector to see these people as quickly as possible.

The main specialities with the challenges are urology and colorectal.

Mr Tidman reflected on the lessons learnt during the previous few weeks. He referred

to the data on page 11 which shows a huge rise in the number of referrals. He stated that the Trust should have invested in more clinical staff to manage the patients rather than rely on current staff working longer hours, which is only ever an interim measure. He was keen to develop a sustainable process to manage the referrals. Mr McEwan added that the Trust should have undertaken more outpatient procedures and cancer should have been prioritised over the routine outpatient referrals.

Mr McEwan completed his presentation by stating that the Trust would deliver the target consistently from September.

Mrs Todd asked why the trajectories for 2 week wait for all cancers and breast cancer showed 'red' at the end of the year. Ms Smith explained that the 12 month year end figure would be below target but the month by month target would show that it had been met. Mrs Todd expressed her concern that whilst no physical harm may have taken place with the delays, there would have been significant psychological harm.

In response to Mr Sleigh, Mr McEwan confirmed that the role of the Finance and Performance committee was to review performance; QGC to review quality and WAG to review workforce in relation to the targets.

Mr McGinity expressed his surprise and concern about the theatre data quality issues. Mr McEwan stated that there had been problems with the theatre computer system but he outlined some work being undertaken independently to improve performance within theatres. He expected this to show results within 12 weeks.

Mr McGinity was very concerned to see that the metrics around hip fractures were not improving. Dr Short acknowledged this and confirmed that the PCIP on avoidable mortality outlined the actions being taken. He was confident that county wide working would see an improvement in the metric.

Mr McGinity then turned to diagnostics. He asked whether the Trust would be employing locum radiologists. Mr McEwan confirmed the arrangements in place to recover the metric. However he stated that there was a national shortage of endoscopy capacity which remained a significant risk to the Trust.

Mr Sleigh stated that the control of discharges was poor. Whilst there were clearly issues accessing out of hospital capacity, the Trust was also at fault for many of the stranded patients. Mr McEwan referred to the latest report from the Emergency Care Improvement Programme (ECIP) which showed metrics were improving. Ms Stevens reinforced the work being undertaken to improve discharge which included bespoke work with ward leaders. She understood Mr Sleigh's frustration, and stated that he would see improvements in due course.

Mr Tidman confirmed the improvements being seen. He stated that as a Trust changes are taking place. Changes are being instigated at the front door to prevent admissions and he was working with partners to review the systemic issues causing the increase in emergency demand. He also referred to the Listening in Action work which was ensuring more patients could get home before lunch

Resolved that the Board

- Reviewed the Integrated Performance Report for April 2016; the key performance issues and the mitigating actions.

Ms Orzel left meeting

55/16/4 **Financial Performance Report**

The Deputy Director of Finance, Mr H Khan, presented the financial performance report (Enclosure H2) and highlighted the main points. He reported that month one was in line with the plan. Income was down due to the performance issues already highlighted and there had been fines levied as well. There was a better grip on agency expenditure. Of the £24.3m savings, £10m had been made and there was £7m planned. The gap of £7m related to the theatre improvement project and further reductions in medical agency. Key for financial success was delivering the planned performance.

Ms Orzel returned to the meeting.

Mrs Todd asked what the position was in respect of fines. Mr Tidman confirmed that the initial guidance in respect of receipt of STP monies was that the CCG fines regime for key STF trajectories would be suspended. He was seeking advice from NHS Improvement and NHS England on that point.

In response to Mr McGinity, Mr Khan stated that there was a risk to £3m of the £24m savings required. This was in respect of medical agency costs.

Resolved that:-
The Board:-

- Reviewed and considered the Trust's financial performance in month 12 and its final position for the 2015/16 financial year.

55/16/5 **Sustainable Development Plan (2016 update)**

Mr Tidman welcomed the update which showed that estates and procurement had worked hard to develop the Trust's approach to sustainable development. He stated that the executives would now consider other schemes in the light of the reduced capital available. Proposals would be with the Finance and Performance Committee in September.

Resolved that:-
The Board supported the following actions:-

- Estates to work with Procurement to ensure the procurement process within the Trust embed a best value approach to all procurement activities.
- The Estates Project Team to present to the F&P Committee within 3 months, outline plans to proceed with energy centre improvements across the Trust and seek Salix funding for the project.
- The Estates Dept will (subject to funding) review the metering strategy across the Trust; better monitoring can yield 10 to 15% savings on consumption of utilities through identification and elimination of avoidable waste.
- Reset the Trust Carbon Reduction Target in line with the NHS target for 2020. Previous Target was 10 % reduction by 2015 based on 2007 emissions level. The Trust achieved a reduction of 4% taking a "business as usual" approach. The target from the 2008 Climate Change act is 34% reduction by 2020 with 1990 as the base year. The prediction is that 9.8% is deliverable with a business as usual approach. To achieve a further 24.2 % will require significant capital investment. The strategy documents shall be updated to reflect these changes. These will manifest significant revenue savings against the Carbon Climate Change Levy (CCL).
- Roll out of the Trust's approach to sustainable development and carbon emissions reduction includes training and staff awareness initiatives. Modest, investments in this area as with procurement services has great potential for unforeseen cost savings and will provide the motivating actions necessary to deliver the 2020

target.

56/16	**GOVERNANCE**
56/16/1	**Audit and Assurance Committee Report**

Mr Sleigh highlighted the annual report on claims management. He expressed concern about the number of claims not linked to investigations already undertaken. He was pleased with the work being undertaken on risk. He reported that he Head of Internal Audit opinion was of limited assurance which was not a surprise given the performance and financial issues experienced in 2015/16, and that the extra grip being put in place towards the end of the year had been recognised by the Trust's Auditors.

Resolved that:-
The Board:

- Approved the membership of the Audit Panel
- Received assurance in relation to the management of claims
- Received assurance in relation to the management of risk
- Noted the receipt of the Whistleblowing annual report
- Noted the Committee Annual Report
- Noted the Gift and Hospitality register for 2015/16
- Noted the report

DATE OF NEXT MEETING
The next Trust Board meeting will be held on Wednesday 6 July at 12 noon in the Charles Hastings Education Centre, Worcestershire Royal Hospital.

The meeting closed at 12:30 hours.

Signed _____ **Date** _____
John Burbeck, Acting Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT 6 JULY 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
9-9-15	CEO report	116/15	Baseline assessment and audit for seven days services	RM	Mar 2016	May 2016 June 2016 July 2016	Executive Team developing a proposal on 7-day services for discussion at the May Board meeting. The Interim COO agreed to circulate the baseline audit undertaken which set out the services already being provided 7 days a week. May update: Baseline audit undertaken. Benchmarked data available mid-May. Report to TB in June with benchmarked data. Benchmarked data not available. Deferred to July. To be presented to QGC - July	
8-6-16	CEO report	51/16	Present LIA at next TB	CT/LT	June 2016		On agenda	

8-6-16	WAG report	54/16/1	Deep dive on turnover	DH			Transferred to WAG	
8-6-16	IPR	55/16/3	Harm review to QGC	RM			Transferred to QGC	
8-6-16	Sustainable Development	55/16/5	Report to F&P in September	CT			Transferred to F&P	

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc C1**

Report to Trust Board (in public)

Title	**Chairman's Action**
Sponsoring Director	**John Burbeck** **Interim Chair**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Board is requested to note and endorse the Chairman's Action taken on 16 June 2016
Previously considered by	Not applicable

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

Related Board Assurance Framework Entries	2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability
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 3 year period.
Glossary	

Key Messages

The Trust received notification from NHS Improvement in respect of a revised control total that requires a £3.7m improvement on the current planned deficit of £51.4m. A decision was required whether to accept this revised control total by midday on 16 June 2016.

I consulted with the Vice Chair, Bryan McGinity.

It was clear that if the Trust agreed to the control total, then:

- The conditions and access to the STF will be backdated to April 2016.
- The Trust will get access to the £13.1m STF and will be able to access the targeted element of the STF to support transformation.
- The Trust will need to hit our quarterly financial bottom line to get access to the STF.
- The commissioners will no longer be able to fine the Trust for the following: RTT, 52 week waits, diagnostics, 62 day cancer, A&E 4 hrs and ambulance handovers. Fines can still be incurred for cancer 2ww..
- The Trust would risk losing some of the STF for the relevant quarter if we do not hit the agreed trajectories for the above indicators.

Title of report	Chairman's Action
Name of director	John Burbeck

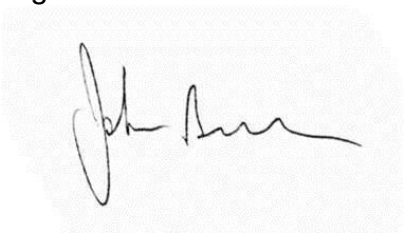
- A further £3.7m savings is required taking the total savings required for 2016/17 to 6.4% of gross cost (£28m).

If the Trust had not agreed to the revised control total, access to the targeted element of STF would be restricted. Applications for the capital loans may not be viewed favourably.

I also discussed the revised total with the Interim Chief Executive and Interim Director of Finance. I noted that they had plans for reductions in spending that would cover the £3.7m additional savings. On that basis and because it brought an additional £13.1m into the Trust I agreed that we should accept the revised control total.

I am recommending that the Board notes and endorsed the action I took on 16 June.

Signed:



Date: 16 June 2016

Title of report	Chairman's Action
Name of director	John Burbeck

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc D1**

Report to Trust Board (in public)

Title	**Future of Acute Hospital Services in Worcestershire (FoAHSW) Clinical Senate Report**
Sponsoring Director	**Chris Tidman, Interim CEO**
Author	**Lucy Noon, FoAHSW Programme Director**
Action Required	The Trust Board is requested to note this report.
Previously considered by	*N/A*

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

Related Board Assurance Framework Entries	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
Legal Implications or Regulatory requirements	
Glossary	

Key Messages

The Future of Acute Hospital Services in Worcestershire Programme was established in January 2012 to identify a sustainable clinical model for the future of acute hospital services in Worcestershire.

West Midlands Clinical Senate review of the proposed Clinical Model

The West Midlands Clinical Senate (WMCS) has approved the clinical model for acute hospital services in Worcestershire put forward by the Future of Acute Hospital Services in Worcestershire Programme Board. The WMCS report is attached for information and is also available on the FOAHSW Programme website, the WMCS website and the three CCG websites.

Approval by the West Midlands Clinical Senate is a critical step for the Programme and allows it to progress to the next stage, assurance by NHS England.

The main proposed changes to services in the proposed clinical model of care are:

- Separation of emergency and planned care to improve outcomes and patient experience
- Creation of centres of excellence for planned surgery
- Urgent care centre for adults and children at the Alexandra Hospital
- A&E remaining at the Alexandra Hospital (adult only) with robust

arrangements for managing a seriously sick child if they arrive unexpectedly or their condition deteriorates and they need an inpatient stay in hospital

- Centralisation of inpatient care for children at Worcester with the majority of children's care remaining local
- Centralisation of consultant-led births at Worcester with ante-natal and post-natal care remaining local
- Centralisation of emergency surgery

NHS England Assurance

The clinical model and the pre-consultation business case which underpins it, will now be submitted to NHS England for assurance. NHS England will confirm if the model is financially and clinically sustainable. The clinical model will be put out to public consultation once assurance from NHS England has been received.

West Midlands Clinical Senate

Future of Acute Hospital Services in Worcestershire - **Stage 2 Clinical Assurance Review Panel Final Report**

Future of Acute Hospital Services in Worcestershire – Stage 2 Clinical Assurance Panel Report

Version number: 1.0

Approved: June 2016

Date of Publication: June 2016

Prepared by: West Midlands Clinical Senate

Classification: OFFICIAL

Contents

Foreword by: Panel Chair, Dr Helen Carter

Worcestershire, like many other health economies across the country, is having to transform whilst continuing to provide care to meet the increasing needs and demands of the local population. The case for change has been well made elsewhere and this report does not intend to duplicate or re-visit this.

The first Senate review Panel that I chaired in 2015 supported the recommendation from the 2014 Independent Clinical Review Panel that some form of Emergency Department provision was required to remain at the Alexandra Hospital site and this position remains unchanged. The detail of the previous model reviewed in 2015 highlighted concerns specifically relating to: patient safety risks, staffing levels, public behaviours, care of paediatric emergencies and the lack of frontline clinical support for the model.

The Panel would like to acknowledge that a significant amount of change has occurred in the last ten months since the first review in terms of changes to senior personnel and the movement of some services from the Alexandra Hospital site to the Worcestershire Royal Hospital site due to patient safety thresholds being exceeded.

I would like to commend this health economy in terms of the progress that has been made since our first Panel assurance review in 2015. Tremendous efforts have been made to address the previous deficiencies in clinical engagement. The Panel accepts that not everyone will agree with the proposals but there has been a large shift in culture within this Provider and across the wider health economy. My 'ask' as chair of the Panel during this second review was to try to determine of the clinicians who did not support the proposed changes and whether this was because they had concerns regarding patient safety or was their lack of support due to other reasons. This was often a difficult task to undertake. Where potential patient safety concerns were raised we developed key lines of enquiry and sought additional assurance from the Programme Board to address these. We would like to thank all of the staff that we met during our site visit and again commend them for their candour and courage in speaking out and voicing their views and opinions.

We would like also to acknowledge the impact that the uncertainty of the future configuration of these hospitals is having upon staff morale, recruitment and retention. We hope that this report, alongside the future Sustainability and Transformation Plans, will provide some clarity and certainty to staff.

The Panel identified many questions outside of the scope of the terms of reference for this review. We agreed to include these within an appendix so that although the Panel is not making any recommendations based upon these discussions, their inclusion gives an indication of the amount of detail and challenge that was covered during this second review.

Finally, I would like to thank the Panel members for their contributions to this review. Many Panel members travelled considerable distances from outside of the West Midlands to participate and support this review. Where they were unable to join the discussions in person, they still dedicated significant amounts of time to reviewing

documents, developing key lines of enquiry and contributing to the development of the recommendations and advice.

1 Senate Chair Summary and Recommendations – Dr David Hegarty

Commissioners and providers across many health economies are faced with ever increasing demands for health care and wide ranging challenges with respect to the most appropriate delivery and location of service provision. As a result of these ever increasing complexities of health care delivery, many health economies are undertaking large scale reviews of the health care services they currently provide and how they might be better optimised within an ever challenging financial envelope. The need to re-configure service provision is often seen as the most appropriate way forward and this very same set of challenges is ever present within the Worcestershire Health Economy.

Faced with these significant set of challenging scenarios the West Midlands Clinical Senate was asked by the NHS England Arden, Herefordshire and Worcestershire Area Team in 2015 to undertake a Stage 2 Clinical Assurance Review of the Summary Model of Care, which had been developed through the Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme. Assurance was sought to assess the clinical quality, safety and sustainability of the proposed model of care. The findings of this first review did not support some aspects of the proposed clinical model and the health economy has been working to address this and requested a second Panel review in February 2016. This second review focused upon the main recommendations made from the first review and was requested by the sponsoring organisations of NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG, on behalf of the FoAHSW Programme Board.

The Panel of external clinical experts that was established to undertake this additional review, wherever possible, included many of the members that took part in the first review to provide some consistency and “memory” within the process. During the three panel review days much documentary, PowerPoint and verbal evidence was presented to the Panel, and discussions were held with a number of key stakeholders in order to allow the Panel to consider the clinical model against the key criteria, including the need to provide high-quality, safe and sustainable care for the population of Worcestershire, both now and in the future. Day two was spent visiting both sites at the Alexandra Hospital (AH) in Redditch and the Worcestershire Royal Hospital (WRH) and was found to be very beneficial for the panel in preparation for day three.

It is extremely encouraging to hear about the very significant progress that has been made by this health economy since the last review was undertaken. Great strides have been evidenced with respect to clinical engagement and buy-in to the proposed model across much of the clinical community. Whilst it is always difficult to gain full support from all staff it is assuring to see staff from both hospital sites embracing the proposed changes and the efforts from both the management team and clinical teams and their level of commitment to the safe care of patients as exemplified by

the relocation of some services from the Alexandra site to the Worcestershire Royal Site on the basis of recent patient safety thresholds.

I would like to thank the Panel members for their expertise and insight in undertaking the review and their many and varied contributions either in person or remotely and of course to the final report. I would like to thank the various organisations, including the Trust, commissioners and other members of the FoAHSW Programme Board and, in particular, I would like to thank the individual clinicians and managers who contributed to this formal assurance process.

1.1 Summary

The West Midlands Clinical Senate was asked by the NHS England Arden, Herefordshire and Worcestershire Area Team in 2015 to undertake a Stage 2 Clinical Assurance Review of the Summary Model of Care, which had been developed through the Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme, prior to public consultation. This first review did not support some aspects of the proposed clinical model and the health economy has been working to address this and requested a second Panel review in February 2016. This second review focuses upon the main recommendations made from the first review and was requested by the sponsoring organisations (NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG), on behalf of the FoAHSW Programme Board.

The West Midlands Clinical Senate established a Panel of external clinical experts to review the proposed clinical model, many of whom had been members of the first panel review to provide some consistency with the process. Three panel review days were held between April 2016 and May 2016. Documentary, PowerPoint and verbal evidence was presented to the Panel, and discussions were held with a number of key stakeholders in order to allow the Panel to consider the clinical model against a number of key criteria, including the need to provide high-quality, safe and sustainable care for the population of Worcestershire, both now and in the future. Day two was spent visiting both sites at the Alexandra Hospital (AH) in Redditch and the Worcestershire Royal Hospital (WRH).

The Panel was asked to make recommendations to the West Midlands Clinical Senate on whether to support the evolved model.

These recommendations are summarised below.

1.2 Recommendations

Recommendation from June 2015 first Panel review	Summary of recommendation from second Panel review May 2016
The Panel recommends that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at Worcestershire Royal Hospital in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.	The Panel concluded this recommendation has been addressed. The evidence presented included the current activity modelling, development of a consultant-led paediatric assessment unit at the WRH site to improve triage, assessment and observation and to reduce length of stay with increasing the provision of care in the community
The Panel has a number of concerns with the detail of the model of Emergency Medicine at Alexandra Hospital with respect to patient safety	The Panel concluded that this recommendation has been met. The Panel now approves the model of emergency care for the AH site based upon the evidence presented including greater clarity of vision regarding the practicalities of the model, the proposed staffing levels and skill mix and frontline clinical support for the model. The Panel made recommendations regarding future Consultant workforce levels and the need for clarity regarding the difference between the Emergency Medicine Department and the co-located Urgent Care Centre specifically with respect to paediatrics
The Panel strongly recommends that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when.	The Panel concluded that this recommendation has been addressed and was appropriate for this stage of development of the model. Even so, the Panel continued to have concerns regarding public behaviour that it believed would need to be addressed during the wider consultation and public engagement phases of development.
The Panel recommends that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability.	The Panel conclude that this recommendation has been addressed. Outside of the ToR relating to the model of Emergency Medicine provision at the AH, the Panel heard evidence from the acute medical consultants at the AH and recommends that further engagement work is done with this group to address their patient safety concerns.

2 Background

2.1 Geographical Background

There are three Clinical Commissioning Groups (CCGs) within Worcestershire, reflecting the natural, geographic communities across Wyre Forest, Redditch and Bromsgrove, and South Worcestershire. Acute hospital services are provided by the Worcestershire Acute Hospitals NHS Trust (WAHT) at Worcestershire Royal Hospital (WRH), the Alexandra Hospital (AH) in Redditch, and Kidderminster Hospital and Treatment Centre (KHTC). In addition, Worcestershire Health and Care NHS Trust provide four community hospitals with Minor Injuries Units (MIUs).

WAHT provides a wide range of services to a population of more than 550,000 within Worcestershire (WAHT 2015). In addition, WAHT also provides services for residents of South Birmingham, Warwickshire, Shropshire, Herefordshire and Gloucestershire.

2.2 Scope and Limitations of Review

This is the second stage 2 assurance review that has been conducted by the West Midlands Clinical Senate on this health economy and this report should be read in conjunction with the first Panel review from June 2015:

http://www.wmscnsenate.nhs.uk/files/8414/3402/0262/WMCS_Final_The_Future_of_Acute_Hospital_Services_in_Worcestershire_Review_-_Version_4.0.pdf

The terms of reference (ToR) were refined to focus upon the main recommendations made during the first Panel review.

The decision was taken deliberately not to undertake this as solely a table top review. The site visit on day 2 was retained so that the Panel could hear directly the views of frontline staff regarding their views of the proposed model.

2.3 Limitations

To meet the challenging timescales it was noted in advance that the site visit was on the day after a Bank Holiday and that during the previous week the junior doctors had been on strike for 2 days and thus the activity levels in the Emergency Departments may not have reflected usual increased levels of activity.

No further specific limitations relating to the review were identified beyond its original terms of reference.

3 Methodology of the Review

The role of the Panel was to examine a significant amount of documentary evidence in advance of the first day, develop key lines of enquiry and discuss these with representatives from the health economy: Provider, Programme Board, Healthwatch and CCGs. The Panel was tasked to explore and challenge the proposed model from its respective areas of clinical expertise and then reach a consensus, draw conclusions and make recommendations. Where clinical guidance exists, this

informed the discussions and, where this was not available, a clinical opinion was given, thus adopting an evidenced based approach wherever possible.

The West Midlands Clinical Senate acknowledges that the sponsoring organisations (NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG), have undergone a first and second stage assurance review as a component of the NHS England assurance process and is now ready to undertake a second 2(b) stage assurance external expert review as part of the FoAHSW review programme (see **Appendix 1:4** NHS England Assurance process).

The 2(b) assurance review will be carried out in line with the key tests and an appropriate selection of best practice checks as a component of the NHS England final assurance process.

3.1 Terms of Reference

The ToR for this review were developed in partnership between the Senate and the FoAHSW Programme Board and reflected the main recommendations made following on from the first Senate Panel review held in June 2015.

In summary the ToR were for the Panel to re-assess the clinical quality, safety and sustainability of the redeveloped Summary Model for Emergency Care, against the recommendations made in the final report of the West Midlands Clinical Senate review, published on 11th June 2015, and to ensure that the suggested changes would not compromise interdependencies with other parts of the model which have already been successfully reviewed.

It was acknowledged that some temporary emergency changes to the current clinical model had been undertaken since June 2015 due to clinical patient safety triggers having been breached. These were made explicit to the Panel prior to day 1, for example the relocation of neonatal and obstetric services from the Alexandra Hospital site to the Worcestershire Royal site.

The Panel was required to assess the clinical quality, safety and sustainability of the clinical model(s) prior to public consultation. The Terms of Reference for the review were developed as per NHS England guidance (see **Appendix 1:4**).

3.2 Objectives

The Independent Clinical Review Panel will:

a) Review and re-assess the redeveloped clinical model for Emergency Care against the recommended criteria set out in the FINAL report of the West Midlands Clinical Senate review, June 2015 (full recommendations are available in **Appendix 1:3**):

Recommendation number	Recommendations from FINAL report of WMCS (June 2015)	
1: Obstetrics and Gynaecology and Emergency Surgery	The Panel supports the proposals set out within the Summary Model of Care to reconfigure the Obstetrics and Gynaecology and Emergency Surgery services through transferring these from Alexandra Hospital and Consolidating them onto the Worcestershire Royal Hospital site.	Recommendation previously supported by the West Midlands Clinical Senate (WMCS) and therefore this element of the model is out with the scope of this WMCS review.
2: Inpatient Paediatrics	The Panel recommends that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at Worcestershire Royal Hospital in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.	This would need to include: 1. A clear plan and risk assessment of the likely shortfall of paediatric nursing recruitment at the WRH site 2. The expansion of car Parking / park and ride provision at WRH to cope with the increased Demands of those travelling by car from Redditch and Bromsgrove.
3: Urgent Medical Care	The Panel has a number of concerns with the detail of the model of Emergency Medicine at Alexandra Hospital with respect to patient safety	These concerns relate to issues of: 1. Sustainable staffing, with a national shortage of Emergency Department (ED) Consultants, middle grades and the potential for trainees to be removed from the AH site 2. Public and staff misunderstanding of the model of Emergency Medical Care at AH (see also Recommendation 4, below) 3. Increased clinical risk arising from the removal of key services from AH aligned to the management of emergency care, including Inpatient Paediatrics and Emergency Surgery - and their further critical interdependencies with other clinical specialties, including Anaesthetics and Critical Care.

4: Urgent Medical Care for Children at AH	The Panel strongly recommends that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when.	This should include: 1. Making absolutely explicit the extent and remit of urgent/emergency paediatric cover 2. Having a clear plan for dealing with paediatric emergency presentations at AH out of hours 3. Undertaking a full risk assessment in respect of any proposals for paediatric emergency provision that are less than 24/7 4. A detailed consideration of how seriously unwell children presenting at the AH site, who do not meet critical care transport team criteria, will be safely transferred to the WRH site. This should encompass personnel, equipment and transport logistics.
5: Engagement and Co-ownership from Frontline Clinical Workforce	The Panel recommends that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability.	

b) Consider the final clinical model for Emergency Care prior to public consultation against the above criteria and make recommendations on whether to support the model to the West Midlands Clinical Senate Council and thereafter to the FoAHSW Programme Board and sponsoring organisations.

3.3 Process

The West Midlands Clinical Senate collated advice between February-April 2016, assisted by an Independent Clinical Review Team (known as the Panel within this report). This Panel included members from professional groups with specific knowledge and expertise in those areas on which the Clinical Senate had been asked to provide advice. To ensure any advice given was robust, transparent and credible. The Panel included clinical experts from outside the West Midlands area where possible (see **Table 1** and **Appendix 1**).

It was agreed with the FoAHSW Programme Board that, in order to provide some continuity in the review process, it would be beneficial to try to use as many of the Panel members from the first Panel in 2015 for this review. Where this was not

possible, new Panel members were recruited from across the country and these new Panel members had pre-review briefings with the Panel chair in advance of day 1.

A confidentiality agreement was signed by all Panel members and any potential conflicts and associations were declared during the process. These are recorded in **Appendix 1:2**.

Panel review dates were held on 21st April, 3rd May and 16th May 2016 (see **Appendices 4-6**). The Panel reviewed documentation provided by the FoAHSW Programme Board and heard presentations from individual members of the FoAHSW Programme Board and key stakeholders including Healthwatch. During Day 2 of the Review, on 3rd May 2016, Panel members undertook site visits to WRH and AH, touring relevant clinical areas.

Where Panel members were unable to attend in person, they reviewed all of the documentation remotely and submitted questions and these were then addressed by the FoAHSW Programme Board.

Table 1

Independent Clinical Review Team

Name	Position	Organisation
Dr Helen Carter Chair	Deputy Director of Healthcare Public Health and Workforce	Public Health England, West Midlands
Prof Guy Daly Vice Chair	Executive Dean of the Faculty of Health and Life Sciences	Coventry University

Members:

Name	Position	Organisation
Dr Rashid Sohail	Deputy Medical Director	East Midlands Ambulance Service
Mr Keith Spurr	Patient and Public Representative	East Midlands Strategic Clinical Network and Senate
Dr Peter Marc -Fortune	Consultant Paediatric Intensivist	Central Manchester University Hospital
Prof Ian Greaves	Professor in Emergency Medicine	South Tees Hospitals NHS Foundation Trust
Mr Athur Harikrishnan	General and Colorectal Surgeon	Sheffield Teaching Hospital NHS Foundation Trust
Prof Edward Davis	Orthopaedic Surgeon	The Royal Orthopaedic Hospital, Birmingham
Dr Helen Hurst	Advanced Nurse Practitioner	Manchester Royal Infirmary
Dr Andrew Phillips	General Practitioner	NHS Vale of York CCG

Mr Peter Sedman	General Surgeon	Hull Royal infirmary
Mr Duncan Learmonth	Orthopaedic Surgeon	The Priory Birmingham
Dr Jackie McLennan	Senior Emergency Medicine Consultant	Manchester
Dr Richard Elliott	Consultant Anaesthetist	Royal Derby Hospital
In attendance		
Rob Wilson	Interim Associate Director	West Midlands SCN and Clinical Senate
Kate Burley	Network Manager	West Midlands SCN and Clinical Senate
Karen Edwards	Clinical Senate PA	West Midlands SCN and Clinical Senate
Rachel Knowles	Clinical Senate Admin Support	West Midlands SCN and Clinical Senate

4 Description of Current Service Model

WAHT provides a wide range of services to a population of more than 550,000 within Worcestershire. Patients are also served from neighbouring areas including: South Birmingham, Warwickshire, Shropshire, Herefordshire and Gloucestershire.

WAHT currently provides services from three main hospital sites:

- Alexandra Hospital (AH) in Redditch;
- Kidderminster Hospital and Treatment Centre (KHTC) in Kidderminster; and
- Worcestershire Royal Hospital (WRH).

In light of its performance challenges, national planning requirements and local commissioning intentions, WAHT recognised the need to 'develop and sustain business as a key strategic priority within its 2013/14 Annual Plan and this remains a current strategic goal within the Trust's Integrated Business Plan 2014/15 – 2018/19. This objective served to focus the Trust on meeting the growing demand for its services while securing a long-term clinical services strategy for the delivery of acute care across its hospital sites. The Trust's Clinical Services Strategy is aimed at supporting the delivery of high-quality care across its services, securing increased levels of efficiency through service redesign, better working practices and the application of best clinical evidence.

The need for change from the current model of care provided by WAHT was highlighted in the strategic themes that emerged from the Clinical Services Strategy. Clinicians at the Trust focused on the need to configure acute services at WAHT in such a way as to:

- Deliver consistently high-quality, safe services
- Overcome medical and nursing workforce challenges in delivering 24/7 specialist care
- Ensure services have the right capacity to meet future demand

- Improve clinical productivity and effectiveness
- Ensure critical clinical adjacencies are secured
- Establish a clinical configuration of services that supports other key strategic initiatives of the trust

In 2015 WRH and AH provided a full range of general and acute hospital services as well as some tertiary services, with Kidderminster offering a 24-hour nurse-led treatment centre and a full range of diagnostic, day-case surgery and ambulatory services.

This Provider Trust was placed into Special measures in December 2015. As a result of this there has been a significant change in senior management and additional external expert support including buddying arrangements to support them to stabilise their current levels of service provision.

During 2015-2016 due to pre-identified patient safety triggers being breached there have been some changes to the current model of service provision between the 2 hospital sites as summarised below:

- neonatal and obstetric services were moved from the AH to the WRH site
- elective abdominal surgery moved from the WRH to the AH site
- the majority of cold elective orthopaedic surgery is moving from the WRH to the AH
- the Clinical Navigation unit at the AH had closed in March 2016 as a result of a commissioning decision

Additionally, Worcestershire Health and Care NHS Trust operates some services from four local community hospitals: Princess of Wales Community Hospital in Bromsgrove, Tenbury Community Hospital, Evesham Community Hospital and Malvern Community Hospital. The services provided at these community hospitals did not form part of the Stage 2 assurance review process.

5 The Case for Change

5.1 The Case for Change

The Worcestershire health economy has been facing the same challenges as many health economies across the country and it has been recognised that there is a need to make some changes in the way that services are delivered to ensure that services are safe and sustainable in the future. This existing work will dovetail into the future Sustainability and Transformation Plans for Herefordshire and Worcestershire that will attempt to redress the triple aim of reducing the gaps for: quality, finances and health and wellbeing.

Similar to the first Panel review in 2015 it was necessary to highlight the process that led to the development of the original 13 options, the subsequent development of the two options that had been presented for review by the ICRP, and the final development of the modified version of Option 1, which the West Midlands Clinical Senate has been tasked to review.

Worcestershire clinicians developed the Case for Change (2014) with involvement from providers, commissioners (initially NHS Worcestershire and, subsequently, the three Worcestershire CCGs), representatives of patient groups and the public as a result of safety concerns relating to a number of services within Worcestershire Acute Hospitals Trust (WAHT). It built upon the Case for Change (2012) set out in the Joint Services Review (JSR) established in January 2012 and that ran until April 2013. It was updated to include the information that has become available since the JSR was replaced by the FoAHSW programme in September 2013, as well as taking into account the recommendations of the Independent Clinical Review Panel, which reported in January 2014.

The detail outlining the case for change for specific specialities (surgery and orthopaedics, emergency care, obstetrics and paediatrics) was described fully in the first Panel review published in 2015 and will not be replicated in this document.
The Panel was of the view that a clear and compelling case for change had already been made, based on sound evidence presented to it on current performance, improvements seen in other regions by reconfiguration of services within multi-site Trusts, the potential long-term benefits, and alignment with national NHS strategy.

Since the first Panel review in 2015 significant progress has been made by this health economy in terms of progressing the vision, detail and clinical engagement for the future models of emergency care at the AH. Two main task and finish groups (Urgent Care and Women and Children) were established with external, senior and experienced chairs. There has also been greater clinical ownership of developing new models as evidenced by the anaesthetists and the maternity and paediatric divisions.

The Panel noted in advance of the review commencing that the proposed future model of care had been approved by all 3 CCG Governing bodies.

6 Summary of Day 1

At the start of this second review the Panel was reminded by the chair of the agreed Terms of Reference. The Panel was specifically asked to review:

- Inpatient paediatrics-including the plans for managing additional capacity at the Worcestershire Royal site when paediatric inpatient moves there from the AH site
- To explore in detail the proposed model of urgent medical care at the Alexandra Hospital site and specifically the care of paediatric patients and the level of frontline clinical support for the model
- To explore the level of clinical engagement and co-ownership

The Panel was briefed upon the key changes that had taken place since the first review including the changes in a significant number of senior staff and the re-location of maternity services from the Alexandra Hospital site to the Worcestershire Royal site due to patient safety triggers having been breached.

The chair tasked the Panel to consider what level of evidence they would like to review to be provided with assurance that the proposed model was safe and in

addition where there was not frontline clinical support to ask questions to understand the reasons for this.

Following the review of the evidence and from the pre-meeting, the following key lines of enquiry were developed by the Panel:

- Clinical support for the model: the Panel was impressed with the level of transparency of the evidence provided to it including the summary of all of the individual comments made by frontline staff during engagement events. The Panel specifically wanted to explore further nursing and allied health professional staff engagement and support. Also the Panel requested more detail regarding the concerns that were being articulated by the acute medical consultants from the Alexandra Hospital site although accepted this would be addressed during the site visit on day 2
- Patient and public behaviours-what lessons had been learnt following the movement of maternity services from the Alexandra Hospital to the Worcestershire Royal site? Does this have any implications for the proposed future model?
- What progress had been made on the transport links between sites for public and staff? A transport impact assessment had been undertaken but it was requested that there was further exploration of this
- To explore further the symbiotic relationship between the two hospital sites and explore further what county wide working may look like in practice
- What is the capacity at the Worcestershire Royal site: both in terms of the ED department and the implications from the new model at the Alexandra site but also inpatient paediatrics
- Transport: explore if any changes had been identified regarding the impacts for West Midlands Ambulance Service (WMAS)- it was noted that during the first Panel review WMAS has presented on the impacts of the service configuration changes on their capacity and WMAS presentation was sent to panel after Day 1 following questions from the panel
- Health Education England support for the model and the placement implications for future junior doctors
- Explore in detail what the model at the Alexandra Hospital is going to be in terms of: the Emergency Medicine Department, staffing levels, skill mix, care of paediatrics and the co-located Urgent Care Centre model.

The Panel heard evidence from a range of individuals representing: the Programme Board, CCGs, Healthwatch Worcestershire, Executives and Divisional Directors from the Provider and key clinicians. The Panel was impressed by the openness and honesty of the Provider and the acceptance that mistakes had been made in developing the first model and much learning had been identified from this.

There was a much greater consensus and clarity of vision regarding the detail of the proposed model for the Emergency Medicine at the Alexandra Hospital site. The Panel supported the proposal that this should be a 16+ only ED department and accepted that mitigations had been developed should a critically ill child be brought in by their carers through having at least one staff member per shift trained in advanced paediatric life support. There was still some clarification sought regarding the consultant and middle grade staffing levels and it was agreed to address this again on day 2 site visit.

The co-located Urgent Care model was still being developed and the Panel recommended that the national model that NHS England were developing should be used to develop this further. Similar to the findings from the first Panel review in 2015, public behaviour and choice were discussed at length and there were still some concerns regarding the Urgent Care Centre and the Emergency Department being co-located, with the former accepting children whilst the latter would not, that required careful messaging with the public.

The feedback from the Panel was that it was very apparent that a huge amount of work had been undertaken over the last nine months and that there had been a fundamental shift in culture and engagement. All of the key lines of enquiry that had been identified in advance by the Panel were addressed satisfactorily and the Panel had a clearer picture of the proposed model for ED at the Alexandra Hospital site.

No significant concerns were identified at the end of the first day and the Panel agreed that the site visit would provide the evidence required regarding frontline clinical engagement and support for the model.

Other key lines of enquiry explored during day 1 are as briefly described below and it is accepted that some of these are outside of the ToR for this review but it was agreed with the Programme Board that it was important that these were included in this report to evidence the breadth of evidence and challenge that was covered during this review:

- Management of acute gastrointestinal haemorrhage in medical patients at the Alexandra Hospital site that then required a surgical review
- Intensive Care Unit capacity at the Alexandra Hospital site and how their model of county wide working operated
- The role of the Worcestershire General Practitioners (GPs) in terms of referring the right patient to the correct site e.g. vascular surgical referrals all going to the Worcestershire Royal site
- Current usage of WMAS protocols e.g. all suspected strokes being sent to the Worcestershire Royal site
- Staffing levels and rota patterns in the Emergency Medicine department and the option of rotating staff between sites to maintain levels of experience and developing a county wide service
- Paediatric consultant led assessment model and the anticipated reduction in overnight stays resulting from this being implemented
- Impact of patient choices on surrounding health economies
- Further details requested regarding the capital development build to increase capacity at the Worcestershire Royal site
- Exploration of the fragility of current service provision for surgery and paediatrics to develop a better understanding of why this had happened, what mitigations had taken place and what impacts this would have upon the proposed model for surgery and paediatrics

7 Summary of Day 2

The Panel was again reminded of the scope of the ToR at the start of the day 2 site visit. The Panel reviewed the evidence from day 1 and the following clinical areas identified for the site visit were:

Alexandra Hospital:

- Emergency Medicine Department
- Critical Care
- One panel member requested to see Theatres at AH on the day of the visits
- Acute Medical Consultants

Worcester Royal Hospital:

- Emergency Medicine Department
- Inpatient Paediatrics
- ITU
- Maternity

The key lines of enquiry identified in advance were:

- To explore in detail the proposed model for emergency care provision at the AH site; including the interdependencies and links to primary care, NHS 111, the Urgent Care Centre and the concept of streaming versus triage
- To explore further the Consultant and middle grade capacity at the AH Emergency Medicine department
- To explore further the AH acute medical consultant concerns
- To explore further the current and planned capacity at the WRH site specifically the Emergency Medicine Department
- To understand better the transport issues: rapid transfers between sites and for staff, patients and the public
- To understand better the review of medical and critical care patients at the AH site by the surgical team (surgical team based at the WRH site).

The following does not capture the full breadth of the discussions that were held between the Panel members and the frontline clinical staff due to the nature of the site visit.

The Panel toured the hospitals in a number of groups and the following is a high level summary of their feedback:

- Critical care: the Panel was very impressed with the county wide model of working that the critical care consultants had developed. There was good rotation between sites and in terms of accessing surgical review at the AH critical care unit no problems were identified. The Panel would encourage other specialities to learn from this culture and model of county wide working
- The Panel agreed that there was much greater clarity of vision and support for the proposed model of care at the AH Emergency Medicine Department from both doctors and nursing staff

- The Panel strongly supported an over-16 years old only treatment policy at the AH Emergency Medicine Department; careful messaging, signage and communication with the public would be required to implement this safely
- The planned co-location at the AH of the Urgent Care Centre with the Emergency Medicine Department, with the former treating children and the latter not, would require careful communication with the public to avoid confusion
- The proposed Urgent Care Centre was still in the planning phase - the service specification was being developed and the Panel encouraged the Programme Board to utilise the national models that are being developed by NHS England as a basis for this
- There was support by the Panel for the move toward developing a model that was based upon functionality rather than historical skill mix
- The Panel acknowledged that plans had been developed to mitigate the risks of a 'once in a blue moon' event of a critically ill child being brought into the department by their carers through investing in training of staff in advanced paediatric life support skills with the rotation through the WRH site to maintain clinical practice and skills
- The Panel noted that currently there were only 4 (+1) ED consultants at the AH site; this is not a sustainable level of cover nor is it providing sufficient levels of consultant presence in the department. The Panel strongly recommended the implementation of the Care Quality Commission (CQC) report (2015) to have 10 ED Consultants per site. However, the Panel appreciated the level of dedication and support from the current ED consultants
- Concerns were raised by a minority of clinicians at the WRH site regarding the proposed model for ED and Urgent Care Centre (UCC) at the AH site, specifically regarding patient safety concerns for the treatment of children. This was agreed by the Panel to be explored further on day 3
- Capacity at the WRH Emergency Medicine Department: the Panel accepted that this was the day after a Bank Holiday and that the level of activity may have been above what is normally experienced but concerns remained regarding capacity within the Department and further details regarding capital investment plans and time scales were requested ahead of day 3
- The elective surgery that had moved from the WRH site to the AH site was reported to be working well with fewer operations cancelled due to improved / better bed capacity at the AH

7.1 Summary of Discussions with the Alexandra Hospital acute medical consultants

The Panel met in private with the acute medical consultants from the AH. There was then a joint session between the Panel, acute medical consultants and representatives from the Programme Board and Trust Management. The rationale for this was to determine whether the concerns that the acute medical consultants had would affect the proposed model for the Emergency Medicine Department at the AH site. In summary, the concerns did not specifically relate to this and hence were outside of the ToR for this review. However, due to the interdependencies with the proposed model it was felt important to reflect the discussions within this report.

The following themes were discussed:

- There was strong support to move to a county-wide model of working across the two hospital sites for acute medicine because the current model was not sustainable
- There was a perception of disengagement between the acute medical consultants and the hospital management and a lack of transparent job planning across sites and as a result the AH medical consultants felt that they were not included in recent job adverts, leading to a feeling of isolation.
- Patient safety: views were expressed regarding current patient safety concerns although the consultants could not provide evidence of an increase in reporting of Serious Incidents or increasing Hospital Standardised Mortality Ratio / Summary Hospital-level Mortality Indicator by speciality or location. They reported that they were all working additional hours to mitigate the risks and that this was not sustainable. The issues underlying this were multiple and included:
    - Workforce capacity and an over reliance on locum and agency staff across all grades of staff including medical consultant, middle grade and nursing. The lack of certainty regarding the future model of care across the two sites was compounding this and affecting staff morale
    - There were delays transferring patients from the AH to the WRH site- not due to transport between sites but due to no bed availability at the WRH site leading to delays in patients receiving the specialist care that was required and inequality of access to service provision resulting from this. This was particularly emphasised with regard to patients admitted to AH who were subsequently diagnosed with stroke or required cardiological intervention.
    - New posts being advertised to a WRH base location rather to a county wide model
- Movement of gastroenterology consultants from the AH to the WRH site: concerns were articulated regarding how the remaining AH consultants would be able to access specialist advice and that the service would no longer be compliant with British Liver guidelines.

The representatives from the Trust and the Programme Board responded to these concerns and agreed that further dedicated work was required with this consultant group. There were some immediate actions that could be put in place to mitigate their concerns for example working with the consultants to develop patient safety escalation triggers for Acute Medicine and utilise these in the Quality and Services Sustainability (QSS) group.

8 Summary of Day 3

The Panel submitted key lines of enquiry ahead of day 3 to the Programme Board and as discussed previously in this report not all of the questions were within the remit of the ToR but for completeness they are contained in **Appendix 7**.

The key themes that emerged from the discussion during day 3 relevant to the ToR were as follows:

- There was acknowledgment and consensus from the Panel in terms of the amount of positive progress that has been made since the previous review across all the recommendations but specifically regarding clinical engagement
- There was strong support for the learning from the development of the county wide model of working that had been developed by the anaesthetists to be cascaded across the organisation
- The detail of the model for the UCC compared to the Emergency Medicine Department: (ED) at the AH site. Clarity was sought by the Panel regarding what this would practically mean for patients arriving at the AH site for example: by ambulance, walk in and GP referrals. It was accepted that the service specification was still being developed by the CCGs and that not all of the detail was available at this stage of development because they had been waiting for the national work to be published. The Panel made some observations regarding progress to date including:
    - Support for streaming rather than a triage based model: if the model relied upon a single triage nurse then this may limit capacity and patient flow through the departments
    - There was the need for a careful review of the clinical procedures proposed to be undertaken in the UCC because with only a limited number of staff some of the procedures could be time consuming and more efficiently carried out in the ED setting
    - The staffing levels for consultant level of cover in the ED should match or exceed the planned level of GP level cover in the UCC i.e. 16 hours per day. The rationale underpinning this is that if the ED consultant cover is provided to mitigate against the impacts of a critically ill child attending the AH UCC then comprehensive data presented shows that paediatric admissions do not decrease until ~ 11pm in the evening (based upon the activity figures that the Panel reviewed after submission by the FoAHSW Programme Board).
    - Consideration of the nomenclature for the UCC to manage public expectations of what can be delivered in this setting and again national guidance may help address this.
- Care of children at the AH in the UCC and ED: this was discussed at length both between the Panel members and with the Programme Board, CCGs and representatives from the Trust. The conclusion was reached by the Panel that this was a pragmatic solution that had been developed to address a complicated issue in terms of children being seen at the UCC but not in the ED at the AH site in the future. The Panel reached a majority agreement that children should not be seen in an ED where there were not any future planned inpatient paediatric facilities, as per the plans for the AH site. The Panel was

only aware of one other ED in the country where this was not the case-all other EDs that accepted children had inpatient paediatric beds. Careful management of public expectations would be required to ensure that children were taken to the right location for the level of care that they required. West Midlands Ambulance Service shared the learning from the protocols that had been developed in other parts of the West Midlands (WM) and this provided reassurance to the Panel that children would be taken to the correct location in a timely manner: including the ability for Paramedics to administer antibiotics in cases of suspected meningococcal meningitis so that delays were not introduced travelling further distances to WRH for children from the Redditch locality. Similarly, for minor ailments where carers had called for an ambulance inappropriately these could be taken to the UCC at the AH site rather than potentially travel further distances to WRH. Careful consideration will need to be taken in identifying which type of cases should go directly to WRH (e.g. deformed fracture or neurovascular complications) and which will go to AH. Impending UCC national guidance may help with this. The Panel felt strongly though that the ED at the AH should continue to make plans to ensure that critically ill children can be treated there although this would not be advertised to the public. This was based upon the clinical experience of the adult only EDs in other parts of the country where occasionally they would have to resuscitate a critically ill child. This could be achieved through: ensuring adequate numbers of staff are trained in advanced paediatric life support but also development of a county wide model of working where middle grade and consultant staff rotate through the WRH or other Providers of paediatric care e.g. Birmingham Children's Hospital to maintain their skills and experience. This was important because it was noted that having undertaken an advanced paediatric life support qualification did not then give an individual the experience and on-going maintenance of skills to lead the full range of care required for treating critically ill children. In addition, it was suggested that the out of hours rota could be developed based around a specific base location to meet the requirement of a 20 min response time to the ED department by the consultant workforce i.e. not all ED consultants would be expected to provide out of hours cover to both sites.

- Consultant staffing levels of the ED departments at both the WRH and AH were discussed: the Panel strongly supports the implementation of the CQC Quality Report (2015) to have 10 ED Consultants on each site to provide and deliver a safe and clinically sustainable model of care
- Impacts of the change in model at the AH on West Midlands Ambulance Service: as noted in the previous Panel report from June 2015 there would be the requirement for additional ambulances to be provided due to increased journey times and transfers between the WRH and AH sites. The Panel accepted that commissioners had been involved with developing this requirement further and agreed that the impacts of this were still relevant. The modelling shows that at least one additional ambulance is required. This ambulance must be in place before any additional transfers due to the reconfiguration commencing or the proposed changes may fail. This could be a rate limiting step.
- Capital build plans at the WRH site: the Panel had concerns regarding the current bed capacity at the WRH site following the site visit on day 2 and the modelling data submitted for review. The Panel felt that the planned reduction

in demand modelling was optimistic. However, details for future capital build plans at the WRH site were discussed and this provided assurances to the Panel regarding where additional bed capacity could be located in the future on this site including additional parking spaces and the park and ride schemes for staff during day light hours. The Panel felt that timely approval and finances would be instrumental in taking this forward.

- Transport for public and staff: it was accepted that further work had been undertaken since the first review and that important lessons had been learnt following the relocation of maternity services from the AH to WRH site i.e. the shuttle bus that was provided was not used and the Trust had not received a single complaint related to transport. The Healthwatch Worcestershire representative provided assurances that work regarding transport was on going with the Local Authority and with approximately 80 different community groups to try to mitigate the transport challenges of this rural locality.

9 Recommendations, Conclusions and Advice

9.1 Recommendations

Recommendation from June 2015 first Panel review	Summary of recommendation from second Panel review May 2016
The Panel recommends that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at Worcestershire Royal Hospital in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.	The Panel concluded this recommendation has been addressed. The evidence presented included the current activity modelling, development of a consultant-led paediatric assessment unit at the WRH site to improve triage, assessment and observation and to reduce length of stay with increasing the provision of care in the community
The Panel has a number of concerns with the detail of the model of Emergency Medicine at Alexandra Hospital with respect to patient safety	The Panel concluded that this recommendation has been met. The Panel now approves the model of emergency care for the AH site based upon the evidence presented including greater clarity of vision regarding the practicalities of the model, the proposed staffing levels and skill mix and frontline clinical support for the model. The Panel made recommendations regarding future Consultant workforce levels and the need for clarity regarding the difference between the Emergency Medicine Department and the co-located Urgent Care Centre specifically with respect to paediatrics
The Panel strongly recommends that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when.	The Panel concluded that this recommendation has been addressed and was appropriate for this stage of development of the model. Even so, the Panel continued to have concerns regarding public behaviour that it believed would need to be addressed during the wider consultation and public engagement phases of development.

The Panel recommends that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability.	The Panel conclude that this recommendation has been addressed. Outside of the ToR relating to the model of Emergency Medicine provision at the AH, the Panel heard evidence from the acute medical consultants at the AH and recommends that further engagement work is done with this group to address their patient safety concerns.

In addition the Panel developed the following recommendation:

- The concerns raised by the acute medical consultants at the Alexandra Hospital site cannot be ignored because of the interdependencies with the Emergency Medicine Department. The perception of current patient safety concerns specifically need further exploration with the identification of patient safety triggers for Acute Medicine through the QSS Group and the movement towards county wide working is encouraged by the Panel.

9.2 Conclusions

The Panel acknowledged that a significant amount of progress has been made since the first review held in June 2015; specifically notable was the clinical engagement but also the openness to the constructive challenge provided by this Panel. Carefully managing public expectations and communications regarding the proposal of developing a 16 years + Emergency Medicine Department and a co-located Urgent Care Centre at the AH site would be vital to the success of the model. The Panel has made some recommendations regarding minimising the risk associated with a critically ill child presenting at the AH site that it would strongly encourage consideration prior to implementation, specifically the consultant staffing levels and the development of a county wide model of working to maintain experience and skills.

9.3 Advice

The following advice has been developed by the Panel following the conclusion of the review:

- It was noted that the majority of the Executive Team at this Provider are on an interim basis. The Panel strongly feels that substantive appointments need to be made to continue with the good momentum that has been made over the last nine months and the palpable change in culture and attitude to staff engagement
- The lessons learnt from the anaesthetic department in terms of developing their county wide model of working are identified and shared wider across the Trust as an example of good practice
- The staffing levels for the ED consultants needs to be at a minimum level of 20 across (10 on each site) the 2 hospital sites to provide a safe and sustainable level of cover as per the CQC Quality Report (2015) advice
- It was suggested that the normal working day for the Emergency Medicine consultants is based upon a county wide rotational basis to retain skills in terms of care of paediatrics at the WRH site. This could be separate from the out of hours provision with the identification of a main site reflecting that not all consultants will live within a response time of 20 minutes

- Middle grade and ED consultants at AH need to rotate to maintain paediatric experience-this could be through experience at WRH as above or at alternative Providers e.g. Birmingham Children's Hospital
- The FoAHSW Programme Board is encouraged to utilise the national model for Urgent Care service specification that is being developed by NHS England
- Support for streaming rather than a triage based model: if the model relied upon a single triage nurse then this may limit capacity and patient flow through the departments
- There was the need for a careful review of the clinical procedures proposed to be undertaken in the UCC because, with only a limited number of staff, some of the procedures could be time consuming and more efficiently carried out in the ED setting
- The staffing levels for consultant level of cover in the ED should match or exceed the planned level of GP level cover in the UCC i.e. 16 hours per day. The rationale underpinning this is that if the ED consultant cover is provided to mitigate against the impacts of a critically ill child attending the AH UCC then comprehensive data presented shows that paediatric admissions do not decrease until ~ 11pm in the evening (based upon the activity figures that the Panel reviewed after submission by the FoAHSW Programme Board).
- Consideration of the nomenclature for the UCC to manage public expectations of what can be delivered in this setting and again national guidance may help address this
- The Panel strongly supports additional further work being undertaken between the Programme Board, Trust Management and acute medical consultants across both sites to develop the vision and implementation for sustainable county wide working

10 References and Glossary of Terms

http://www.bsg.org.uk/clinical-guidelines/liver/index.html (accessed 18.5.16)

Care Quality Commission (02/12/2015) Quality Report, Worcestershire Acute Hospitals NHS Trust, http://www.cqc.org.uk/provider/RWP (accessed 18.5.16)

Future of Acute Hospital Services in Worcestershire Case for Change (2012)

Future of Acute Hospital Services in Worcestershire Case for Change (2014)

Future of Acute Hospital Services in Worcestershire Joint Service Review (2012)

NHS England, (undated), Urgent and Emergency Care Route Map http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx (accessed 18.5.16)

NHS England, (2015), West Midlands Clinical Senate – The Future of Acute Hospital Services in Worcestershire Stage II Clinical Assurance Review Panel Final Report http://www.wmscnsenate.nhs.uk/clinical-senate/publications/west-midlands/current/stage-ii-assurance/ (accessed 18.5.16)

Worcestershire Acute Hospitals NHS Trust, 2013/2014 Annual Plan http://www.worcsacute.nhs.uk/ (accessed 18.5.16)

Worcestershire Acute Hospitals NHS Trust, Integrated Business Plan (2014/15-2018/19

The following list is a glossary of terms used throughout the ICRP report:

A&E – Accident and Emergency
AH – Alexandra Hospital
CCG – Clinical Commissioning Group
CEM – College of Emergency Medicine
CQC – Care Quality Commission
ED – Emergency Medicine Department
FoAHSW – Future of Acute Hospital Services in Worcestershire
GPs – General Practitioners
HEWM – Health Education West Midlands
HSMR – Hospital Standardised Mortality Ratios
ICRP – Independent Clinical Review Panel
ICRT – Independent Clinical Review Team
JSR – Joint Services Review
KHTC – Kidderminster Hospital and Treatment Centre
MIU – Minor Injuries Unit
QSS – Quality and Service Sustainability Sub-Committee
RCPCH – Royal College of Paediatrics and Child Health
ToR – Terms of Reference
UCC – Urgent Care Centre
WAHT – Worcestershire Acute Hospitals NHS Trust

WM – West Midlands
WMAS – West Midlands Ambulance Service
WMCS - West Midlands Clinical Senate
WRH – Worcestershire Royal Hospital

11 Appendices

12 Appendix 1 Terms of Reference

NHS England

West Midlands Clinical Senate

Future of Acute Hospital Services in Worcestershire (FoAHSW) Stage 2 (b) Review

Terms of Reference

THE NHS CONSTITUTION

West Midlands Clinical Senate

Future of Acute Hospital Services in Worcestershire (FoAHSW) Review

Terms of Reference

First published: March 2016

Prepared by: West Midlands Clinical Senate

TERMS OF REFERENCE

Independent Clinical Review of The Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme

Sponsoring Organisation: FoAHSW Programme Board
Clinical Senate: West Midlands

NHS England (regional or area team): NHS England, West Midlands

Terms of reference agreed by:

Name: Dr David Hegarty on behalf Clinical Senate

Date: 23.03.16

Name: Joanna Newton on behalf of sponsoring organisation

Date: 01.04.16

1. Clinical Review Team Members

Chair and Vice Chair:

Name	Position	Organisation
Dr Helen Carter	Deputy Director of Healthcare, Public Health and Workforce	Public Health England West Midlands
Prof Guy Daly	Executive Dean of Faculty of Health and Life Sciences	Coventry University

Members:

Name	Position	Organisation
Dr Rashid Sohail	Deputy Medical Director	East Midlands Ambulance Service
Mr Keith Spurr	Patient and Public Representative	East Midlands Strategic Clinical Network and Senate
Dr Peter Marc-Fortune	Consultant Paediatric Intensivist	Central Manchester University Hospital
Prof Ian Greaves	Professor in Emergency Medicine	South Tees Hospitals NHS Foundation Trust
Mr Athur Harikrishnan	General and Colorectal Surgeon	Sheffield Teaching Hospital NHS Foundation Trust
Prof Edward Davis	Orthopaedic Surgeon	The Royal Orthopaedic Hospital, Birmingham

Dr Helen Hurst	Advanced Nurse Practitioner	Manchester Royal Infirmary
Ms Andrea Pope Smith	Retired Director of Social Care	n/a
Dr Andrew Phillips	General Practitioner	NHS Vale of York CCG
Mr Peter Sedman	*General Surgeon*	Hull Royal infirmary
Mr Duncan Learmonth	Orthopaedic Surgeon	The Priory Birmingham
Ms Penny Snowden	Deputy Chief Nurse	United Lincolnshire Hospitals
Dr Jackie McLennan	Senior Emergency Medicine Consultant	Manchester
Dr Richard Elliott	Consultant Anaesthetist	Royal Derby Hospital
Mr Murray Spittal	Consultant Anaesthetist	United Lincolnshire Hospitals
In attendance		
Rob Wilson	Interim Associate Director	West Midlands SCN and Clinical Senate
Angela Knight Jackson	Clinical Senate Manager	West Midlands SCN and Clinical Senate
Karen Edwards	Clinical Senate PA	West Midlands SCN and Clinical Senate
Rachel Knowles	Clinical Senate Admin Support	West Midlands SCN and Clinical Senate

N.B; All clinical review team members will sign a declaration of conflict of interest and confidentiality agreement (see appendix 1 and 2), and their names and affiliations will be published in the Clinical Senate review report.

2. Aims and Objectives of the Clinical Review

2.1 Aim

To re-assess the clinical quality, safety and sustainability of the redeveloped Summary Model for Emergency Care, against the recommendations made in the final report of the West Midlands Clinical Senate review, published on 11th June 2015, and to ensure suggested changes will not compromise interdependencies with other parts of the model which have already been successfully reviewed. Any changes already instigated since the Senate review, published on 11th June 2015, should be made known and available to the West Midlands Clinical Senate Review Panel to ensure they are consistent with the clinical quality, safety and sustainability of the overall model.

2.2 Objectives

The Independent Clinical Review Panel will:

a) Review and re-assess the redeveloped clinical model for Emergency Care against the recommended criteria set out in the FINAL report of the West Midlands Clinical Senate review, June 2015 (full recommendations are available in appendix 3):

Recommendation number	**Recommendations from FINAL report of WMCS (June 2015)**	
1: Obstetrics and Gynaecology and Emergency Surgery	The Panel supports the proposals set out within the Summary Model of Care to reconfigure the Obstetrics and Gynaecology and Emergency Surgery services through transferring these from Alexandra Hospital and consolidating them onto the Worcestershire Royal Hospital site.	Recommendation previously supported by the West Midlands Clinical Senate (WMCS) and therefore this element of the model is out with the scope of this WMCS review.
2: Inpatient Paediatrics	The Panel recommends that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at Worcestershire Royal Hospital in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.	This would need to include: 1. A clear plan and risk assessment of the likely shortfall of paediatric nursing recruitment at the WRH site 2. The expansion of car parking/park and ride provision at WRH to cope with the increased demands of those travelling by car from Redditch and Bromsgrove.
3: Urgent Medical Care	The Panel has a number of concerns with the detail of the model of Emergency Medicine at Alexandra Hospital with respect to patient safety.	These concerns relate to issues of: 1. Sustainable staffing, with a national shortage of ED Consultants, middle grades and

		the potential for trainees to be removed from the AH site 2. Public and staff misunderstanding of the model of Emergency Medical Care at AH (see also Recommendation 4, below) 3. Increased clinical risk arising from the removal of key services from AH aligned to the management of emergency care, including Inpatient Paediatrics and Emergency Surgery - and their further critical interdependencies with other clinical specialties, including Anaesthetics and Critical Care.
4: Urgent Medical Care for Children at AH	The Panel strongly recommends that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when.	This should include: 1. Making absolutely explicit the extent and remit of urgent/emergency paediatric cover 2. Having a clear plan for dealing with paediatric emergency presentations at AH out of hours 3. Undertaking a full risk assessment in respect of any proposals for paediatric emergency provision that are less than 24/7 4. A detailed consideration of how seriously unwell children presenting at the AH site, who do not meet critical care transport team criteria, will be safely transferred to the WRH site. This should encompass personnel, equipment and transport logistics.
5: Engagement and Co-ownership from Frontline Clinical Workforce	The Panel recommends that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability	

b) Consider the final clinical model for Emergency Care prior to public consultation against the above criteria and make recommendations on whether to support the model to the West Midlands Clinical Senate Council and thereafter to FoAHSW Programme Board and sponsoring organisations.

3. Timeline

Work is taking place with NHS England to ensure the FoAHSW programme progresses in a timely manner. NHS England has stated that their assurance process should ideally be completed by June 2016. Given these timescales, and that this is a review revision rather than a complete review, the timeline will proportionately reflect this. Taking these factors into consideration a suggested timeline is indicated below:

Week Beginning	Action	Organisation
22/02/2016	Teleconference re arrangements for the Panel assessment, site visits and reporting	CS, CCG's, FoAHSW Programme Board
23/03/2016	Agree terms of reference	CS, CCG's, FoAHSW Programme Board
28/03/2016	CS request for documentation from the sponsoring organisation	CS
04/04/2016	CS receives documentation from the sponsoring organization	CCG's, FoAHSW Programme Board
11/04/2016	Documentation sent to ICRT	CS
21/04/2016	First Panel assurance	CS
03/05/2016	Second Panel assurance and site visit	CS
16/05/2016	Third Panel assurance and conclude review	CS
23/05/2016	Report draft to CCGs	CS, CCG's, FoAHSW Programme Board
30/05/2016	Finalise report	CS
w/e 13/06/16	Virtual WMCS Board for sign off	CS

4. Methodology

The role of the review team will be to examine documentary evidence, and decide recommendations. The West Midlands Clinical Senate acknowledges that the sponsoring organisations (NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG), have undergone a first, and second stage assurance review as a component of the NHS England assurance process and is now ready to undertake a 2(b) stage assurance external expert review as part of the FoAHSW review programme (see Appendix 4 NHS England Assurance process) .

The 2(b) assurance review will be carried out in line with the key tests, and an appropriate selection of best practice checks as a component of the NHS England final assurance process. The Clinical Senate (through its Council) will be responsible for the review being carried out.

A formal report containing clinical senate advice will be returned to the CCG's via the Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme Board who will share it with NHS England as part of their assurance evidence.

The West Midlands Clinical Senate acknowledges that the sponsoring organisation has undertaken an external expert review as part of the FoAHSW Reconfiguration programme and the report will be made available to the Panel.

It is anticipated that the review will take place during April and May 2016.

The clinical review team will need to consider the following;

- Has the review revision satisfactorily met all the recommendations detailed in the WMCS report, published June 2015?
- Has relevant available evidence been effectively marshalled and applied to the specifics of the proposed scheme?
- Is there alignment with other national, regional and local intentions?
- Is there evidence of clinical overstatement or optimism bias in the proposals?

5. Reporting

A draft report from the Clinical Review Team will be made available to the sponsoring organisation for fact checking prior to publication. Any comments / correction must be received within 5 working days.

The Clinical Review Team will submit a draft report (see Independent Clinical Review Team Report Template appendix 5) to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report. The council may wish to take a view or offer advice on any issues highlighted that should be taken into consideration in implementing change.

The Council will be asked to comment specifically on the:

- Comprehensiveness and applicability of the review
- Content and clarity of the review and its suitability to the population in question
- Interpretation of the evidence available to support its recommendations
- Likely impact on patient groups affected by the reconfiguration
- Likely impact / ability of the health service to implement the recommendations

The final report will be submitted to the FoAHSW Programme Board by June 2016 and the clinical advice will be considered as part of the NHS England's West Midlands assurance process for service change proposals. The report is not expected to comment upon issues of the NHS England assurance process that will be reviewed elsewhere (e.g. patient engagement, GP support or the approach to consultation).

The review report will remain confidential until placed in the public domain at the conclusion of the review process and /or with agreement with the sponsoring organisation(s).

6. Communication and Media Handling

The Clinical Senate review will be published on the website of the Clinical Senate and council and assembly members will provide support to disseminate the review at local level. The sponsoring organisation(s) will handle all media inquiries in the first instance. The Clinical Senate may engage in various activities with the sponsoring organization(s) to increase public, patient and staff awareness of the review.

7. Resources

The West Midlands Clinical Senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation(s).

8. Accountability and Governance

The clinical review team is part of the West Midlands Clinical Senate accountability and governance structure.

The West Midlands Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation(s).

The sponsoring organisation(s) remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation(s) may wish to fully consider and address before progressing their proposals.

9. Functions, Responsibilities and Roles

9.1. The sponsoring organisation(s) will:

- Provide for the clinical review Panel all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions).
- Respond within the agreed timescale to the draft report on matter of factual inaccuracy. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
- Submit the final report to NHS England for inclusion in its formal service change assurance process.

9.2 Clinical Senate Council and the sponsoring organisation(s) will:

- Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.
- Clinical Senate council will:
    - Appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member.
    - endorse the terms of reference, timetable and methodology for the review
    - endorse the review recommendations and report
    - provide suitable support to the team.
    - Submit the final report to the sponsoring organisation(s)

9.3 Clinical review team will:

- Undertake its review in line with the methodology agreed in the terms of reference
- Follow the report template and provide the sponsoring organisation(s) with a draft report to check for factual inaccuracies.
- Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
- Keep accurate notes of meetings.

9.4 Clinical review team members will undertake to:

- Commit fully to the review and attend all briefings, meetings, interviews, Panels etc that are part of the review (as defined in methodology).
- Contribute fully to the process and review report
- Ensure that the report accurately represents the consensus of opinion of the clinical review team.
- Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it.

Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

Appendix 1 (of ToR)

Declaration of Conflict of Interest

West Midlands Clinical Senate Independent Clinical Review Team
Future of Acute Hospital Services in Worcestershire (FoAHSW)
Stage II Part B

To be completed by all members of the clinical review team. Clinical Senate Council members should also consider if they have any conflicts in considering the review team's report.

For advice on what items should and should not be declared on this form refer to the Conflicts of Interest Policy issued by the West Midlands Clinical Senate. Further advice can also be obtained from the Clinical Senate Manager.

Name:

Position:

Please describe below any relationships, transactions, positions you hold or circumstances that you believe could contribute to a conflict of interest:

For completion

Type of Interest – Please supply details of where there is conflict in accordance with the following list:

A direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

An indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

A direct non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

An indirect non-pecuniary interest: where an individual is closely related to, or in a relationship, including friendship, with an individual in categories a-f.

A direct non-pecuniary benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

An indirect non-pecuniary benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value but is a benefit to peers or colleagues (for example, a recommendation which results in an increase in revenue or status to their employing organisation or results in their organisation becoming the preferred provider).

An indirect non-pecuniary conflict: where the evidence of the senate may bring a member into direct or indirect conflict with their contracting or employing organisation, to the extent that it may impair the member's ability to contribute in a free, fair and impartial manner to the deliberations of the senate council, in accordance with the needs of patients and populations.

Other – please specify

Name	
Type of Interest	
Details	
Action Taken	
Action Taken By	
Date of Declaration	

I hereby certify that the information set forth above is true and complete to the best of my knowledge.

Signature:

Name:

Date:

Appendix 2 (of ToR)

Confidentiality Agreement

West Midlands Clinical Senate Independent Clinical Review Team
Future of Acute Hospital Services in Worcestershire (FoAHSW)
Stage II Part B

I (name) …….
hereby agree that during the course of my work (as detailed below) with the West Midlands clinical senate I am likely to obtain knowledge of confidential information with regard to the business and financial affairs of an NHS body, or other provider, its staff, clients, customers and suppliers, details of which are not in the public domain ('confidential information') and accordingly I hereby undertake to and covenant that:

I shall not use the confidential information other than in connection with my work; and

I shall not at any time (save as required by law) disclose or divulge to any person other than to officers or employees of West Midlands clinical senate, other NHS organisations, staff, clients, customers and suppliers whose province it is to know the same any confidential information and I shall use my best endeavours to prevent the publication or disclosure of any confidential information by any other person.

The restrictions set out above shall cease to apply to information or knowledge that comes into the public domain otherwise than by reason of my default of this Agreement.

The 'Work' (clinical review) is:
Future of Acute Hospital Services in Worcestershire (FoAHSW)
Signed _____ Date: _____

Name (caps) _____

Appendix 3 (of ToR)

Recommendations from the final report of the West Midlands Clinical Senate published on 15th June 2015. A copy of the full report can be accessed from the West Midland Clinical Senate website here.

13.1 Recommendations

Recommendation 1: Obstetrics and Gynaecology and Emergency Surgery

The Panel **supports** the proposals set out within the Summary Model of Care to reconfigure the Obstetrics and Gynaecology and Emergency Surgery services through transferring these from AH and consolidating them onto the WRH site.

Recommendation 2: Inpatient Paediatrics

While the Panel **supports in principle** the proposal set out within the Summary Model of Care to transfer Inpatient Paediatrics from AH to the WRH site, it remains concerned, however, regarding the capacity to accommodate additional paediatric inpatients from Redditch and Bromsgrove at WRH. The proposed model of care relies on ambitious plans to reduce the average length of hospital stays through prompt discharge of children into the community for on-going care. The ability to achieve this objective is a risk, the extent of which needs to be clearly understood and managed.

The Panel, therefore, **recommends** that clear plans are drawn up to demonstrate how additional paediatric capacity can be developed at WRH in order that the flow of inpatients from Redditch and Bromsgrove can be accommodated at the site, with evidence-based ambitions set for the prompt discharge of children into the community for on-going care.

This would need to include:

- A clear plan and risk assessment of the likely shortfall of paediatric nursing recruitment at the WRH site
- The expansion of car parking/park and ride provision at WRH to cope with the increased demands of those travelling by car from Redditch and Bromsgrove.

Recommendation 3: Urgent Medical Care

While the Panel endorses the previous Independent Clinical Review Panel's findings that some form of ED provision is required at the AH site, the Panel **does not support** the detail of the proposed model of Emergency Medicine at AH as set out within the Summary Model of Care.

The Panel has a number of concerns with the detail of the model of Emergency Medicine at AH with respect to patient safety. These concerns relate to issues of:

- Sustainable staffing, with a national shortage of ED Consultants, middle grades and the potential for trainees to be removed from the AH site
- Public and staff misunderstanding of the model of Emergency Medical Care at AH (see also Recommendation 4, below)
- Increased clinical risk arising from the removal of key services from AH aligned to the management of emergency care, including Inpatient Paediatrics and

Emergency Surgery - and their further critical interdependencies with other clinical specialties, including Anaesthetics and Critical Care.

Recommendation 4: Urgent Medical Care for Children at AH 2
The Panel was particularly concerned about the practicalities and clinical risks associated with the delivery of the proposed model of urgent medical care for children presenting at the AH site, as well as by the varying interpretations of the proposed paediatric service model at AH that it had received from frontline staff.

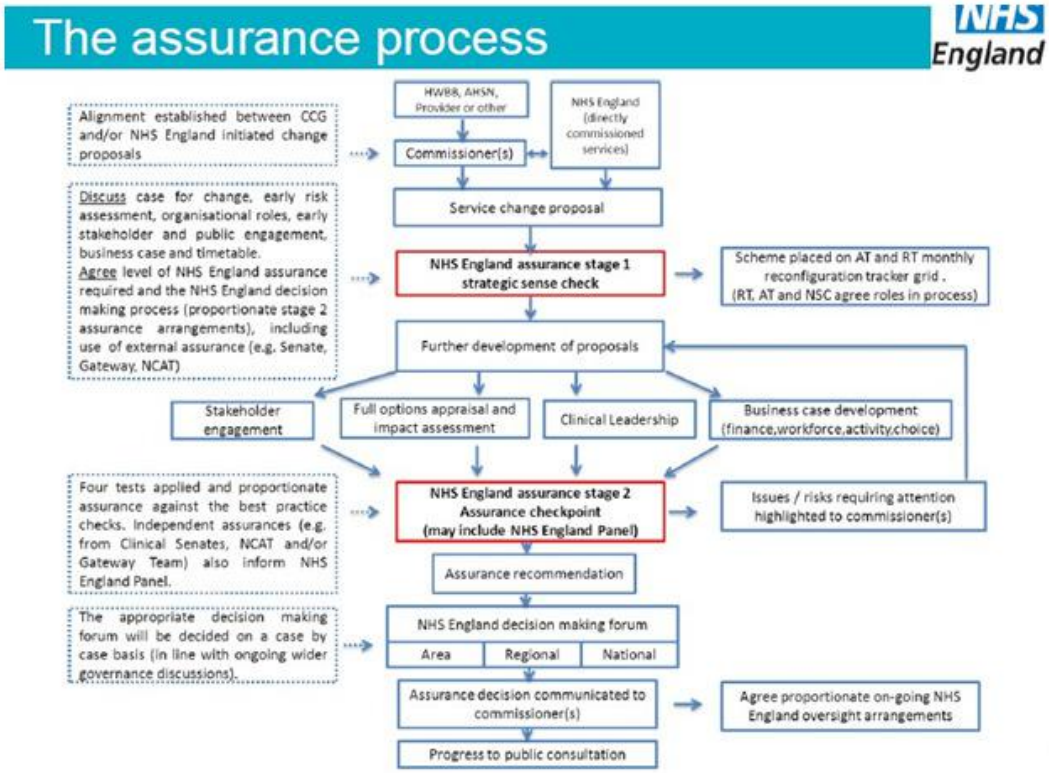
The Panel, therefore, strongly **recommends** that further work is required to develop a common understanding between both staff and members of the public regarding where sick children from Redditch and Bromsgrove should be taken to and when. This should include:

- Making absolutely explicit the extent and remit of urgent/emergency paediatric cover
- Having a clear plan for dealing with paediatric emergency presentations at AH out of hours
- Undertaking a full risk assessment in respect of any proposals for paediatric emergency provision that are less than 24/7
- A detailed consideration of how seriously unwell children presenting at the AH site, who do not meet critical care transport team criteria, will be safely transferred to the WRH site. This should encompass personnel, equipment and transport logistics.

Recommendation 5: Engagement and Co-ownership from Frontline Clinical Workforce
The Panel accepted that a certain amount of clinical engagement had taken place within WAHT to develop the proposed model of care for the 'Emergency Centre' at the AH site. During Day 4, however, it became apparent that there was not strong clinical support for this model, due to concerns about patient safety and service sustainability.

The Panel, therefore, **recommends** that before any model proceeds to formal public consultation it should be demonstrated that there is strong clinical support from frontline clinicians across WAHT for this model from the perspectives of both patient safety and clinical sustainability.

Appendix 4


The assurance process
NHS England
HWBB, AHSN, Provider or other
NHS England (directly commissioned services)
Alignment established between CCG and/or NHS England initiated change proposals
Commissioner(s)
Service change proposal
Discuss case for change, early risk assessment, organisational roles, early stakeholder and public engagement, business case and timetable.
Agree level of NHS England assurance required and the NHS England decision making process (proportionate stage 2 assurance arrangements), including use of external assurance (e.g. Senate, Gateway, NCAT)
NHS England assurance stage 1 strategic sense check
Scheme placed on AT and RT monthly reconfiguration tracker grid . (RT, AT and NSC agree roles in process)
Further development of proposals
Stakeholder engagement
Full options appraisal and impact assessment
Clinical Leadership
Business case development (finance,workforce,activity,choice)
Four tests applied and proportionate assurance against the best practice checks. Independent assurances (e.g. from Clinical Senates, NCAT and/or Gateway Team) also inform NHS England Panel.
NHS England assurance stage 2 Assurance checkpoint (may include NHS England Panel)
Issues / risks requiring attention highlighted to commissioner(s)
Assurance recommendation
The appropriate decision making forum will be decided on a case by case basis (in line with ongoing wider governance discussions).
NHS England decision making forum
Area
Regional
National
Assurance decision communicated to commissioner(s)
Agree proportionate on-going NHS England oversight arrangements
Progress to public consultation

Appendix 5 (of ToR)

West Midlands Clinical Senate Independent Clinical Review Team Report Template

Future of Acute Hospital Services in Worcestershire (FoAHSW)

[senate email]@nhs.net

Date of publication to sponsoring organisation:

CHAIR'S FOREWORD (Clinical Review Team)

Statement from Clinical Senate Chair

SUMMARY & KEY

RECOMMENDATIONS

BACKGROUND

- [CLINICAL AREA]
- [Description of current service model]
- [Case for change]
- [Review methodology]
- Details of approach taken, review team members, documents used, sites visited, interviewees]
- [Scope and limitations of review]
- [Recommendations]

CONCLUSIONS AND ADVICE

[References]
This should include advice against the test of 'a clear clinical evidence base' for the proposals
and the other checks defined in the terms of reference agreed at the outset of the review.
Has the proposal been founded on robust clinical evidence? What evidence has been used and how has it been applied to local circumstances?
Has the available evidence been marshalled effectively and applied to the specifics of the proposed scheme?

GLOSSARY OF TERMS

APPENDICES:

Terms of reference
Clinical review team members and any declarations of interest
Background information

13 Appendix 2 ICRT Panel Members' Biographies

MEMBER BIOGRAPHY/PROFILE

Name	Dr Helen Carter
Dr Helen Carter is the Vice Chair of the West Midlands Clinical Senate. She is a medical doctor by background who moved into Public Health Medicine in 2001. She has worked in a variety of organisations including: health authorities, Primary Care Groups and Trusts, Strategic Health Authority and joined Public Health England in 2013. Her current portfolio includes generic healthcare public health, screening and immunisations, specialised commissioning, dental public health and public health workforce development.	

Name	Prof Guy Daly
Professor Guy Daly is Executive Dean of the Faculty of Health and Life Sciences at Coventry University. The Faculty educates and trains some ten or more health and social care professionals. In addition, Professor Daly is a; Non-Executive Director of Coventry and Warwickshire Partnership NHS Trust (and Chair of its Safety and Quality Committee) Member of Health Education England - West Midlands Local Education and Training Board Member of Coventry Health and Wellbeing Board. He is a social policy academic and researches in the areas of social care, local policy, housing and health.	

Name	Dr Rashid Sohail
Dr Rashid joined East Midlands Ambulance Service in 2013 as Deputy Medical Director and has been a consultant in emergency medicine since 2000. He continues to practice clinically on a part-time basis. He has previous experience as a Clinical Director of Emergency Medicine and Chair of Medicine with North West Deanery Health Education. As well as his clinical knowledge Rashid is an Assistant Coroner in Manchester City Jurisdiction and a Member of Coroners Society of England & Wales.	

Name	Mr Keith Spurr

Professionally; A retired HR Professional and an accredited Trade Union Representative. Represented both Organisations and Individuals at Employment Tribunals.

Patient Representative Role; Diabetic Type 1. Since retirement, recognised as the Diabetes UK Champion for the South Lincolnshire Area and a diabetic "voice". Endeavouring to improve the facilities of Diabetic support especially education. Organised a Diabetes Education Event in Stamford and established a self-help group for people with diabetes.

Member of the East Midlands Clinical Senate and a National PPV for NHS England.

A member of Lincolnshire Healthwatch. Secretary to St Mary's Medical Centre PPG

Name	Dr Peter-Marc Fortune

Peter-Marc Fortune is a Consultant Paediatric Intensivist based at Royal Manchester Children's Hospital since 2002. He was Clinical Director of Critical Care from 2005-2012 and has been Associate Clinical Head of the Hospital since then.

He has interests in patient safety, resuscitation, ethics and medical education. He is currently President-Elect of the Paediatric Intensive Care Society, Chair of the Making it Safer Together (MiST) children's patient safety collaborative, a member of The NHS England Children's Patient Safety Expert Group, a member of the Resuscitation Council (UK) Executive Committee, and chair of the NAPSTaR and Human Factors working groups of the Advanced Life Support Group.

Name	Prof Ian Greaves

Colonel Ian Greaves qualified in medicine at Birmingham in 1986 and trained in emergency medicine in Yorkshire before joining the Armed Forces on appointment as a consultant in Peterborough in 1997. Since 2002, Colonel Greaves has been consultant in emergency medicine at James Cook University Hospital in Middlesbrough which is now a regional major trauma centre. He was appointed to a visiting professorship in emergency medicine at the University of Teesside in 2003.

In civilian life, Professor Greaves leads the Academic Department of Emergency Medicine at the University of Teesside and James Cook Hospital which has received a number of major grants and established a particular reputation in the field of mild traumatic brain injury (mTBI) research. The department is strongly committed to multi-professional research and currently has nursing PhD and paramedic MSc fellows.

Professor Greaves has published widely in the fields of trauma, pre-hospital care and

military medicine. Formerly the editor of the Journal of the Royal Army Medical Corps, he now edits the quarterly journal Trauma. Professor Greaves has written or edited ten textbooks including key texts in the field of Immediate Care and paramedic practice and contributed to a wide range of other books. He lectures widely on all aspects of pre-hospital care and trauma management. He was formerly a member of the Executive and Faculty Board of the Faculty of Pre-hospital Care and is the secretary of the charity Trauma Care. He recently served on the Department of Health Clinical Advisory Group on Pre-hospital and Transfer Medicine.

Still a serving officer, Colonel Greaves was tri-service lead for emergency medicine and pre-hospital care from 2008 – 2014, responsible for co-ordinating the delivery of an emergency medicine capability in the UK and on operations in Afghanistan. He has deployed to both Iraq and Afghanistan. From 2010–2014. Colonel Greaves was Honorary Surgeon to HM Queen Elizabeth II. He lives in a small Yorkshire Dales village with his wife, two sons and a menagerie of assorted animals his children promised to clean up after. One day, he will finish his masterpiece on the historical architecture of north Yorkshire and complete his model railway.

Name	Dr Helen Hurst

Helen Hurst has worked in renal medicine for over 25 years, working in all areas of renal medicine and community. Since 2000 she has worked as an advanced nurse practitioner in the renal drop-in service at Manchester Royal Infirmary; developing and growing the service to enhance ambulatory care. She has been involved in research and completed a PhD in 2011 in patient experience and has collaborated on many research projects; including publications, and is a regular reviewer for specialist and nursing journals.

She is an active member of the British Renal Society, co-chair of the upcoming conference and a member the International Society of Peritoneal Dialysis Education Committee. She is also a member of the Clinical Senate for the region. She is an associate member of the Research and Development North West team. She has formulated a renal patient research group and is interested in patient involvement and collaboration in research. She has presented nationally and internationally and has recently collaborated with Manchester University to set up the renal course for nurses and is the clinical lead. Helen has also been involved in the Well North Project, a strategic collaborative programme funded by Public Health England which seeks to tackle the wider social determinants underlying substantive health inequalities. More recently Helen has been asked to lead a project within the Trust on ‘open visiting’ and has been awarded a CLAHRC fellowship.

Name	Mr Peter Sedman
Peter Sedman is a Consultant Upper Gastrointestinal Surgeon in Hull, where he was appointed in 1995. He leads the Upper GI Unit there and Chairs the Medical Advisory Committee of the local private hospital. Peter Sedman is currently the President of the Association of Laparoscopic Surgeons of Great Britain and Ireland (ALSGBI) and sits on the Yorkshire and the Humber Clinical Senate of the NHS.	

Name	Dr Jackie McLennan
Lt Col Jackie Mclennan trained at Leicester University and qualified as a doctor in 1998 while being sponsored by the Royal Army Medical Corps. She undertook house officer jobs at The Glenfield, Leicester Royal infirmary and Leicester General Hospital. SHO jobs were at Peterborough Hospital, Frimley Park Hospital in Camberley, Surrey and underwent officer training at the Royal Military Academy Sandhurst. This training was interspersed with deployments to Northern Ireland, Kosovo and Iraq. Training as a Registrar was based initially at the James Cook University Hospital, Middlesbrough, before moving to the North Western Deanery where she rotated though Manchester Royal Infirmary, Stepping Hill Hospital and Wythenshawe Hospital. She started Work as a consultant in Emergency Medicine in June 2010 at Manchester Royal Infirmary where she was part of the team that worked on the massive transfusion protocols across the region and completed a doctorate on production of a clinical decision rule to help guide people on the need for massive transfusion in major trauma. She has recently started work as a consultant in Emergency Medicine at the Royal Stoke University Hospital and continues to be a Consultant in the Defence Medical Services.	

Name	Dr Richard Elliott
Qualified in 1980 MB BCh (Wales). FRCA 1987 Lecturer in University of Calgary, Canada 1989. Consultant Anaesthetist in Derby appointed in 1992. Service Director and Lead Clinician in Anaesthesia/Critical Care for 6 years. Member of Reshaping Health Services in Derby, leading to new hospital design/build. Chair Mortality review group for 12 yr. Member of Trust transformation team. NCEPOD clinical advisor/ambassador. Member of East Midlands Clinical Senate	

Name	Prof Edward Davis
I was appointed as a consultant orthopaedic surgeon at The Royal orthopaedic hospital in 2007 in the hip and knee arthroplasty unit. I undertake primary and revision hip and knee replacements at The Royal orthopaedic hospital and also have sessions at Russells Hall hospital in Dudley where I undertake primary joint replacements and undertake an on-call trauma commitment. I graduated from Birmingham University in 1996 and undertook my basic and higher surgical training in the West Midlands. I undertook a year's fellowship in revision hip and	

knee arthroplasty in Toronto, Canada.

I have an MSc in Trauma and a postgraduate certificate in medical education as well as the FRCS (Trauma and Orthopaedics). I have a keen interest in research and have a large research portfolio extending from drug treatments for osteoarthritis to the development of new surgical techniques, including computer navigation. I am the Director for Research and Development at The Royal Orthopaedic Hospital in Birmingham. I have been invited faculty at national and international meetings on hip and knee arthroplasty.

I am actively involved in education as an honorary Senior Clinical Lecturer and Senior Clinical Examiner at The University of Birmingham. I am also the Head of Academy at The Royal Orthopaedic Hospital co-ordinating all undergraduate medical education and the module lead for orthopaedics at the University of Birmingham.

I am married and enjoy spending my free time with my wife and 3 young children.

Name	Mr Duncan Learmonth
I have lived in the West Midlands since 1978 being a surgical trainee and consultant within the West Midlands area over the last 25 years. For a period of that time I have lived in the Barnt Green and Bromsgrove area and have used the Alexandra Hospital in the past. I have also visited the Alexandra and Worcester Hospitals for teaching and also visiting patients. I have also visited the Kidderminster Ambulatory Care Centre in the past.	

Name	Mr Athur Harikrishnan
Athur Harikrishnan is a consultant laparoscopic colorectal surgeon in Sheffield Teaching Hospitals. He trained in East Anglia and worked as a consultant in Doncaster for 4 years before moving to Sheffield in 2014. He is the Associate Training Programme Director for general surgery in the Yorkshire Deanery and holds an Honorary Clinical Senior Lecturership with Edge Hill University. His managerial roles include Yorkshire chapter representative of the Association of Coloproctology of GB & Ireland and member of the Yorkshire and Humber Clinical Senate.	

Name	Dr Andrew Phillips
	Unavailable

14 Appendix 3 Declaration of Interests

No declarations of interest were declared by the ICRT.

15 Appendix 4 ICRT Agenda Day 1

NHS England
West Midlands Clinical Senate

DAY 1

Independent Clinical Review Panel

Stage II Part B Clinical Assurance of the Future of Acute Hospital Services in Worcestershire Review

Thursday 21st April 2016, 10.00 am until 4.00 pm, Venue: Birmingham Research Park

PLEASE REPORT TO THE MAIN RECEPTION – YOU WILL THEN BE DIRECTED TO THE RELEVANT MEETING ROOMS

AGENDA

Item			Purpose
09:30		Arrival with Refreshments *(30 mins allocated)* Panel Pre-meet Helen Carter, Guy Daly and Clinical Senate Team	
10:00	1	Introduction by the Chair *(30 mins allocated)*	Introductions Housekeeping Declaration of Interest Review ToR
10:30	2	Programme Board Presentation and follow up Q&A *(1 hour 15 mins allocated)* (sponsoring organisation) Context and background Proposed Model of Care and how it meets the recommendations made by the West Midlands Clinical Senate previously The temporary emergency changes to services which have already been made	Commissioners presentation regarding context and background, proposed model of care and temporary emergency changes to services
11:45	3	Panel Discussion – Review of Documentation Submitted and Key Lines of Enquiry *(45 mins allocated)* *Think about further key questions for commissioners* Capturing the Changes: Develop a common understanding of the process and challenges to date	Overview of the documentation Explore and clarify specific issues Formulate questions for Commissioners
12:30		Lunch and Refreshments *(45 mins allocated)*	
1:15	4	Panel Discussion – Continuation Review of Documentation Submitted and Key Lines of Enquiry *(60 mins allocated)* *Think about further key questions for commissioners*	As above
2.15	5	Panel Questions to Sponsoring Organisation *(30 mins allocated)* *(sponsoring organisation)*	Explore and clarify any specific issues
2:45		Refreshments *(15 mins)*	
3:00	6	Panel Deliberations *(45 mins allocated)* Purpose:- 1. Assess Evidence Presented 2. Capture themes 3. Next Steps and Day 2	Assess, Agree, Capture, Next Steps
3:45	7	ICRT Chair and Vice Chair Debrief with Sponsoring Organisation *(15 mins allocated)*	Debrief
4:00		END	

16 Appendix 5 ICRT Agenda Day 2

NHS England
West Midlands Clinical Senate

DAY 2

Independent Clinical Review Panel

Stage II Part B Clinical Assurance of the Future of Acute Hospital Services in Worcestershire Review

Tuesday 3rd May 2016, 10.00 am until 4.00 pm

Venue – (AM) Alexandra Hospital, Woodrow Drive, Redditch, B58 7UB
(PM) Worcestershire Royal Hospital, Charles Hastings Way, Worcester, WR5 1DD

PLEASE REPORT TO THE MAIN RECEPTION AT ALEXANDRA HOSPITAL – YOU WILL THEN BE DIRECTED TO THE RELEVANT MEETING ROOMS

AGENDA

Item			Purpose
08:45		COACH TO BE BOOKED FROM BIRMINGHAM NEW STREET TO ALEXANDRA HOSPITAL	
09:30		Arrival with Refreshments *(30 mins allocated)* Panel Pre-meet Helen Carter, Guy Daly and Clinical Senate Team	
10:00	1	Welcome to Panel and Review of Day One *(20 mins allocated)* *(Alexandra)*	Introductions Housekeeping Declaration of Interest Review of Day 1
10:20	2	Tour of Alexandra Hospital *(60 mins allocated) (Alexandra)* (affected areas only) *(2 groups of 8 in parallel or 3 groups of 5)* Emergency Department Intensive Care Unit	Meet and discuss clinical engagement with clinical staff
11:20	3	Panel to Meet with Acute Medical Consultants *(40 mins allocated)* *(Alexandra)* Please note: timings may change to fit around the availability of the acute medical consultants (to meet either during tour of department or as a separate entity/meeting)	Meet and discuss clinical engagement with clinical staff
12:00	4	Reconvening of Panel *(30 mins allocated)* *(Alexandra)*	Feedback returned from panel to ICRT Chair
12:30	5	Lunch and Refreshments *(30 mins allocated) (Alexandra)*	
13:00	6	Travel to Worcestershire Royal Hospital *(40 mins allocated)* *(Minibus to be booked from Alexandra to WRH)*	
13:40	7	Tour of Worcestershire Royal Hospital *(90 mins allocated) (WRH)* *(affected services only)* *(3 groups of 5)* *Emergency Department and In-Patient Paediatrics* *Maternity Services* *Intensive Care Unit* *(both department and clinicians)*	Meet and discuss clinical engagement with clinical staff
15:10	8	Panel Questions to Sponsoring Organisation *(30 mins allocated) WRH)* *(sponsoring organisation)*	Explore and clarify any specific issues with sponsoring organisation
15:40	9	Reconvening of Panel for Deliberations (20 mins allocated) *(WRH)* Purpose:- 1. Assess Evidence Presented 2. Capture themes 3. Next Steps and Discuss Potential Day 3	Assess, Agree, Capture, Next Steps
16:00	10	ICRT Chair and Debrief with Sponsoring Organisation	Debrief
16:00		END – COACH TO BE BOOKED FROM WRH TO ALEX THEN TO BIRMINGHAM NEW STREET	

17 Appendix 6 ICRT Agenda Day 3

West Midlands Clinical Senate

DAY 3

Independent Clinical Review Panel

Stage II Part B Clinical Assurance of the Future of Acute Hospital Services in Worcestershire Review

Monday 16th May 2016, Venue: First Floor Meeting Rooms, The Rep Theatre, Broad Street, Birmingham

PLEASE REPORT TO THE MAIN RECEPTION – YOU WILL THEN BE DIRECTED TO THE RELEVANT MEETING ROOMS

AGENDA

Item			Purpose
09:30		Arrival with Refreshments *(30 mins allocated)* Panel Pre-meet Helen Carter, Guy Daly, Clinical Senate Team	
10:00	1	Introduction by the Chair	Introductions, housekeeping
West Midlands Ambulance Service Representatives in attendance throughout the day to answer questions			
10:15	2	• Panel Discussion – Review of Day Two • Scope of Terms of Reference • Key Lines of Enquiry • Further Documentation Submitted	Review ToR Overview of documentation Formulate questions / areas of clarification for Commissioners
11:00	3	Programme Board Follow up Q&A (sponsoring organisation)	Commissioners Q&A following Day Two
12:30		Lunch and Refreshments *(45 mins allocated)*	
1:15	4	Panel Discussion – Key Lines of Enquiry (with / without sponsoring organisation) – dependant on timings	Explore and clarify specific issues Formulate questions for Commissioners
2.15	5	Panel Questions to Programme Board (sponsoring organisation)	Explore and clarify specific issues
3:00		Refreshments *(15 mins allocated)*	
3:15	6	Panel Deliberations	Assess evidence presented, Agree, Capture themes, Next Steps
3:45	7	ICRT Chair, Vice Chair, Clinical Senate Team Debrief with Sponsoring Organisation Teleconferencing Details Dial In 0800 915 1950 or 0203 463 9697 Participant passcode: 47598189 then #	Debrief Report writing process

18 Appendix 7 Questions considered by the Panel outside of the scope of the Terms of Reference

West Midlands Clinical Senate
FoAHSW Review Stage II Part B
Comments / Questions from Panel Members post Day 2

Comment / Question	In/Out of ToR, which ToR objective plus related narrative
1. Perhaps as an aside or may be directly relevant, the key impression left with me is whether there are still real issues clinically (EM, Acute Medicine) or whether this is a cultural and leadership matter/challenge wherein some Trust staff are still on the old bus and have yet to get on the new one?	Out - cultural issue?
2. Terms of reference- ignoring medicine will be very artificial	Out - beyond remit
3. The team in Redditch seem to think that keeping children in Redditch was in their brief - is that correct? I cannot see how having an urgent care unit and an A&E in the same hospital with the same front door makes any sense. The public will never get this. It either has to be a minor injuries unit for all, an adult A&E (but with limited opening hours) or a GP-referred urgent care unit, but not a mix.	In Ob 4 - need to think about public messaging
4. Children cannot come to Redditch A&E - the numbers will be small, and the staff will de-skill no matter how well trained	In Ob 4 - need to think about public messaging
5. How many medical admissions are there in Redditch? How does this compare with say 5 years ago? Your quote "95% of patients will still go to Redditch" - who are they and what is the 5% that does not? Does that include maternity etc, as these changes have been made	Out - medical admissions are not an objective
6. What are the HSMR/SHMI figures for Worcester hospital and Redditch overall and for strokes, MI's and all medicine admissions? - what are the length of stay figures for the same patients? Are the "Worcester only" gastro jobs just an oversight or a deliberate policy by Worcester medicine?	In? - tricky as the stats are a proxy for care but relate to whole hosp? good to have data
7. I think we should have an acute hospital Worcester; a day case hospital Kidderminster and an elective hospital in Redditch. Can you do the maths to see how that works?	Out - an opinion not an objective?
8. Ambulance Query; This may be outside of the review. I'm seeking a clear justification for another ambulance crew -there is a lot of information but we have to work out for the justification. The majority of calls are for slips, trips and falls so, as in other Areas, establish a falls team to enable people being treated at home and avoiding going to Hospital. In other words, I suggest that this should give them an opportunity to review their system especially as patients will be going to the Alex as opposed to the Royal	Out - refer to evidence by sponsors

9. Transport Query; I am still concerned about the 15% who do not have cars. Is the Hospital Shuttle going to continue? Cost of parking is an issue will there be dispensation for those who travel? From observation parking spaces will be an issue for a long time. Relying on the extension of the bus is not going to be viable. The Local Authority will say it is a NHS issue and the NHS will say it is a Local Authority issue, i.e who pays. Is the Trust going to pump fund community travel organisations? Can volunteering be developed to transport patients? There needs to be a clear strategy as especially from the focus groups the major concern is transport. It would be better for consultation to say that this is what we are going to do and not we are hoping to happen.	Out - refer to evidence from sponsors
10. Overnight Stay Query; Did we review the availability of parents/partners staying overnight at the Royal? How many positions are there and what happens if they are full?	Out - beyond remit
11. Concerns around staffing	In Ob 3
12. Paediatrics - what is length of stay for admissions at Worcester & is this in line with other Paediatric units? Will they provide consultant support to Alexandra Hospital? What provisions for child safe guarding when the co-located primary care unit closes at Alexandra?	In Ob 2
13. Emergency Medicine - ED consultants at Worcester don't wish to provide support / cover to Alexandra. Have the ED physicians 'bought' into the Trust strategic vision? Ability to recruit & retain middle grade & consultants into ED?	In Ob 2
14. Ambulatory medicine - why are there different ambulatory pathways into Alexandra & Worcester Hospitals? Some managed by acute medicine & some by emergency medicine? Duplication of processes	In Ob 2
15. Why different 'observation' facilities at Alexandra - one managed by acute medicine & one by emergency medicine? Duplication of processes	In Ob 2
16. The co-located primary care unit - why do they wish to perform investigations if they are providing primary care? This should be done by the ED (duplication / waste of resources)	In? Ob2
17. Processes for inter-facility need to be robust & funding for additional vehicles for WMAS must be secured	Out? - refer to evidence by sponsors
18. Additional bed capacity appears lacking at Worcester? Insufficient parking facilities at Worcester site	In? Ob 2?
19. Road signage needs to reflect only adult unit at Alexandra	In Ob 4 - possibly already covered by sponsors evidence
20. The AH site Operating Model for AH could potentially miss the opportunity of increased flow by adopting its planned triage step and not 'stream-lining' the front of ED.	In Ob3
21. The transfer of sub-specialties from AH has the potential to render the proposed service not viable because of the mitigation of risk response to the shift in Paediatrics to WRH. This is further undermined by the instability in the Acute Medical Team at AH.	In Obs 2, 3 & 4

22. The communications Strategy to inform customers of the changes to service provision will have to be extremely effective to mitigate the political backlash and to change their behaviours when choosing to access urgent and emergency care. There is some evidence that the current engagement Strategy has been ineffective in providing Trust Staff with confidence.	In Ob 4 - need to think about public messaging
23. There is a significant challenge in providing sufficient workforce in a broad swathe of specialties and skill-sets to be in a position to deliver FoAHSW, notwithstanding the need for seven-day services in the future.	Out? - general statement
24. The shift of clinical cover to WRH appears to generate the need for additional beds. The level of additional bed provision (80-160) is not convincing because the evidence and analysis is lacking and vague.	In? Ob 3 & 5
25. The description of Countywide services, and by implication; the requirement for under-resourced teams to provide flexible cross-site cover, appears to need further work-up and modelling. As a solution it is not supported by many of the Medical Consultants	In? Ob 3 & 5

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Date: June 2016

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 6 July 2016 **Enc E1**

Report to Trust Board

Title	**Quality Governance Committee – report to Trust Board**
Sponsoring Director	**Dr Bill Tunnicliffe, Associate Non-Executive Director, Chair**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is requested to: • Receive assurance on the management of the Patient and Carer Experience Committee • Note the summarised annual report into the management of complaints and the actions currently being taken • Thank the Patient and Public Involvement Forum for their work • Note the assurance received in the management of people who have had their appointments delayed • Note the deep dive report into SCS division • Note the report into VTE assessment • Note the report
Previously considered by	Not applicable

Priorities (√)

Investing in staff	
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience 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 16 June 2016

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Date of Trust Board: 6 July 2016 **Enc E1**

REPORT TO TRUST BOARD – 6 JULY 2016

1. Situation

This report provides the Board with key quality issues and risks discussed at the QGC's meeting held on 16 June 2016.

2. Background

This report provides the Board with assurance on matters related to patient safety and quality. The QGC reviews reports from its sub-committees, quality performance data, and risks to meeting strategic quality 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 Safety and Improvement

Ms Stevens presented her work on Safety and Improvement. This was using an umbrella campaign for all issues in relation to this topic. She was also keen to develop the trust's own resources in improvement and would be putting on training for this to develop a virtual faculty. She continued to express concern about the 'ward to board' reporting and would develop a clinically led Clinical Governance Committee to ensure better reporting to QGC. This would replace the Operational Governance Committee.

3.2 Patient and Carer Experience Committee

The Associate Director for Patient Experience presented a comprehensive report on the work of this committee. QGC were frustrated with the lack of progress with the Friends and Family Test but were assured that the performance was as expected with the methodology used. QGC asked whether options using new technology (e.g. texting) would be viable and it was agreed to pursue the use of Charitable Funds to fund such a way forward.

Unfortunately, the Trust may not be able to achieve the Accessible Information Standard as it relies on alerts from the patient administration system which currently does not function properly. Work is progressing with IT on this issue.

It was noted that the Dementia Screening CQUIN was achieved in 2015/16.

The Committee learnt that the Patient and Public Involvement Forum have given over 1400 hours of voluntary activity in 2015/16 which is a tremendous achievement.

QGC received an annual summary of performance against the complaint targets. There has been an increase in complaints of 16% from 2014/15 to 2015/16. This is mainly due to an increase in relation to A&E and patient flow. The Trust response time is 66% against a target of 90%. The Interim CNO is working to streamline the complaints process and is conducting a course on writing complaint responses for staff. QGC were assured that by November the metrics on complaints would show an improvement.

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

3.3 Cancer and RTT – harm

QGC received assurance in respect of the care of patients who have been delayed being seen under the two week target. This included speaking directly to patients and giving them information as to what to do if their symptoms got worse. No harm has been recorded to have occurred due to any delays.

3.4 Avoidable mortality

It was reported that 50-60% of primary mortality reviews are being undertaken. Secondary reviews, whilst reported as zero, have in fact taken place as serious incident investigations and learning has taken place via that route. It was acknowledged that the data needed to reflect this. A new approach to the recording of the management of Sepsis is currently being rolled out. The time to theatre for fractured neck of femur remains under achieving. The group overseeing this has identified several reasons for this including unfit patients and lack of theatre space. There continued to be work on solutions to the issue.

3.5 Prescribing errors

The Committee received a report showing that the gaps in control in respect of prescribing errors had all been mitigated except the introduction of the electronic prescribing system which was under control.

3.6 Safeguarding Annual Report

QGC would like to commend this report to the Trust board. It is a separate agenda item. The Committee were impressed with the grip on the agenda by the new Safeguarding lead.

3.7 Quality Exception Report

The Specialised Clinical Services division presented their deep dive report. The number of open incidents was reducing. The recent QA visit in pathology resulted in ISM accreditation.

The Committee has requested a review of the reporting of deep dives as the length of the report is not conducive to assurance being gained by members.

3.8 Quality Impact Analysis

As requested by the Trust Board, the Committee reviewed its approach to QIAs and have agreed that an annual report in November is adequate.

3.9 VTE Quality Account

The Committee expressed its disappointment that the Quality Account has received a qualified opinion for the second year running on VTE assessment. Actions have not been followed through and learning has not taken place. Members have requested a quarterly report on this for the next year.

4 Recommendation

The Board is requested to:

- Receive assurance on the management of the Patient and Carer Experience Committee
- Note the summarised annual report into the management of complaints

and the actions currently being taken
- Thank the Patient and Public Involvement Forum for their work
- Note the assurance received in the management of people who have had their appointments delayed
- Note the deep dive report into SCS division
- Note the report into VTE assessment
- Note the report

Dr Bill Tunnicliffe
Chair – Quality Governance Committee

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 06 July 2016 **Enc E2**

Report to Trust Board in Public

Title	Patient Care Improvement Plan (PCIP)
Sponsoring Director	Sarah Smith, Director of Planning and Development
Author	COO, CNO, CMO, Director of HR & OD
Action Required	The Board is asked to receive the latest published PCIP report and to support the further actions described to ensure that satisfactory progress is being made.
Previously considered by	Combined Quality Improvement Review Group (QIRG) – CQC, NHSI, NHSE, CCGs))

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	

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
Legal Implications or Regulatory requirements	Subject to satisfactory improvement, the CQC has included conditions on the Trust's registration relating to the time to initial assessment in the Emergency Department.
Glossary	NHS I – NHS Improvement NHSE – NHS England CQC – Care Quality Commission CCG – Clinical Commissioning Group NEL – Non Elective LoS – Length of Stay #NoF – Fractured Neck of Femur

Key Messages

The Patient Care Improvement Plan (PCIP) is fundamental to the Trust being able to demonstrate sustainable change and improvement in key areas of Trust operations and governance systems, in response to external scrutiny.

Despite significant effort by staff, progress with the PCIP has been slow. Additional resource has been identified to ensure that the Trust can pick up the pace and increase the levels of engagement, capacity and capability within the Trust to drive improvement work and this should start to bring about the step change required.

This month, effort has been exerted to improve the clarity of reporting of the PCIP to and the further development of the project and programme plans. With additional capacity coming on stream there should be demonstrable improvement in some key metrics over the next three months which should be evident in the streamlined report to the Trust Board.

Title of report	Patient Care Improvement Plan
Name of director	Sarah Smith

Date of meeting: 06 July 2016 **Enc E2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JULY 2016

1. Situation

This paper presents the latest published version of the Trust Patient Care Improvement Plan (PCIP) as presented to the combined Quality Improvement Review Group (QIRG) on June 30th 2016. The QIRG, which meets monthly, comprises the CQC, NHSI, NHSE and the CCGs and, as the Trust is in special measures, is responsible for the oversight of the Trust's improvement plans.

2. Background

The Patient Care Improvement Plan (PCIP) is the mechanism through which the Trust is addressing the key areas of improvement identified from the CQC Chief Inspector of Hospitals Inspection visit in July 2015, in addition to previous safety concerns raised following unannounced CQC visits to the Trust's emergency departments in March 2015.

The Trust defined the scope of this improvement programme to include three priority areas namely Urgent Care and Patient Flow, Avoidable Mortality and Organisation Development and Staff Engagement.

3. Assessment

Please refer to the PCIP report for the full detail. The main exceptions and priorities are as follows:

Urgent Care and Patient Flow

The project plans, governance arrangements and improvement measures are established and there are signs of improvement in line with trajectories in some key areas such as NEL LoS, resulting from a daily multiagency focus on long LoS, the re-establishment of the frailty assessment unit on the emergency floor of the main hospital and more general ambulatory emergency care. The PCIP work programme is closely aligned with the ECIP intensive support programme which should help accelerate improvement. There was a step improvement in time to initial assessment in the ED at WRH due to the consistent deployment of Senior Initial Assessment Nurses (SIAN). The Trust has developed a robust pilot programme to support roll-out of the SAFER bundle over the next period. There is more work to be done to embed these developments at AGH. The Trust has recently employed a dedicated project manager to drive delivery of the UC/PF programme.

Reducing Mortality Programme

The Interim CMO who was the SRO has left the organisation. Nonetheless, there are a well - developed set of project plans and governance arrangements to support the delivery of the improvements required and the new Interim CMO is engaged. Overall the programme lacks the required level of clinical engagement, and external support has been identified to create the right conditions and culture for the changes, as part of a supporting quality and safety campaign. The capacity and capability to deliver the necessary

improvement work is also constrained and a programme of training in improvement skills for key individuals is about to be launched. There is more work to be done to understand the performance issues around #NoF in particular at AGH.

Organisation Development and Staff Engagement

Diagnostic work continues to identify the development needs of key leaders across the organisation and training and skills development in improvement methodologies is about to commence to support the development of a culture of quality and safety. There are range of staff engagement improvements in train at the Trust including Listening into Action which is developing at pace and scale. The Trust anticipates that there will be some improvement in staff engagement measures in due course although there are some key staff groups that require a specific focus, which will take longer to turnaround. There has been an overwhelmingly positive response to the new roles being developed at the Trust and a lot of effort is being expended to recruit new nursing and care staff and retain graduates from the local university. A medical recruitment plan is being rolled out under the auspices of the Workforce Assurance Group.

Governance and Safety

The Trust has made some operational improvements to governance and safety systems and is now receiving support from both the buddy Trust OUH NHS FT, and a dedicated experienced governance manager. As a result the Governance and Safety PCIP is being refreshed to focus on a smaller number of high value work streams. A new governance performance framework and a revised governance structure are also planned.

HDU Review

A small number of operational and governance improvements are in train, however the project needs more strategic development and focus, and the Executive lead has instigated a review of the project aims and objectives and will lead the project going forward.

Outpatients

A dedicated project manager has been appointed to support, coordinate and drive delivery of the work streams. A successful launch workshop was held on June 16th which engaged a broad range of staff involved in the delivery of outpatient care and cemented the work programme.

Women and Children

The leadership team has embedded and continues to deliver the governance and safety improvements developed since the CQC inspection in July 2015. The main risks to patient quality and safety relate to maintaining compliant staffing rotas across two sites. The Division has robust quality and safety monitoring arrangements in place.

3.1 Key risks

Through the development of the PCIP, it has become evident that the Trust lacks a significant degree of improvement and project/programme management capacity and capability, and that day to day operational pressures are a frequent source of distraction from the improvement work.

Additional resource and support has been identified to ensure that the Trust can pick up the pace and increase the levels of engagement, capacity and capability within the Trust to drive improvement work and this should start to bring about the step change required in some key areas.

The Trust has a range of improvement work in train including the PCIP, Listening into Action and the cost improvement programme and we need to ensure that staff are engaged in improvement and have clarity around the Trust plans and their own contributions. There is on-going work to increase staff engagement and understanding of the Trust plans and priorities.

3.2 Controls in place

The Trust has developed an improvement framework which is starting to be consistently adopted. There is further work to do to ensure that this becomes embedded and additional support is being provided to the PMO to deliver best practice and consistency of approach.

The lack of pace with the delivery of the PCIP has been recognised and there is additional resource in place to ensure that individual work programmes have dedicated capacity to focus on improvement work. The Trust is continuing to benefit from support from the NHSI Improvement Director and the 'buddy' Trust support.

The Trust Improvement Board will be reviewing the PCIP on July 13th to scrutinise the improvement plans and to identify the areas requiring greater focus, and the steps required to demonstrate that we are making progress.

The Trust 2016/17 Control Plan will be published imminently, which captures on one page the Trust priorities and programmes in a format that can be applied to most levels within the Trust.

3.3 Gaps in controls and mitigation

Chronic issues around clinical staffing levels in the Trust will continue to impact on the delivery of the PCIP however there are active recruitment plans in place.

4 Recommendation

The Board is asked to receive the latest published PCIP report and to support the further actions described to ensure that satisfactory progress is being made.

Sarah Smith
Director of Planning and Development

WAHT Patient Care Improvement Plan - Overview as at 31st May 2016

Programme	SRO/Lead	Workstream	QTR 1 A	QTR 1 M	QTR 1 J	QTR 2 J	QTR 2 A	QTR 2 S	QTR 3 O	QTR 3 N	QTR 3 D	QTR 4 J	QTR 4 F	QTR 4 M	Progress during this period	Planned in next period	Impact to date
Urgent Care & Patient Flow	**COO**	**Overall Programme**															
	Lynda Ferron/Anne Carey	Safer Bundle													A SAFER bundle pilot was launched 1st April-30th June 2016 on 3 WRH wards, and 3rd May – 30th June on 3 AGH wards. As of 16 May the Patient Flow Centre in-reach nurse will join the 8am board rounds on the 3 pilot wards at WRH. A daily multi-agency multidisciplinary review of the longest waiting stranded patients was implemented from 21st April, to escalate and eliminate treatment or discharge delays. Red and Green day audits commenced in June for pilot areas	Planning is underway for wide scale 'spread' event in June/July 2016, based on the pilot outcomes. This will include the performance monitoring framework for SAFER.	The 3 pilot wards achieved 26% discharges before midday compared to the Trust average of 17.6% in May. Discharges on the EDD for pilot areas was 45% compared to Trust average of 30.7%.
	Lynda Ferron/ Randeep Kular	ED & Acute Care Model													From 31 May a directory of services will be implemented for internal referrals to specialty clinic appointments from ED, MAU and AEC at WRH. A trial of Senior Immediate Assessment Nurse triage was implemented at WRH in the week commencing 25th April. A two week trial of an ambulatory model for medical admissions at AGH MAU was completed by 15th May. An escalation process has been implemented for specialty review delays, and a breach report has been developed.	SIAN triage trial to be conducted at AGH. Implement hospital at night ensuring specialty doctors have capacity to prioritise ED patient review. Review of AEC and MAU model at WRH. Communication plan to support PCIP actions is to be shared with staff in ED, MAU and AEC at both the AGH and WRH sites. To work with Divisional Medical Directors to improve 1 hour specialty review. To work with CCG colleagues on reviewing ED frequent attender with a view to determining possible alternative pathways.	% NEL patients with LoS 0-24 hours increased in May in line with trajectory. Corresponding reduction in NEL conversion to admission rate. Time to initial assessment (95th percentile)- Trust level (all attenders) reduced to 35 minutes in line with trajectory).
	Lynda Ferron/ Chris Cashmore	Patient Flow Centre													An ECIP facilitated workshop to redesign PFC held in April; A workshop was held with staff to review current work practices on 21 April; PFC in-reach to SAFER pilot wards from 16th May; PFC information system 'Framework I' to be installed at WRH capacity hub by 16th May;	PFC to transfer to new host arrangements by 1st July. Divisional Director for Nursing Capacity and Flow was appointed in April and starts at WAHT on 4th July	The Trust has started to see some improvement in average NEL LoS (excl 0-24 hours) - May 15: 6.7 days; May 16: 6.0 days
	Lynda Ferron / Caroline Lister	Frailty Service													Closed Aconbury East Ward ; Created SOPs and developed referral criteria for OPAL (ambulatory), Silver Unit (0-72 hours) and Avon 4 (0-7 days): Began recruitment of an elderly medicine nurse consultant; developed and agreed success/monitoring criteria for OPAL; Launch OPAL at WRH. Pilot of OPAL at AGH started	Implement OPAL in MAU at AGH.	Silver Unit % stranded patients was 47% in May against a trajectory of 55%. NEL ave LoS > 75 years in May was 7.8 days against a trajectory of 8.3 days.
Mortality Reduction	**CMO**	**Overall Programme**															
	Lead TBC	Management of Sepsis													Sepsis screening criteria have been reviewed and a unified screening tool developed which has been piloted in both Emergency Departments. Use of sepsis boxes in the ED has been investigated - the contents have been agreed with view to roll out. First sepsis project team meeting has taken place – further weekly project huddles are being planned. Weekly audit data detailing screening rates is now sent to key members of the clinical team. Project lead under discussion following departure of Interim CMO	Agree one sepsis screening and identification document for use at WAHT. Work directly with urgent care teams to understand, identify and resolve reasons for non-compliance with key quality standards. Obtain best practice information from other providers. Pilot and evaluate in both Emergency Departments and Medical Assessment Units. Develop communication to Surgical, Gynae and Paediatric assessment units. Develop training and awareness sessions in each unit. Work with ED team at each site to ensure specific focus on improving sepsis care. Collate audit data and display within each unit.	% patients that met the criteria for sepsis screening and were screened: 47% in May against trajectory of 55%; 56% in June to date against trajectory of 60%
	Dr Steven Graystone	Mortality Reviews													Mortality review process redesigned. A demand and capacity review of the administrative process supporting mortality review determined sufficient capacity is available to manage workload. Metrics have been established to provide visual management of demand, capacity and backlog thus enabling better process management. A formal process has been established by the CMO through the Divisional Medical Directors to ensure ownership of review when the responsible consultant is a locum within the trust. All outstanding secondary review forms since Jan 2016 have been reissued to the responsible Division via the DMD.	Review the structure of Trust Divisional Governance team meetings to confirm dedicated slots to enable the secondary review process A rapid test of change planned for review of the Serious Investigation Review Process, the learning from this will be used to reformat the Mortality Meeting approach to review and learn from the secondary review process.	Mortality review process has been process mapped and improvements made. Backlog of outstanding primary review forms has been reduced from 41 to 0
	Mr Charlie Docker	Fractured NoF													Project team has met to scope the #NOF improvement priorities. Project work streams have been established. Current state review underway to determine the changes required for successful implementation. Support sought from the operational teams, anaesthetics and medicine to ensure buy in to providing best practice and reviewing care were standards have not been met	Establish project management board. Establish weekly forum for review of appropriate patients. Establish process for documenting reasons for delay in surgery with action plan to expedite surgery. Begin pilot of 'Golden Hip' concept at WRH	
	Joanne Logan / Alison Spencer	NEWS													Project team have established work streams. Current state review underway to determine the changes required for successful implementation. 26 existing trust forms have been identified where the existing early warning is used – leads for change and timeline for adoption have been defined. Communication events (x 3 half days) have occurred to enable rapid spread to the clinical teams. Support sought from the Training and Development team to identify further options for establishing training and awareness for NEWS roll out. Principles of the escalation process agreed. Links made through the new Hospital @ Night improvement work stream. PARS and subsequently NEWS scoring has been developed as part of the ward level performance dashboard facilitating ward managers to actively improve usage at ward level.	Launch ward level performance metrics for early warning score (currently PARS) adherence and usage. Work with the Hospital at Night project team to ensure active incorporation within this work stream. Confirm audit requirements for the NEWS implementation. Confirm NEWS roll out plan. Work with Training and Development Team to develop training data capture and reporting. Determine upper quartile data and set as trajectory for N1. Identify all documents which include an early warning score, redesign documents as appropriate. Remove all PARS documentation from clinical areas, replace with revised documentation. Complete and roll out comms plan to support launch. NEWS leads to acquire invitation to Divisional Meetings – as part of comms plan to support launch	
Organisational Development	**Dir HR & OD**	**Overall Programme**															
	Sandra Berry	Leadership													Scoping of Snr Nurse Leadership programmes commenced and discussed with CNO. Managers Training Needs Analysis commenced. OD Practitioner appointed to complete Managers TNA and scoping of Leadership Strategy	Draft Talent Management Strategy for consultation with Execs and Divisional Directors. Complete Senior Managers TNA. Review existing leadership programmes and skills development programmes provided. Source appropriate 360 degree tool. Source potential providers for bespoke nursing leadership programmes. Review Deloittes feedback to scope Board Development Programme	
	Jan Stevens	Safety Improvement Culture													LiA launched. External support secured to work with Improvement team - finalise arrangements. PID , project plan , project team for Care Out of Hours agreed - Commenced work with OUH NHS FT to review governance arrangements. Complaints and SI training sourced.	Test new Incident form. Pilot RCA for pressure ulcers. Design patient summit – liaise with Kings Fund. Agree safety campaign branding/approach. Scope work programme to strengthen dashboards	

	Debbie Drew	Workforce Plan	Divisional Medical Workforce KPI's were produced as a baseline and presented to WAG in January 2016. Tactical plan to reduce medical and corporate locum spend has been implemented including the agency cap rates from November 2015 and a further reduced cap from February 2016. Head of HR met with Divisions in January to confirm the agreed workforce changes for 2016/17. List shared with Finance and Strategy colleagues and verified to identify those changes that were realistic within the timeframe and attached to agreed business cases.	Head of HR to continue working with Divisions to consider their gaps and how they can use new roles, or skill mix reviews, to help address recruitment difficulties. HR and Nursing to work closely on strategic actions for all recruitment and students support. HCA and Band 5 Assessment centres are scheduled throughout the year, focussing on high risk areas such as Surgery. Adverts to be placed for new Housekeeper and Ward Administrator roles. Attend Physician Associates "What's in it for me" event at University of Worcester – 17th June 2016.	
	Diane Pugh	Policies / Standards	Policy plan developed in conjunction with Staff side partners. Bullying and Harassment Awareness Training refreshed to attract higher numbers. Case management monitoring reviewed and new system implemented to reflect current picture. PDR Policy reviewed in readiness for Policy Working Group. LIA project agreed and commenced focussing on Mandatory and Statutory Training. Review of Mandatory Training frequencies undertaken.	Scope work to strengthen case management reporting to include informal case capture. Review Disciplinary and Grievance Policies and Processes. Re-align HR Advisory Team to support changes in practices and develop HR training and development plans in support of team and recruit to gaps. Scope and develop HR Training Programme. Review current Bank Systems.	Non - medical staff appraisal rates 83% in May against trajectory and target of 85%. Mandatory training compliance 89.9% in May 16.
	Lisa Thomson	Engagement & Communications	ChatBack launched and first survey underway. LiA launched. 10 first LiA ideas confirmed and groups formed. Commissioning of the new website and intranet underway. Induction - Staff handbook drafted and Corporate slides for induction drafted and trialled. Staff Engagement Group formed and work to raise awareness and communicate results from the national staff survey. Trust-wide communication materials of values developed and tested to include the high level strategic direction. Team brief – different approaches trialled including video conferencing and podcast. Staff Reward and Recognition Programme. Scoping of opportunities investigated and tested.	ChatBack - Communications programme to deliver wide awareness of results. Plan and programme developed and delivery commenced with those areas highlighting additional work required . LiA - Pulse Survey completed - Leadership Scorecard™ completed - second Navigation day completed - LiA events delivered (one to be completed in July). Second group of LiA teams underway - LiA champions progamme developed. Website and Intranet - User group (internal and external) identified and testing of options delivered. Induction - Staff handbook trialled with a wider user group and finalised - Work commenced on generic induction materials and presentations. Staff Engagement Group - Widen membership of the Staff Engagement Group - Hold first open staff engagement session. Staff Reward and Recognition Programme - Programme publicised - Health and Wellbeing programme of events - Programme of specific events developed with the Staff Engagement Group and wider staff engagement -event timetable and opportunities publicised	
	Caroline Edwards	New Roles	Each ward identified number of posts required for Band 4 Nurse. Foundation Degree Associate Nurse Band 4 Programme agreed with UW and entry requirements agreed. Recruitment advertisement placed for Ward Housekeeper and Ward Administrator role. Draft Generic Physicians Associate Job Description agreed. Commenced review of number of nurse student placements with a view to increase numbers and review of mentors available to support students. Attended Student nurse "Job opportunity" event at UW to encourage current students to take up permanent posts at WAHT. "What's in it for me "event held for Associate Nurse Role – 1st and 6th June with 70 attendees. Ward Managers briefed on implementation of Associate Nurse role.	Bridging Programme for Band 4 Nurse role at UW commencing 22.6.16. Hold recruitment event for ward administrators and ward housekeeper's role. Agree with Clinical Divisions number of Physicians Associate posts to be recruited and completion of ATR for approval. Advertise for Physicians Associates. Attend "What in it for me to work at WAHT" event at PA event at UW on 17th June 2016. Divisional Training plans and commissions with Universities agreed to support skills development and programmes to support new roles.	Significant local interest in new roles established at WHAT
Governance & Safety	**CNO**	**Overall Programme**			
		Floor to Board Quality reporting	Roll out Duty of Candour monitoring function in Datix. Trajectories for improving patient safety incident management agreed. Backlog of 'potential serious concern' incidents reduced through use of an external resource. Additional investigation training sourced	Revision of PCIP with a focus on the high value actions and workstreams. Complete revision of the incident reporting and investigation policies into a 'pathway' format to include changed processes. Medicines Optimisation Committee to create action plan for medicines training for patients and storage	Trajectories for improving patient safety incident management agreed – initial 50% target met and trajectory to achieve zero open >20 working days set. Notable improvement from 2015 position.
		Governance support structure		Complete review of the governance arrangements and framework and produce recommendations	
		Governance and Safety Performance framework	Phase 3 Ward Dashboard completed	Complete review of quality KPIs and include in Trust dashboards. Phase 4 of Ward Dashboard roll-out to be planned	
HDU Review	**COO**	**Overall Programme**			
	Dr Ed Mitchell	HDU acuity audit	Initial audit completed. Audit being repeated on both units led by Dr E Mitchell. 4 weeks of data collection completed. Group agreed to do a further 2 weeks – now completed	Analyse audit data	
	Sarah King	Nurse Training & Competence	Current nursing workforce skills and staffing complement reviewed	Identify funding stream for B6 Practice Development Nurse for 6 months duration. ATR to be approved at 16/05/16 meeting. Develop generic JD & PS (including rotation to night duty) – draft by next meeting 16/05/16	
	Dr Ed Mitchell	Governance		Quarterly Datix report needed for incidents within HDUs. Scope joint governance arrangements between Critical Care and HDUs. Identify resource to support data entry on ICNARC database. Review operational policies on HDUs	
Outpatients	**COO**	**Overall Programme**			
	Dawn Robins	Outpatient environment	Dedicated Project Manager appointed (start date 16 May). Project Structure in place: Governance Structure Reporting Schedule (template devised and submission dates confirmed with workstream leads – first report deadline 17 June 2016 OIP Project Team meeting dates set and confirmed with workstream leads Risk Register & Stakeholder List OIP Launch Workshop Scheduled – 16 June 2016	Develop and sign off plans with workstream leads Complete all follow up actions post workshop Host first Project Team Meeting Developing measures, data capture and reporting for each workstream Submit first progress report (internal PCIP 24 June) Completion of actions as per workstream plans Obtain support from communication team for: - Regular OIP updates to be circulated across the trust - To celebrate progress / quick wins To promote the outpatient service across the three sites	
	Lynne Mazzocchi	Standards & operating procedures			
	Kira Mortelmans	Clinic room scheduling & utilisation			
	Sabrina Brown	Efficiency and productivity			
	Sabrina Brown	Strategy			
	COO	**Overall Programme**			
Woman & Children (Phase II)	Cathy Garlick	Workforce	Known issues - being closely monitored and scrutinised at Executive Team level. There remain gaps and there is a need to continue to use over cap agency staff and consultants acting down to maintain the medical staff rota. Business Continuity Plan in development and cross divisional work to seek potential solutions to enable an agreed emergency plan.	Continue to monitor and review	

	Cathy Garlick	Governance and Safety		Governance processes are monitored weekly within the division via the weekly Risk & Safety meeting following the concerns raised by the CQC. High levels of performance continue from Phase I programme	Continue with weekly processes	
	Faye Baillie	Caesarean Section		Local Action Plan is in place based on the Reducing CS National Tool Kit. There are weekly review meeting to review all emergency CS and the decision making process. Review of previous month's cases supports the majority of the decisions made, there were a small number of cases that were inappropriately coded and in 3 cases, alternative management may have changed the outcome.	Focus remains on this key patient safety indicator.	Total CS rate decreased to 27.3% in May 16 against a target of 27% (in line with national rates)
	Cathy Garlick	Gynaecology capacity		Several cancellations each week due to bed pressures. Options to use maternity designated beds for elective Gynae procedures is being planned with a trial week in June.	Trial use of designated beds for Elective Gynae	

Work stream underdeveloped - no *sustainable* improvement to report this month

Work stream well developed - no evidence of *sustained* improvement to report this month

Work stream progressing well with evidence of *sustained* improvement this month

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 July 2016 **Enc F1**

Report to Trust Board

Title	**Workforce Assurance Group (WAG) Update**
Sponsoring Director	**John Burbeck** Chair of the Workforce Assurance Group
Author	**Kimara Sharpe** Company Secretary
Action Required	The Board is requested to: • Receive assurance on the development of the OD strategy • Receive assurance on staff engagement • Note the position on agency spend • Note that the Committee considered the Nursing and Midwifery report and the assurance that this gives • Note report on staff turnover • Note the report
Previously considered by	*N/A*

Priorities (√)

Investing in staff	√
Delivering better performance and flow	
Improving safety	
Stabilising our finances	

Related Board Assurance Framework Entries	• Risk 2678: If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels. • Risk 2893: Failure to engage and listen to staff leading to low morale, motivation and productivity as well as missed opportunities • Risk 2894: Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems.
Legal Implications or Regulatory requirements	

Title of Report	**Workforce Assurance Group**
Name of director	**John Burbeck**

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 July 2016 **Enc F1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JULY 2016

1. Situation

To inform the Trust Board on the actions and progress of the Workforce Assurance Group (WAG) at its June meeting.

2. Background

The Workforce Assurance Group provides assurance to the Trust Board on all workforce issues.

3. Assessment

Organisational Development Strategy

The Committee received the final version of the OD strategy. A number of minor amendments were suggested and the Strategy will be presented to the Trust Board in September. Assurance was given in respect of the actions being undertaken in relation to the Patient Care Improvement Plan.

Staff Engagement Update

The results from the Medical Engagement survey, ChatBack and Listening in Action were presented. These showed considerable engagement with staff and progress being made in tackling the areas of concern to staff. Data were available by Division and by directorate and Divisions were urged to take action on the results. This will be monitored through the performance review process. The Board received a presentation on the findings at the Board Seminar on 29 June.

3.2 **Agency staff**

The Committee received assurance that the expenditure continued to fall. Divisions would present their forecasts to the Finance and Performance Committee. Expenditure would probably increase in September due to the number of projected vacancies. Recruitment was taking place as much as possible, but the Trust was reliant on Health Education West Midlands to release the training posts before recruitment can take place. The centralisation of locum coordinators will provide more control and recruitment was underway for these posts.

3.1 **Medical Workforce**

The Committee was pleased to see the number of medical vacancies has decreased from 137 wte to 116 wte. Work was progressing to redesign hard to recruit posts. The Approval to Recruit process was noted to be currently fit for purpose.

3.3 **Nursing and Midwifery report**

This is a Board agenda item. The Committee considered the report and can assure the Board on the progress in this area.

Workforce report for Professional, Clinical Support and Corporate staff

The Committee received the report and were assured that there were no issues to raise at the Board.

Title of Report	**Workforce Assurance Group**
Name of director	**John Burbeck**

3.5 **CQUINs**

There are three elements to the CQUIN associated with staff wellbeing. The Trust is confident that the elements relating to increasing physical exercise and mental health wellbeing will be achieved. However the final element, ensuring 75% of staff have the flu vaccine will be challenging. A vaccination plan has been drawn up. Nationally, it is unlikely that this particular target will be achieved.

3.6 **Staff turnover**

A deep dive into the increase in staff turnover was presented. This showed that the rate whilst increasing in May, is likely to decrease in future months. There was no national benchmarking but locally, the Trust's turnover was similar to other trusts. The main reasons for leaving were retirement, work/life balance, rostas and flexible working. Some local trusts had recruitment premia which was attracting staff. Some staff were returning to the Trust. The Group did not receive assurance that there was the clear understanding about why the turnover rate would now decrease and have requested another report in two months.

3.7 **Other items considered:**

- **Workforce KPIs**
- **Workforce Race Equalities National Survey**: The Trust is forming a BME group to take the actions forward.

4 **Recommendations**

The Board is requested to:

- Receive assurance on the development of the OD strategy
- Receive assurance on staff engagement
- Note the position on agency spend
- Note that the Committee considered the Nursing and Midwifery report and the assurance that this gives
- Note report on staff turnover
- Note the report

John Burbeck
Chair of the Workforce Assurance Group

Title of Report	**Workforce Assurance Group**
Name of director	**John Burbeck**

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc F2**

Report to Trust Board

Title	**Nursing and Midwifery Workforce Report**	
Sponsoring Director	**Jan Stevens, Chief Nursing Officer**	
Author	**Sara Needham, Lead Nurse Education & Workforce**	
Action Required	The Group is asked to receive the report on: • Nursing and Midwifery Workforce metrics and associated actions • Safe Staffing Status • Workforce Review	
Previously considered by	Workforce Assurance Group	
Priorities (√)		
Investing in staff		**√**
Delivering better performance and flow		
Improving safety		
Stabilising our finances		**√**
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	Quality Commission standards, NICE Safer Staffing Guidelines	
Glossary	HCSW – Health Care Support Worker NHSI– NHS Improvement (formerly Trust Development Authority) NICE –National Institute for Health and Care Excellence NMC Nursing and Midwifery Council	

Key Messages

- Safe staffing status and performance against NHSI benchmark remains positive.
- An update on the continuing nursing and midwifery workforce review
- Progress on the reduction of use of agency staff.
- Implementation of Nursing Associate roles
- Fast track Adult RN training at Birmingham City University (BCU)

Date of meeting: 6 July 2016 **Enc F2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 6 JULY 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 (NQB) 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.

The Secretary of State has since requested a refresh of the NQB Staffing Guidance and in February 2016 Safe Sustainable Staffing Guidance Programme was launched. This will result in 8 Safe Sustainable Staffing Guidance documents for different care setting s during 2016. These will include
Urgent and Emergency Care, Maternity Services, Childrens Services and Inpatient wards for adults in acute hospitals.

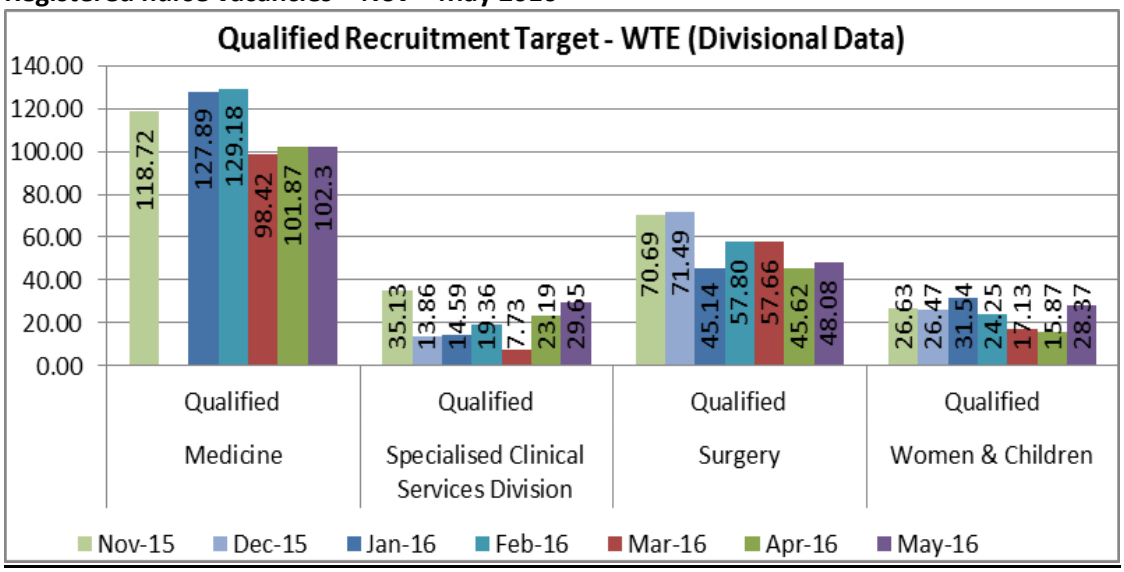
Key points within the new National Quality Board guidance will be :

- Expectations in terms of delivery will be reframed and reduced in number.
- Boards have shared responsibility for staffing.
- Staffing models to look at multi-professional teams

Date of meeting: 6 July 2016 **Enc F2**

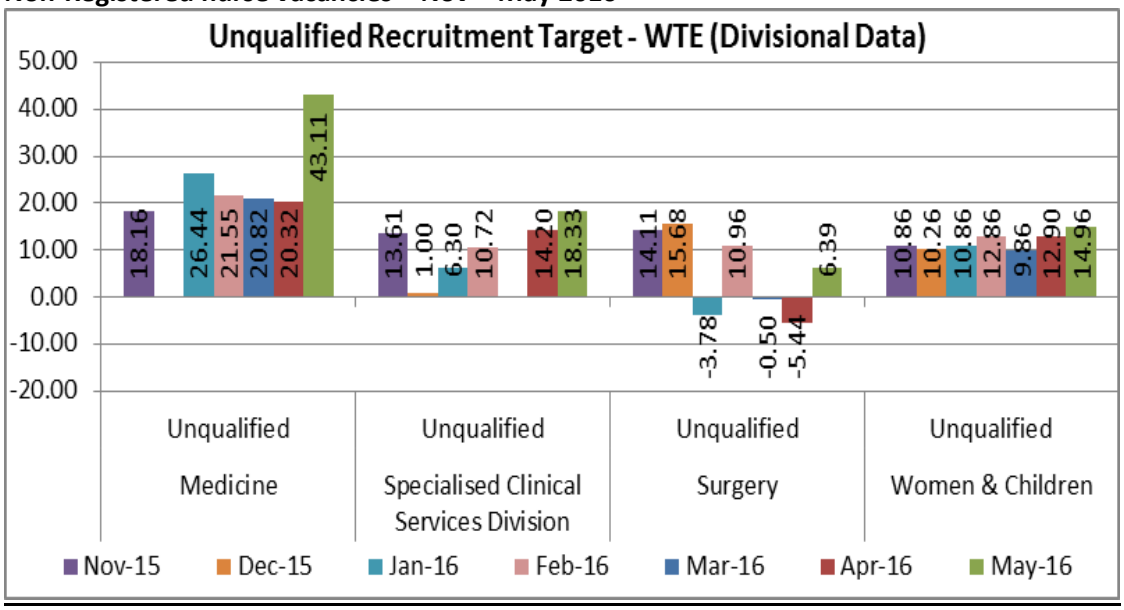
3. Assessment

3.1 Registered nurse vacancies – Nov – May 2016



3.2

Non-Registered nurse vacancies – Nov – May 2016



Surgery

The vacancies for registered nurses within Surgery are 48.08 WTE for May 2016. This is compared to 45.62wte for April 2016.

The vacancies for non –registered nurses in surgery were 6.39 for May 2016 This is compared -5.44 WTE for April 2016.

Some areas within surgery are showing an increase in qualified vacancies however this has occurred following a skill mix review which required an increase in the trained nurse establishment. A number of resignations have occurred since the amalgamation of Head and Neck and Gynaecology services. However, a service review and consultation with this area will take place to identify the issues and challenges and put steps in place to stabilise the workforce.

A number of the qualified vacancies sit within the establishment at the AGH. Some of these posts have been appointed to and the unqualified workforce has been increased to support the challenges in recruitment within the trained workforce.

The division has also been successful in seconding a number of staff to the Nursing Associate training with 8 commencing in cohort one in June 2016 and a further 9 in cohort 2 commencing in September 2016.

Medicine

The vacancies for registered nurses within medicine were 102.3 WTE in May 2016. This is compared to 101.87WTE in April 2016.

The vacancies for non- registered staff were 43.11 WTE in May 2016 compared to 20.32 WTE April 2016.

Hard to recruit areas continue to be a challenge however, recruitment days specifically for the AGH are planned for July. A workforce review has taken place, in view of the new ED expansion and workforce reviews are taking place for the rest of the division.

Staff have been selected for the Nursing Associate training and supported by the division. Appointments have also taken place for the Dementia Lead post and complaints coordinator post.

Specialist Clinical Services Division (SCS)

The vacancies were 29.65 WTE in May 2016 for registered staff and 23.19 WTE for April 2016. The vacancies for non-registered staff were 18.33 WTE in May 2016 compared to 14.20 WTE in April 2016.

Theatres at the AGH and WRH continue to be a challenge from a recruitment perspective. New ways of working are currently being scoped with the consideration of the implementation of the Theatre practitioner role at a Band 4 level. This workforce review will be part of the theatre workforce strategy.

The Theatre internal bank continues to be a success and the number of appointees to the bank continues to increase. The Senior Matrons post for Theatres is also due to go out to advert and an interim post has been secured until the substantive post secured.

Women & Children

Within Women and Childrens Division the vacancy position was 28.37 WTE for May 2016 compared to 15.87 WTE in April 2016. The vacancies for non-registered staff were 14.96 WTE for May 2016 compared to 12.90 WTE for April 2016.

Gynaecology is becoming extremely hard to recruit to, as the nurses want to work in a female only ward delivering Gynaecology care, and don't want to be in a mixed sex ward where there is pressure in getting elective patients onto the ward. It has been identified that neighbouring hospitals have recruited some of the experienced workforce to work in elective Gynaecology. The Division is trying very hard to create ring fenced beds to enable the nurses to work with Gynae patients.

Obstetric Theatres continues to be a risk for the Division as there has been no permanent post holder in the ODP or Scrub Nurse role for 18 months. The Division has asked Clinical Specialised Services Division (SCSD) to manage this area, this has been agreed in principle. This relationship will cover elective lists only and the midwives will continue to scrub for emergency caesarean sections out of hours. The Division believes that the Women's Directorate will need to develop a business case to support staffing for out of hours.

The Divisional Director of Nursing & Midwifery job description, has been revised to incorporate Trust wide paediatric responsibilities. The banding has been uplifted to reflect this. The closing date for the advert is 3rd July and we have had 4 expressions of interest

Maternity have scoped the benefits of utilising a Band 3 ward administrator post and a Band 2 house keeper in the workforce establishment and are due to submit ATR's for these posts.

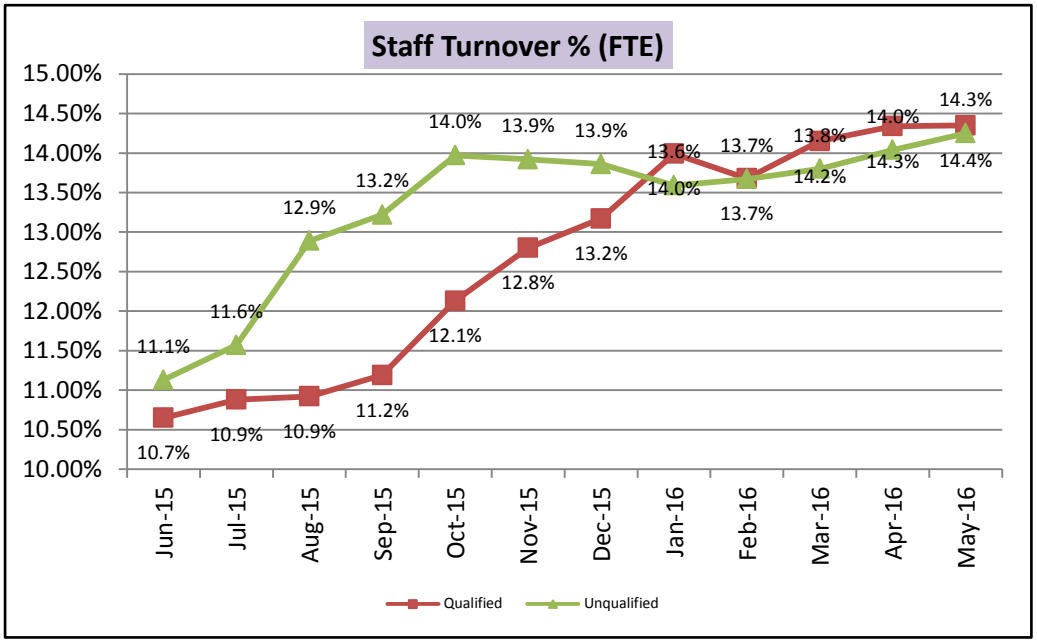
Recruitment Actions

A recruitment event is planned at Worcester University for July and students will be given their final placements in areas which they wish to work.

Recruitment events are being identified regionally and locally and a scoping exercise will take place to evaluate the potential cost/ benefits for these events. Partnership working with our educational providers in the Worcestershire area is also being planned which is envisaged to attract students into the organisation.

The divisions are also due to meet to discuss bespoke rotational programmes for future new recruits and a new perceptorship programme is going to be developed for our newly qualified staff, the new Associate nurse posts and potentially a Band 6/7 programme.

Retention



The staff turnover rate has increased slighted across the qualified and unqualified workforce over the last month. A deep dive into the rationale of staff leaving the Trust is being conducted. Once the issues and challenges have been identified action plans will be put into place to address.

3.2 Safer staffing
Trust overall fill rates for May 2016

	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 (%)**
ALEXANDRA HOSPITAL	99.1%	108.4%	98.9%	94.2%
KIDDERMINSTER HOSPITAL	85.6%	87.8%	99.8%	99.5%
KIDDERMINSTER TREATMENT CENTRE	100.0%	100.0%	100.0%	0.0%
WORCESTERSHIRE ROYAL HOSPITAL	96.6%	123.6%	96.8%	99.2%

The above table indicates that overall our hospital sites are working either to or above the required 80% benchmark set by the NHSI for safer staffing.

The table below outlines all the wards that did not meet the 80% fill rates required by the NHSI for May 2016. Improvements can be seen in terms of fill rates, and support continues to be given to NHSP in term of improving their recruitment numbers. All new recruits will be asked to opt into NHSP to support the organisations temporary staffing requirements and a sharing of information process is being implemented with new recruits consent to reduce the paper work required for recruitment. NHSP have also been asked to join future recruitment days with the University to help increase enrolment numbers.

	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Acute Stroke Unit	94.8%	107.2%	101.4%	114.3%
Avon 2- Gastro	103.9%	92.1%	116.1%	127.1%
Avon 3- Infectious Diseases	94.0%	100.5%	113.5%	145.7%
Laurel 1 Cardiology-CCU	97.3%	91.7%	99.2%	106.2%
Laurel 2 Resp	97.7%	86.0%	98.1%	102.5%
Medical Assessment Unit WRH	109.5%	95.6%	88.7%	87.1%
Silver Assessment Unit	107.1%	98.1%	80.3%	86.3%
GP Unit WF - ward (TCS)	85.6%	87.8%	99.8%	99.5%
MAU ALX	87.3%	103.5%	103.0%	99.2%
Ward 12 Medicine	110.5%	110.4%	106.6%	94.5%
Ward 2 Specialist Med	84.8%	91.0%	120.7%	103.2%
Ward 6	94.7%	95.8%	94.3%	100.9%
CCU- Alex	87.4%	-	100.0%	-
Ward 11	116.9%	95.3%	112.4%	87.7%
Ward 16	93.3%	106.6%	95.8%	91.6%
Ward 17	103.8%	156.9%	72.8%	63.1%
Ward 18	95.3%	108.7%	77.8%	118.1%
SCDU & SHDU	109.2%	79.9%	100.0%	90.7%
Beech B	93.2%	119.1%	100.9%	74.6%
Chestnut	87.6%	104.4%	101.3%	101.0%
Severn Unit & HDU	113.7%	67.3%	100.8%	88.2%
WRH Delivery Suite & Theatre	83.4%	107.1%	92.8%	82.3%
WRH Postnatal Ward	89.7%	95.0%	89.5%	67.7%
WRH Riverbank	84.1%	91.0%	92.2%	87.1%
Alex Ward 1	100.2%	77.4%	106.4%	90.1%
WRH Gynaecology - Chestnut Ward	90.3%	93.5%	93.5%	93.5%
WRH Neonatal	96.4%	87.1%	96.0%	90.3%
WRH TCU Nursery Nurses	67.7%	103.2%	54.8%	96.8%
WRH Antenatal Ward	94.2%	89.2%	87.1%	96.8%

Key

- 80%	
80-94.9%	
95% +	

3.4 Progress with the use of Bank and Agency Staffing

Title of report	Nursing and Midwifery Workforce Report
Name of director	Jan Stevens, Interim Chief Nursing Officer

Further work is taking place in partnership with NHSP to develop guidance for staff to understand the processes for the escalation through the tiers, when staff are not identified to cover staffing gaps via NHSP.

4 Overview of actions and assurances taking place to address the issues which are across the Divisions

Number	Action	Responsible
1.	91 applicants were received for Nursing Associate training. 26 were selected to commence in June and 33 were selected for cohort 2 to commence in September 2016.	Sarah Needham Education and Workforce Lead
2	Shortlisting of Ward house keepers and Ward Administrators has taken place and recruitment and selection process has been agreed and training needs analysis completed. Interviews to commence the week commencing 11th July.	Lisa Miruszenko Deputy Chief Nurse
3	Support continues to take place with NHSP to increase numbers of staff working on the bank. A piece of work has taken place to identify staff not currently registered on the bank and how they can be attracted to sign up.	Lisa Miruszenko Deputy Chief Nurse & Sarah Needham Education and Workforce Lead
4	Plans in place to support staff wanting to transfer to different clinical areas without going through a recruitment and selection process where appropriate in attempt to increase retention.	Julie Stupart HR
5	Positive news regarding workforce development is being sent to the communication department to raise the Trusts profile and ensure that the workforce is aware of the developments taking place within the Trust.	Sarah Needham Education and Workforce Lead
6	Work is taking place to scope the issues and challenges of incorrect inputting of data onto the E roster system and how cost savings could be identified by workforce efficiencies.	Debbie Drew (HR) and Sarah Needham Education and Workforce Lead
7	A scoping exercise re staff within the Worcestershire area who have lapsed their NMC registration has taken place. Support is being sort from the Communication team to get the message out to the public that support for return to practice is available	Sarah King Divisional Director of Nursing
8	Scoping exercise is being led by HR to develop better systems and processes to identify rationale for nurse leavers	Julie Stupart HR

Jan Stevens
Interim Chief Nursing Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc F3**

Report to Trust Board in public

Title	**Medical Workforce Report**
Sponsoring Director	**Dr Andrew Short** **Acting Chief Medical Officer**
Author	**Sarah Allan** **Human Resources Manager**
Action Required	Note the content of the report and assurances that current key priorities are being progressed to support the management of the Medical Workforce.
Previously considered by	*The Workforce Assurance Group*

Priorities (√)

Investing in staff	√
Delivering better performance and flow	
Improving safety	
Stabilising our finances	√

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	
Glossary	

Key Messages

Date of meeting: 6 July 2016 **Enc F3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

1. Background

The medical workforce detail contained in this report identifies a range of key priorities for implementation and delivery.

2. Purpose of the Report

To provide an update on key performance indicators for the medical workforce. The report will also include an update to the Workforce Group on progress of related projects.

3. Workforce Capacity

3.1 Medical Vacancies

Overall, the position is 116.9wte vacancies compared to last month's reported position of 136.85wte. There has been progress with 10 WTE consultants and 2 WTE career grade doctors appointed between 21st May 2016 and 17th June 2016.

The Divisions have been asked to complete a revised return with further detail to confirm the interim arrangements including agency bookings to cover vacancies and the long term recruitment plans. The HR Team will continue to work with the divisions to update action plans weekly and appropriate actions will be taken to mitigate any risks. The recruitment hotspots/ key areas of risk were discussed at WAG.

3.2 Health Education England (HEE) update

3.2.1 August 2016 trainee allocation

The trainee fill rates for August 2016 have increased from 57% reported in May to 81% (251 out of 308) posts now filled. The numbers of posts still to be confirmed for August changeover is consistent with previous years. Whilst all HEE recruitment is complete, allocations to CMT and GP posts continue which accounts for 32 of the 57 posts. Final fill rate/vacancies in these training schemes will be confirmed by the end of June.

Daily updates are received from HEE and the directorates have been informed of their fill rates. Options to cover confirmed vacancies to date include rota redesign, local recruitment and role redesign and HR are working with the divisions to agree and progress the preferred alternative option(s) to ensure continuity of service. This will be progressed in more detail after 6th July once the outcome of the BMA referendum is announced.

3.2.3 Guardian of Safe Working

There are two expressions of interest for this role and the interview panel is being arranged to take place either w/c 4/7/16 or 11/7/16, with a training event hosted by NHS Employers on 26 July 2016.

4. Workforce Costs

4.1 Clinical Excellence Awards (CEA)

The deadline for applications for the 2015 CEA scheme was extended to 27th May following agreement by the Medical Management Committee. Additional eligible applications received have been circulated to the TCEAC panel members for scoring, with the panel scheduled to meet to award points on 13 July 2016. In total there are 52 eligible applications.

5. Workforce Efficiency

5.1 Medical Casework

Tailored actions are in place to ensure all cases reach the agreed milestones by the end of June.

5.2 **Locum Co-ordinator Centralisation**

Due to the complexities of locum co-ordinators having dual roles and difficulties of agreeing the transfer of resources to support a centralised function; an alternative action plan is in progress to appoint required resources externally. An agreed action plan to support the training and development of operating procedures will be developed in conjunction with HCL Workforce during July.

6. Workforce Compliance

6.1 **Revalidation**

As at 30th April 2016, 375 doctors hold a prescribed connection to the Trust with 293 doctors revalidated, which is in line with the GMC revalidation trajectory timeline.

6.2 **Appraisal**

The medical appraisal completion rate as at 31st May for all medical staff is 83.6% which is a 3.4% increase against the April figure of 80.1%. Whilst slightly below the Trust target of 85% completion, this equates to just 5 appraisals required to take place to achieve the target.

A breakdown by staff group is as follows:

Appraisal completion rate (as at 31/5/16)	Direction of travel since 30/4/16	Medical Staff Group
83.6%	⬆ 3.4%	All eligible medical staff
85.7%	⬆ 2.1%	Consultant Staff
75.36%	⬆ 8.7%	SAS and career grade

Corrective actions to improve engagement and increase the medical appraisal rate include:

- Appraisal training for SAS/career grade doctors on 21st and 27th June. Just 7 further appraisals would achieve the 85% completion target which the training is expected to facilitate.
- Expired appraisals escalated to the CMO, which during April resulted in 19/65 expired appraisals being completed. The same process will be followed for the 55 expired appraisals identified in May.
- Implementation of the amended Trust Medical Appraisal and Revalidation policy during June which will improve staff engagement by the introduction of an early reminder process which will reduce the risk of non-appraisal completion.

6.3 **Job Planning**

The current status for job planning is 73% as at 15 June 2016, a 2% decrease from 75% as at 16 May 2016.

The number of current job plans as at 15th June now total:

- Consultants - 203 out of 268 (76%)
- SAS Doctors - 22 out of 45 (50%)

The reduction in the SCS Division is primarily due to 20 job plans that expired within the Anaesthetics Department which was escalated to the Deputy DMD. Three updated job plans have subsequently been received. All consultants are engaged in the process and the remaining job plan meetings have been arranged for June and July.

In addition to the current reports and escalation processes, future actions implemented to support job plan review meetings and improve completion rates include:

- To highlight to the divisions job plans due to expire within a forthcoming three month period to support sufficient time to organise job plan review meetings
- Additional training and support to SAS Doctors on the policy and procedure to complete their job plan review to be finalised.

7. Recommendation

7.1 To note the content of the report and assurances that current key priorities are being progressed to support the management of the Medical Workforce.

Dr Andrew Short
Acting Chief Medical Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc F4**

Report to Trust Board public

Title	**Responsible Officer Annual Report – July 2016**
Sponsoring Director	**Dr Andrew Short, Acting Chief Medical Officer**
Author	**Kim Elmer, Revalidation Support Officer**
Action Required	The Trust Board is requested to: • Receive assurance in respect of the current status for medical appraisal and revalidation and support the required actions to achieve Trust and national targets. • Approve the 'Statement of Compliance' confirming the organisation as a designated body is in compliance with the Medical Profession (Responsible Officer) regulations (**Appendix 1**).
Previously considered by	*N/A*

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

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 medical staff to be revalidated to maintain their licence to practise.
Glossary	**RO:** Responsible Officer **GMC:** General Medical Council **CMO:** Chief Medical Officer **SAS:** Specialty Doctor and Associate Specialists **MPIT**: Medical Practise Information Transfer form **QAMA:** NHS England Framework of Quality Assurance for Medical Appraisers **NCAS**: National Clinical Assessment Service

Key Messages

This report is provided to inform the Board with an update on the progress and management of medical appraisal and revalidation with associated risks and corrective actions. The Board is asked to accept this report and be aware that it will be shared with the Trust's Responsible Officer's Higher Level Responsible Officer.

Date of meeting: 6 July 2016 **Enc F4**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD

1. Situation

This report describes the progress in implementing the Responsible Officer Regulations and management of medical appraisal and revalidation since the annual report presented to the Board in July 2015.

2. Background

Medical revalidation launched in 2012 is the process by which licenced doctors demonstrate to the GMC that they are up-to-date and fit to practise. Full engagement in annual appraisal is integral to successful progression through revalidation and demonstration that medical and dental staff are working in accordance with the GMC's Good Medical Practice framework. The Trust has a statutory duty to support the RO in discharging their duties under the Responsible Officer Regulations.

3. Assessment

3.1 Revalidation

As at 31st May 2016, 375 doctors hold a prescribed connection to the Trust with 293 doctors revalidated, which is in line with the GMC revalidation trajectory timeline set in 2012.

A breakdown of the recommendations is below:

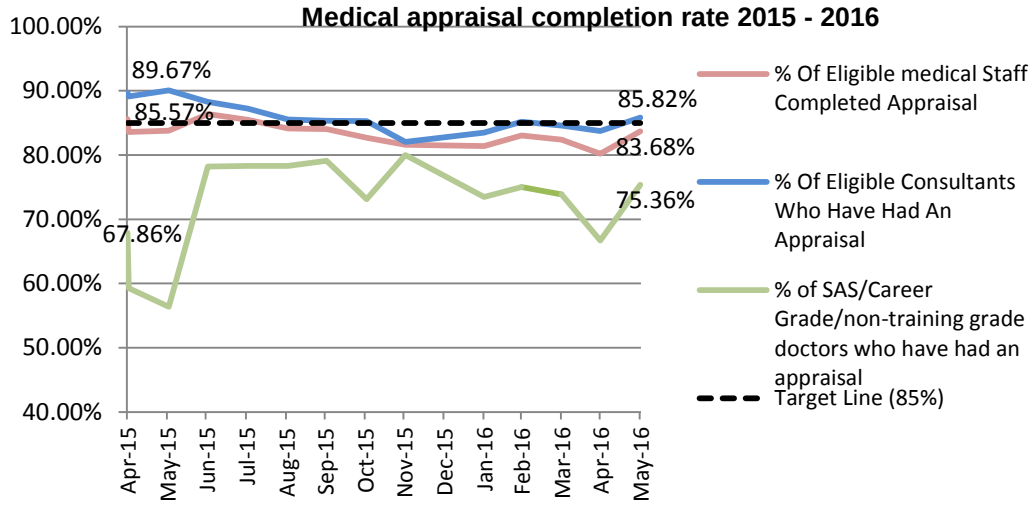
Recommendation	2014-2015	2015-2016
*Total recommendations	160	108
Number of recommendations submitted on time	152 (95%)	108 (100%)
Positive recommendations	125	96
Deferral recommendations	30	12
Non-engagement notification	5	0

*The total recommendations submitted between April 2015-March 2016 reporting period are less than in the 2014-15 reporting period due to the majority of doctors being allocated a revalidation date in the earlier part of the national revalidation cycle.

The Trust achieved 100% compliance submitting revalidation recommendations on time for the 2015 – 2016 period as described above. The percentage of deferral submissions made by the Trust RO since 2012 is 12.1% of all recommendations, which is below the national average of 15.6%. No doctors were referred to the GMC as non-engaging in the 2015-16 period. The RO quality reviews all appraisal input and outputs ahead of a doctor's revalidation date to ensure they are compliant with the requirements of revalidation as shown in **Appendix 2**. Of 98 appraisal folders reviewed, 96 were fully compliant with 2 doctors requiring further information resulting in these doctors being deferred for revalidation.

3.2 Medical Appraisal

The total medical appraisal rate reached the Trust compliance 85% target in July and August 15 has shown a slight decrease as shown below.



The rate has shown recent improvement in May 16 to 83.68% for all medical staff which is a 3.49% increase against the April figure of 80.19% - this equates to just 5 appraisals required to take place to achieve the 85% Trust target. The Consultant rate of appraisal is compliant with the 85% target in May, with the SAS doctor group requiring just 7 further appraisals to achieve this rate. Appraisal training for SAS/career grade doctors on 21st and 27th June is expected to facilitate target compliance by August 2016.

The NHS England Annual Organisational Audit (AOA) submitted for the 2015-16 period reflected a significant reduction in the number of missed appraisals to 98 appraisals from the previous 14-15 reporting period of 121 missed appraisals. However, this remains an area of improvement for the Trust and is captured in the corrective actions in paragraph 3.8.

3.3 Appraisers

New and update appraiser training took place in the first two weeks of April receiving positive feedback from delegates. The Clinical Support division had identified a lack of appraisers as a reason for appraisal non-completion. There are now an additional 5 new appraisers in the division as a result of the training to facilitate improved appraisal completion.

New Appraiser training increased the appraiser pool by 9 appraisers to a total of 72. The Trust's appraiser to doctor ratio is 1:5 which is compliant with the NHS England requirements of between 1:5 – 1:20.

3.4 Recruitment and Engagement Background Checks

The Trust has a centralised Medical Staffing team who process pre-engagement checks for all doctors employed by the Trust in accordance with the NHS Employment Check Standards. A recruitment and engagement annual audit check has identified delays in obtaining the Medical Practise Information Transfer (MPIT) form from other organisations within one month of a doctor's start date. In June 2016, a revised process was implemented including timescales to improve the response rate.

Doctors sourced from locum agencies and through the Trust bank via the HCL Skillstream System are compliant with the Health Trust Europe (HTE) assurance framework with any areas of non-compliance flagged in the system to ensure doctors are not booked. Currently the system does not record the same categories as the Trust which have been proposed

as a development request for the Skillstream system to ensure consistency of employment check standards for locum staff.

3.5 Responding to concern about a doctor's practice

The RO meets with the Director of Human Resources and Assistant Director of Human Resources on a fortnightly basis to discuss all medical casework or doctors of concern. Advice is sought from the GMC Employer Liaison Advisor and NCAS where appropriate.

3.6 Mitigations

The Trust Clinical Appraisal leadership role became vacant from January 2015. After several unsuccessful attempts to fill, the training element of the role has been filled on an interim basis for six months effective from 1st April 2016, leaving the Quality Assurance element unfilled.

3.7 Key risks

- Doctors failing to undertake appraisal will result in the Trust compliance rates not being met. Such doctors pose a governance risk to the organisation as the process ensures doctors are regularly assessed against the GMC's Good Medical Practice standards.
- The Clinical Lead for Appraisal and Revalidation (Quality Assurance role) remains vacant with the potential risk of poor quality appraisal inputs/outputs not being identified in real time and non-compliance with the NHS England Framework for Quality Assurance Medical Appraisers (QAMA).
- Failure to complete pre-engagement checks poses a risk to governance and a doctors fitness to practise being undetermined with a potential risk to patient safety.

3.8 Controls in place and Corrective Actions

Corrective actions to improve engagement and increase the medical appraisal rate include:

- Continue to issue RAG rated appraisal status reports to divisional management teams as a tool to monitor and manage appraisal completion with escalation to the CMO of expired appraisals for follow up with appropriate divisions where required including a trajectory for the next 12 months.
- Implementation of the amended Trust Medical Appraisal and Revalidation policy during June/July which will improve staff engagement by the introduction of an early reminder process and formal process to request postponement of appraisal (as recommended by NHS England). This is expected to reduce the risk of non-appraisal completion and identify the reasons for missed appraisals to enable the Trust to report on those and enable trend analysis and corrective actions to be taken to avoid re-occurrence.
- Appraisal training for SAS/Trust grade doctors on 21st and 27th June with 20 doctors confirming attendance. Just 7 further appraisals would achieve the 85% completion target which the training is expected to facilitate. Training resources will be circulated to all SAS/Trust grade staff to support them with appraisal preparation and completion.
- Appraiser network events will take place in July and December as a mechanism for peer review, calibration of judgement and opportunity for key NHS England and GMC updates to be shared by the Clinical Lead/Responsible Officer to appraisers.
- Re-advertisement of the Trust Clinical Lead for Appraisal and Revalidation role including both training and quality assurance elements.

3.9 Success criteria

Title of report	Responsible Officer Annual Report
Name of director	Dr Andrew Short

- To achieve medical appraisal compliance rate of 85% in all staff groups by August 2016, with 90% compliance by December 2016.
- To maintain 100% compliance with timely submission of revalidation recommendations.
- To revalidate all doctors under notice by March 2018 in line with the GMC trajectory timeline.
- To achieve 100% compliance in completing all pre-engagement checks in accordance with the NHS Employment Check Standards within 1 month of a doctor's start date.

4.0 Recommendation

The Trust Board is requested to:

- Accept assurance in respect of the current status for medical appraisal and revalidation and support the required actions to achieve Trust and national targets.
- Approve the 'Statement of Compliance' confirming the organisation as a designated body is in compliance with the Medical Profession (Responsible Officer) regulations (**Appendix 1**).

Dr Andrew Short
Acting Chief Medical Officer and Responsible Officer

Date of meeting: 6 July 2016 **Enc F4**

Appendix 1 Designated Body Statement of Compliance

The board/executive management team – Worcestershire Acute Hospitals NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: The Trust's Clinical Lead for Appraisal and Revalidation is partially filled (training element only) therefore the full Quality Assurance process will be implemented following appointment to this element of the role.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: The Trust has made recent progress in achieving the 85% appraisal target - specifically the completed consultant appraisal rate annual rate is 85.71% as at 31st May 2016. Appraisal Training for SAS and Trust Doctors has taken place in June to support the SAS doctors' engagement in appraisal and to improve the appraisal completion rate.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Yes

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes

Signed on behalf of the designated body

Name: Signed: _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _

[2] 375 Doctors with a prescribed connection to the designated body on the date of reporting.

Date of meeting: 6 July 2016 **Enc F4**

Appendix 2

Audit of Quality Assurance of appraisal inputs and outputs (April 2015 – March 2016)

Total number of appraisals completed		**271**
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	98	96
Appraisal Outputs	98	98
Appraisal Summary	98	98
Appraiser Statements	98	98
Personal Development Plan (PDP)	98	98

Worcestershire NHS
Acute Hospitals NHS Trust

06 July 2016 **Enclosure G2**

Report to Trust Board in Public

Title	Integrated Performance Report (May 2016)
Sponsoring Director	Sarah Smith, Director of Planning and Development
Author	COO, CNO, CMO, Director of HR & OD
Action Required	The Board is asked to review the Integrated Performance Report for May 2016. The key performance issues and the mitigating actions are described in the report itself.
Previously considered by	*F&P*

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 sustainable and financially viable and makes the best use of resources	√
Continuously improve our services to provide the best outcomes and experience for our patients	√

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience
Legal Implications or Regulatory requirements	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. 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 SHMI – Summary Hospital Mortality Indicator HSMR – Hospital Standardised Mortality Ratio YTD – Year to Date RTT – Referral to Treatment STF – Sustainability and Transformation Fund PTL – Patient Tracking List

Key Messages

For full detail on performance in May 2016, please refer to the IPR report and Trust summary dashboard. The main exceptions and priorities as agreed by the Executive Team are included in this covering paper.

Title of report	Integrated Performance Report
Name of director	Sarah Smith, Director of Planning and Development

Worcestershire NHS
Acute Hospitals NHS Trust

06 July 2016 **Enclosure G2**

REPORT TO TRUST BOARD

1. Situation

This paper presents an integrated corporate performance report (IPR) for May 2016.

2. Background

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. For full detail on performance in May 2016, please refer to the IPR report and Trust dashboard.

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:

Emergency Access Standard

The Trust did not achieve the 95% Emergency Access Standard (EAS) in May 2016. Performance remained below 95% at 82.2%; a decrease from 84.4% in April 2016. There was significant pressure on the ED from levels of attendances (13,799 attendances in May 2016 compared with 12,688 in May 2015) and on-going issues with exit block resulting in overcrowding in the WRH ED in particular. The Trust is working with partners in the System Resilience Group and the Emergency Care Improvement Programme to address the range of Trust and System issues underpinning this performance.

The Trust failed to deliver the national 15 minute standard for assessment in Emergency Department (ED) for the 95th percentile wait (all patients) however performance remained improved at 35 minutes compared to 46 minutes in March 2016. The median wait for treatment in the ED was 70 minutes in May 2016, which is greater than the national standard of 60 minutes.

18 weeks Referral to Treatment (RTT)

Since February 2016, the Trust has been unable to report compliance with the 92% 18 Week referral to treatment incomplete pathways target. Performance in May 2016 was 88.8%.
This performance challenge is largely a result of the temporary reduction in elective capacity during March and April (from changes in Trust policy in respect of additional 'ad hoc' clinical activity, a reduction in capacity over the long Easter Bank Holiday weekend and the Junior Doctors Industrial Action (that resulted in cancellations to allow Consultant staff to work on the front line)). It is anticipated that the performance will not be recovered until Q3 2016/17 in line with the STF trajectory.

Cancer and diagnostic waiting time performance has also been adversely affected as follows and the Trust has urgently developed plans and trajectories to recover this performance during 2016/17.

Cancer Performance

The 62 - day target of 85% for cancer first treatment was not achieved in May 2016 and performance was 77.3%, an increase from 74.0% in April 2016. It is anticipated that the deterioration in performance against 2ww standard will have a significant detrimental impact on the 62 day standard throughout Q1 of 2016/17 and possibly into Q2.

Title of report	Integrated Performance Report
Name of director	Sarah Smith, Director of Planning and Development

In respect of the 2 week wait (2ww) cancer targets (where there had been a marked improvement in performance towards the 93% target), this trend was reversed in March and in April 2016 when performance as anticipated dropped to unprecedented levels due the reduction in available capacity described above. This was the area of activity affected most significantly. For referrals under the 2 week rule, performance in May recovered to 63.6% from 39.4% in April. It is anticipated that the performance will improve in June to circa 75% but will not be recovered until July 2016.

For breast symptomatic patients performance in May dipped further to 27.8% compared with 34.5% in April. Urgent work was undertaken in April and May 2016 to tackle the backlog of 2 week waiters and to develop recovery plans. It is anticipated that the Directorate will return to the levels of historic performance (circa 80%) in July with further improvements in August.

Diagnostics Waiting Time Standard

In May 2016, the Trust failed achieved the target of < 1% of patients waiting longer than 6 weeks for diagnostic tests; actual performance was 5.90% due to going capacity issues in particular in radiology and endoscopy. It is anticipated that the Trust's performance will remain below standard and above the Trust's trajectory during Q1, whilst the backlog is being cleared, prior to sustained recovery from Q2 onwards.

Finance

The Trust recorded a cumulative deficit of £10.4m in May, broadly in line with the plan. Further detail including turnaround actions is provided in the Financial Performance report.

4 Recommendation

The Board is asked to review the Integrated Performance Report for May 2016. The key performance issues and the mitigating actions are described in the report itself.

Sarah Smith
Director of Planning and Development

Title of report	Integrated Performance Report
Name of director	Sarah Smith, Director of Planning and Development

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: May 2016

Patient Safety

Area	Indicator Type	Indicator		May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Incidents and Never Events	Local	QPS3.3	Incidents - SI's open > 60 days (Awaiting closure - WAHT)	10	6	6	5	14	5	3	3	8	9	4	7	6	-	-	Local	0	-	>0	CMO	
	National	QPS4.1	Never Events	0	0	0	0	0	0	1	1	0	0	0	0	0	0	2	National	0	-	>0	CMO	
	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	5	2	2	1	3	0	2	2	6	2	0	3	1	4	26	Local	<=1	-	>=2	CNO	
	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	0	2	0	0	3	2	0	1	0	0	2	1	0	1	12	Contractual	0	1 - 3	>=4	CNO	
	Contractual	QPS7.7	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 4 Avoidable (Monthly)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	Contractual	0	-	>=1	CNO	
Mortality*	National	QPS9.1	Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge - rolling 12 months	109	112	113	113	110	108	109	111	110	108				-	-	National	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months	113	109	109	109	106	105	107	106	106	106	107			-	-	National	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.21	% Primary Mortality Reviews completed**			14%	24%	18%	42%	69%	64%	73%	65%	66%	55%	21%	38%		Local - Q1 target	60		<60	DPS	
	National	QPS.9.22	% Secondary Mortality Reviews completed**			0%	0%	0%	14%	0%	7%	17%	0%	0%	0%	0%	0%		Local - Q1 target	20		<20	DPS	
	National	QPS9.20	Crude Mortality - Trustwide	3.77	2.83	3.48	3.09	3.50	3.27	3.62	3.55	4.15	3.98	3.93			-	-	National				DPS	
Safety Thermometer	National	QPS10.1	Safety Thermometer - Harm Free Care Score	95.12%	95.78%	93.25%	94.57%	92.86%	93.09%	94.20%	92.86%	94.28%	94.82%	93.77%	90.97%	93.33%	-	-	National	>=95%	90% - 94%	<90%	CMO	
VTE	National	QPS11.1	VTE Risk Assessment	95.31%	95.71%	96.67%	95.43%	96.17%	95.65%	94.91%	94.19%	93.20%	93.86%	93.58%	93.82%	95.94%	94.88%	95.00%	National	>=95%	94% - 94.9%	<94%	CMO	
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	3	3	2	4	2	3	0	2	2	3	2	2	4	6	29	National	15/16 Threshold <= 33 16/17 Threshold < =			CNO	
	National	QPS12.4	MRSA Bacteremia - Hospital Attributable (Monthly)	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	National	0	-	>0	CNO	
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective - NEW***	97.58%	97.01%	96.65%	96.68%	99.14%	91.86%	95.70%	97.97%	95.31%	98.61%	95.40%	94.50%	95.00%	-	-	National	>=95	-	<95%	CNO	
	Contractual	QPS12.15	MSSA Cases (Trust Attributable)	3	0	3	2	3	1	0	1	1	2	3	1	1	2	19	Local	-	-	-	CNO	

Patient Experience

Area	Indicator Type	Indicator		May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Complaints & Compliments*	Local	QEX1.1	Complaints - Numbers (In Month)	37	53	59	47	50	54	68	36	63	57	64	59	61	120	629	-	-	-	-	CNO	
	Local	QEX1.3	Complaints - Number per 10,000 Bed Days (YTD)	15.87	17.70	19.09	19.31	19.58	19.91	21.09	20.30	20.52	20.84	21.29	25.80	26.02	26.02	21.29	-	-	-	-	CNO	
	Local	QEX1.14	Complaints - % of Category 2 complaints responded within 25 days (WAHT)	59.0%	53.0%	53.0%	64.0%	86.0%	81.0%	62.0%	77.0%	81.0%	61.0%	55.0%	64.0%			67.0%	Local	>=90	80-90%	<79%	CNO	
Friends & Family****	National	QEX2.1	Friends & Family - A&E (Score)	77.2	72.5	68.0	66.2	61.9	69.6	76.6	70.7	72.4	61.6	63.2	70.2	57.4	70.2	70.8	National	>=71	67-<71	<67	CNO	
	National	QEX2.61	Friends & Family - Acute Wards (Score)									77.0	74.6	77.1	83.2	80.1	83.2	76.0	National	>=71	67-<71	<67	CNO	
	National	QEX2.7	Friends & Family - Maternity (Score)	84.5	80.7	87.4	86.4	88.5	86.0	82.5	84.9	86.7	78.2	76.1	85.9	89.01	85.9	84.2	National	>=71	67-<71	<67	CNO	
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	1	0	1	0	0	0	0	0	0	0	0	0	0	0	2	National	0	-	>0	CNO	

Effectiveness of Care

Area	Indicator Type	Indicator		May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current YTD	Prev Year	Tolerance Type	2016/17 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%	0.5%	0.4%	0.4%	0.4%	0.5%	0.3%	0.5%	0.3%	0.4%	0.5%	0.3%	0.5%	0.4%	0.4%	-	-	-	-	CMO	
EDS	Local	QCQ1.2	Completion of Electronic Discharge Summaries	75.8%	77.7%	77.2%	74.5%	75.6%	79.7%	79.1%	78.1%	74.0%	74.7%	74.6%	73.2%	67.7%			-	-	-	-		
Hip Fracture**	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	70.4%	70.0%	68.0%	71.0%	78.0%	56.0%	76.0%	61.8%	59.0%	76.0%	63.1%	55.0%	65.9%	59.1%	66.0%	National	>=85%	-	<85%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Treatment Pts	79.2%	84.0%	76.0%	75.0%	88.0%	63.0%	87.0%	76.0%	68.0%	80.0%	75.9%	63.0%	79.4%	69.1%	75.9%	National	>=85%	-	<85%	CMO	

Risk Register Activity

Area	Indicator Type	Indicator		May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Risks	Local	QR1.0	% of approved risks overdue for review	30.0%	24.0%	21.0%	19.0%	27.0%	17.0%	14.0%	11.0%	18.0%	12.0%	18.0%	9.0%	14.0%	14.0%	18.0%	Local	<15	15-49	>=50	CNO	
	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%	29.0%	20.0%	23.0%	20.0%	27.0%	27.0%	23.0%	Local	<15	15-29	>=30	CNO	

*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. These metrics have previously been reported in month, these are now reported 'rolling 12 months', this is on advice from HED and the Trust Mortality lead. All months have been changed.
**Primary and Secondary Reviews - Targets have been applied from April 2016.
*** QPS12 There has been an in depth review of the way in which the MRSA metric is calculated internally versus the national guidance. Previously reported data was not compliant, hence this new indicator has replaced the previously reported MRSA metrics.
**** Friends and Family metrics have been reviewed and have been adjusted in accordance with latest guidance. The A&E & Wards metric has been replaced with separate ones.
*****The target for Fractured NoFs has changed to 85% from 90% - effective April 1st, 2016. The 2015/16 performance is RAG rated against 90%.
Worcestershire Acute Hospitals NHS Trust (WAHT)is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register. This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

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

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: May 2016

Area	Indicator Type		Indicator	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Waits	Local	PW2.0	No. Patients on Incomplete Waiting List	18,524	17,899	18,435	18,901	19,876	19,097	28,655	28,086	27,745	29,167	31,569	32,549	32,971	32,971	31,569	Local	-	-	-	COO	
	Local	PW3.0	No. Patients on Inpatient Waiting List	8,028	7,914	7,868	7,610	8,032	8,084	6,705	6,691	7,071	7,237	7,415	7,681	7,802	7,802	7,415	Local	-	-	-	COO	
	Local	PW4.0	Backlog > 18 weeks (Admitted)	3628	3119	2952	3008	3122	2997	3134	2764	2770	3083	4202	4483	4,556	4,556	4,202	Local	-	-	-	COO	
	National	PW1.1.3	6 Week Wait Diagnostics (Proportion of waiting list)	0.81%	1.06%	1.30%	0.95%	0.98%	0.87%	0.97%	1.55%	1.05%	0.71%	3.52%	5.20%	5.90%	5.56%	1.28%	National	<1%	-	>1%	COO	
	National	CW3.0	RTT - Incomplete 92% in 18 Weeks	87.68%	89.07%	90.25%	89.42%	88.81%	89.00%	92.05%	92.05%	92.04%	91.50%	89.20%	88.90%	88.80%	88.80%	89.20%	National	>=92%	-	<92%	COO	
	Local	CW4.1	Over 52 week waiters who have been treated in month - NEW	1	1	3	0	0	1	0	0	0	0	0				7	Local	0	-	>0	COO	
Theatres	Local	PT2.1	Booking Efficiency - ALX	72.00%	72.00%	73.00%	70.00%	71.00%	70.00%	72.00%	71.00%	71.00%	77.00%	75.00%	74.00%	69.00%		-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT2.2	Booking Efficiency - WRH	84.00%	81.00%	86.00%	82.00%	81.00%	82.00%	84.00%	77.00%	82.00%	77.00%	85.00%	86.00%	80.00%		-	Local				COO	
	Local	PT2.3	Booking Efficiency - KGH	70.00%	67.00%	67.00%	74.00%	68.00%	69.00%	70.00%	70.00%	68.00%	71.00%	71.00%	74.00%	74.00%		-	Local				COO	
	Local	PT1.1	Utilisation - ALX	66.00%	69.00%	70.00%	69.00%	71.00%	68.00%	70.00%	70.00%	70.00%	72.00%	70.00%	72.00%	66.00%		-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT1.2	Utilisation - WRH	75.00%	73.00%	74.00%	74.00%	76.00%	72.00%	73.00%	70.00%	72.00%	70.00%	72.00%	74.00%	68.00%		-	Local				COO	
	Local	PT1.3	Utilisation - KGH	66.00%	63.00%	65.00%	71.00%	67.00%	68.00%	68.00%	66.00%	65.00%	68.00%	68.00%	67.00%	70.00%		-	Local				COO	
A & E	National	CAE1.1	4 Hour Waits (%) - Trust *	86.71%	85.46%	85.61%	86.43%	85.00%	88.21%	88.83%	86.97%	81.37%	78.70%	78.77%	80.60%	78.28%	79.60%	85.30%	National	>=95%	-	<95%	COO	
	National	CAE1.1a	4 Hour Waits (%) - Trust inc. MIU - from September 14 *	88.59%	88.21%	88.35%	88.83%	87.64%	90.25%	90.66%	89.07%	84.30%	82.40%	82.30%	84.40%	82.20%	83.30%	87.90%	National	>=95%	-	<95%	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile ^ (inc Kidd MIU)	20	23	25	34	31	28	28	28	35	49	54	38	30	32	-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment (All Patients) (Mins) - 95th Percentile ^ (inc Kidd MIU)	22	23	24	27	31	24	28	28	32	42	46	34	35	34	-	National	<=15mins	-	>15mins	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	49.65%	47.14%	43.50%	41.16%	38.20%	41.09%	42.04%	41.58%	41.74%	38.40%	37.74%	54.00%	56.10%	55.10%	43.43%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	92.16%	90.85%	89.69%	87.99%	86.34%	87.23%	88.10%	88.18%	86.02%	85.58%	81.65%	91.70%	90.20%	91.00%	88.62%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes - WMAS data	6	17	30	29	39	22	26	38	29	26	68	31	51	82	381	Local	0		>0	COO	
Cancer*	National	CCAN5.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	85.12%	75.37%	78.10%	86.50%	75.10%	79.30%	79.40%	89.10%	86.30%	84.40%	75.30%	74.00%	77.30%	76.50%	81.20%	National	>=85%	-	<85%	COO	
	National	CCAN7.0	62 Days: Wait For First Treatment From Consultant Upgrades: All Cancers *		60.00%	18.20%	66.70%	54.60%	66.70%	55.60%	100.00%	80.00%	100.00%	100.00%	58.33%	66.70%	69.90%	70.00%	National	>=90%	-	<90%	COO	
	National	CCAN8.0	2WW: All Cancer Two Week Wait (Suspected cancer)	90.28%	86.84%	83.10%	81.80%	81.40%	85.00%	88.30%	90.40%	84.10%	89.00%	77.30%	39.40%	63.60%	57.70%	85.70%	National	>=93%	-	<93%	COO	
	National	CCAN9.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	98.15%	84.21%	63.50%	83.10%	66.90%	71.40%	80.10%	82.60%	82.90%	91.20%	79.40%	34.50%	27.80%	31.20%	80.00%	National	>=93%	-	<93%	COO	
	National	CCAN10.1	Cancer Long Waiters (104 Day +) includes suspected and diagnosed - treated in month - NEW			10	2	6	12	10	6	2	4	5	10	12			-	-	-	-	COO	
Stroke	Local	CST1.0	80% of Patients spend 90% of time on a Stroke Ward (Final)	95.56%	80.39%	77.80%	81.00%	80.77%	83.33%	74.60%	73.20%	72.55%	81.10%	89.80%				82.21%	Local	>=80%	-	<80%	COO	
	Local	CST2.0	Direct Admission (via A&E) to a Stroke Ward	92.86%	76.92%	67.70%	75.00%	68.18%	77.08%	66.00%	69.20%	69.23%	77.30%	66.10%				74.40%	Local	>=70%	-	<70%	COO	
	Local	CST3.0	TIA	62.00%	61.20%	66.70%	61.50%	56.41%	71.05%	68.20%	65.90%	62.07%	64.70%	60.00%				64.23%	Local	>=60%	-	<60%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH **	100%	103%	100%	100%	101%	101%	102%	102%	108%	102%	102%	102%	100%	101%	102%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX **	93%	91%	85%	91%	93%	94%	96%	94%	104%	104%	96%	91%	93%	92%	94%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN2.3	Beds Occupied by NEL Stranded Patients (>7 days) - last week of month										41.60%	48.40%	55.60%	55.70%			Local	<=45	-	>45		
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute***	37	48	41	39	31	59	25	34	26	33	27	36	33	69	457	-	-	-	-	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute***	2198	1146	1178	1010	778	1362	817	918	807	1,090	725	739	788	1,527	14561	-	-	-	-	COO	
	Local	PIN4.2	Bed Days Lost Due To Acute Bed No Longer Required (Days)	3,359	2,876	2,783	3,438	3,057	3,900	3,133	3,832	3,966	3,320	3,468	3,038	3,252	6,290	40,369	-	-	-	-	COO	
Elective	National	PEL3.0	28 Day Breaches as a % of Cancellations****	15.9%	10.2%	23.8%	16.4%	18.4%	12.3%	12.7%	42.6%	19.7%	14.6%	36.1%	38.3%	14.94%	24.49%	20.1%	TBC	<=5%	6 - 15%	>15%	COO	
	National	PEL3.1	Number of patients - 28 Day Breaches (cancelled operations)						7	7	17	14	14	26	23	13			TBC	-	-	-	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	0	0	0	0	0	1	1	1	1	0	0	0	1	100.00%	4	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	5.1	5.1	5.3	4.9	4.8	4.5	4.3	4.6	5.0	4.6	4.7	4.7	4.37	4.6	4.8	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	6.7	6.7	7.0	6.5	6.4	6.3	5.9	6.5	6.9	6.5	6.5	6.5	6.08	6.3	6.6	-	-	-	-	COO	

** Cancer _this involves small numbers that can impact the variance of the percentages substantially.*
***Bed occupancy data source is Bed State Report.*
****w/c 22nd Oct was not available, so the previous week has been used to calculate October performance.*
*****Some of these figures may have been updated in later months due to validation - however the Trust dashboard data remains as published, this means that there may be a slight discrepancy between PEL3.0 and PEL3.1 for months prior to February 2016.*

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

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Worcestershire Acute Hospitals NHS Trust

Workforce Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: May 2016

Area	Indicator Type	Indicator		May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO
																				On Target	Of Concern	Action Required	
Vacancies & Recruitment	Local	WVR1.1	New Starters (WTE)	32	50	32	221	130	52	67	42	67	106	49	57	50		906	Local	-	-	-	DoHR
Turnover	Local	WT1.0	Staff Turnover WTE %	10.5%	10.5%	11.0%	11.4%	11.6%	12.3%	11.9%	12.3%	12.8%	12.7%	13.0%	13.0%	12.9%		12.97%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.3	Nursing Staff Turnover - Qualified	10.7%	10.7%	10.9%	10.9%	11.2%	12.1%	12.8%	13.2%	14.0%	13.7%	14.2%	14.3%	14.4%		14.2%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.4	Nursing Staff Turnover - Unqualified	11.6%	11.1%	11.6%	12.9%	13.2%	14.0%	13.9%	13.9%	13.6%	13.7%	13.8%	14.0%	14.3%		13.8%	Local	9-10%	<>9-10%	-	DoHR
Sickness & Absence	Local	WSA1.0	Sickness Absence Rate Monthly (Total %)	4.02%	4.10%	4.18%	4.31%	4.50%	4.82%	4.39%	4.62%	4.69%	4.32%	4.05%	3.89%	4.01%		4.05%	Local	<= 3.50%	>=3.51% & <=3.99%	>= 4.00%	DoHR
Temporary Staffing	Local	WTS1.0	Agency Staff - Medics (WTE) Indicative	157.6	158.1	165.8	173.0	176.0	176.7	170.7	163.4	159.4	154.8	158.7	126.6	128.1		158.7	Local	<=85	85.1-100	>100	DCE
Induction	Contractual	WIN1.3	% of eligible staff attended Induction	89.7%	95.5%	89.2%	92.1%	93.5%	73.8%	87.3%	94.6%	100.0%	73.4%	87.0%	100.0%	93.6%	97%	88.2%	Contractual	>= 90%	80 - 89%	< 80%	DoHR
Statutory and Mandatory	Contractual	WSMT10.2	% Of Eligible Staff completed Training	83.7%	84.5%	85.8%	82.1%	84.2%	84.4%	85.5%	87.2%	87.1%	86.9%	86.8%	87.7%	89.9%	88.8%	85.1%	Contractual	>= 90%	60.1-89.9%	<=60%	DoHR
Appraisals	Contractual	WAPP1.2	% Of Eligible non-medical Staff Completed Appraisal	79.6%	80.4%	82.7%	77.0%	75.2%	74.4%	74.5%	78.2%	78.3%	76.2%	79.9%	81.1%	84.9%	83%	77.9%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP2.2	% Of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	83.6%	83.8%	86.4%	85.1%	84.1%	84.0%	82.7%	81.6%	81.4%	83.0%	82.4%	80.2%	83.6%	82%	83.6%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP3.2	% Of Eligible Consultants Who Have Had An Appraisal	89.1%	90.0%	88.3%	87.2%	85.5%	85.3%	85.3%	82.0%	83.5%	85.2%	84.6%	83.7%	85.7%	85%	86.2%	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.*

*** With the exception of IG the mandatory training target has been revised from 95% to 90% effective from Feb 2016. Data from Feb 2015 is now calculated against 90% (except IG)*

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

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Worcestershire Acute Hospitals NHS Trust

Maternity Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: May 2016

Area	Indicator Type	Indicator		May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Current YTD	Prev Year
Scheduled Bookings	National	MSB1.1	Women Booked Before 12 + 6 Weeks	85.6%	88.0%	89.0%	87.7%	89.0%	88.5%	93.3%	92.0%	88.5%	88.6%	91.3%	85.9%	89.4%	87.6%	89.2%
Deliveries	Contractual	MDEL1.0	Deliveries	511	519	507	472	484	496	484	439	447	462	496	441	458	899	5782
Births	Contractual	MBIR1.0	Total Births	521	532	515	478	490	504	492	447	454	470	502	449	465	914	5876
	Local	MBIR1.1	Of which - Birth Centre Births - NEW	54	58	49	39	61	46	58	46	50	55	63	50	75	125	607
Normal Vag. Deliveries	Contractual	MNVD1.0	Maintain Normal Vaginal Delivery Rate	57.5%	56.6%	57.7%	62.7%	63.7%	56.9%	56.8%	56.7%	57.3%	60.6%	63.3%	56.0%	60.5%	58%	59.3%
C- Section	Contractual	MCS1.0	Total Caesareans	28.2%	33.7%	32.6%	28.1%	26.6%	31.3%	32.6%	30.5%	29.8%	28.6%	27.6%	32.7%	27.3%	29.9%	29.6%
	Contractual	MCS1.1	Elective Caesareans	9.3%	12.8%	12.3%	10.0%	11.0%	15.0%	13.6%	13.2%	11.6%	13.0%	11.7%	13.8%	12.0%	12.9%	12.2%
	Contractual	MCS1.2	Emergency Caesareans	18.8%	20.8%	20.3%	18.1%	15.6%	16.3%	19.0%	17.3%	18.1%	15.6%	15.9%	18.8%	15.3%	17.0%	17.4%
Outcome Indicators	National	MOI1.0	Breast Feeding Initiation Rates	71.1%	72.5%	73.0%	72.0%	74.6%	73.0%	68.6%	69.7%	70.1%	71.1%	70.6%	71.7%	68.6%	70.1%	71.4%
	Contractual	MOI3.0	Midwife Led Care %	21.0%	22.0%	21.1%	20.5%	23.9%	20.1%	20.9%	19.4%	18.3%	22.5%	22.4%	19.5%	24.7%	22.1%	21.3%

Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kite mark
	On Target	Of Concern	Action Required		
National	>=90%	-	<90%	CNO	
Local	>=5890 deliveries in the year			CNO	
Contractual	<=480	481 - 531	>532	CNO	
Local	>=800 births in the year			CNO	
Contractual	>63%	63% - 60%	<60%	CNO	
Contractual	<27%	27% - 30%	>30%	CNO	
Contractual	<=11.2%		>11.2%	CNO	
Contractual	<=15.2%		>15.2%	CNO	
National	> 74%	70% - 74%	< 70%	CNO	
Contractual	>= 37.7%		<37.7%	CNO	

NB: Please note that tolerances are adjusted between financial years

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Worcestershire NHS
Acute Hospitals NHS Trust

6 July 2016 **Enclosure G3**

Report to Trust Board (public)

Title	**Financial Performance – Month 2 2016/17**
Sponsoring Director	**Rob Cooper – Interim Director of Finance & Information**
Author	**Haq Khan – Deputy Director of Finance** **Jo Kirwan - Assistant Director of Finance**
Action Required	The Board is asked to note: - The Trust is broadly in line with plan at Month 2. - Income is below plan due to activity being under plan. - The Trust is required to deliver an additional £3.7m savings to achieve the revised control total. - The Trust has received a high volume of data queries from Commissioners and a number of contractual notices are expected imminently.
Previously considered by	Finance & Performance Committee

Priorities (√)

Investing in staff	
Delivering better performance and flow	
Improving safety	
Stabilising our finances	✓

Related Board Assurance Framework Entries	2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service. 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability
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 3 year 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.

Key Messages:

At the end of May the Trust recorded a cumulative deficit of £10.4m broadly in line with the plan. Although overall the Trust is delivering to plan there are significant variances across income and expenditure. The slides attached provide a summary of the key variances and highlight the following key themes:

- Contract fines and penalties
- Vacancies
- Reduced income and expenditure due to elective activity below plan

Looking forward there are significant challenges to delivering the planned deficit, these include:

- Potential shortfall on CIP of £6.8m
- Unfunded cost pressures of £3.6m
- Further £3.7m improvement to the position required following agreement of new control total of £34.6m.

POINTS TO NOTE

- The position is benefitting from the back phased CIP with only £2.1m of the £24.3m target phased into the YTD position. Plans need to be formulated and implemented urgently to coincide with the ramp up of the target over the coming months.
- Activity levels have recovered to an extent in May but further improvements are required across a number specialities, particularly in day cases and electives, to achieve contracted levels and reduce fines through improved performance. For Q1, anticipated fines on local CCG contracts have reached the 2.5% cap.
- The expenditure variance to some extent reflects the lower than planned activity levels and reduced expenditure associated with additional activity sessions.
- The Trust will need to deliver another £3.7m of savings to achieve the agreed control total and any new cost pressures will need to be tightly managed within budgets.

Title of report	Financial Performance – Month 2 2016/17
Name of director	Rob Cooper

Financial Risks & Forecast – The Trust has a challenged cancer performance and waiting list position and will need to source additional capacity over the coming months to improve the position. In addition there are a number of new consultant vacancies across medicine and surgery that will increase the agency run rate in the short term. The other key consideration is that the CIP target is back ended so the I&E position is on plan but the run rate is higher than where we need to be. In short, a combination of new cost pressures, the continued shortfall against CIP plans and an additional savings requirement following the agreement of a new control total has led to the current risk of not delivering our planned outturn that is in the region of £13m.

Urgent action is required to address these three key risks.

Control Total and Sustainability & Transformation Fund update

After careful consideration the Board has agreed the revised control total of £34.6m deficit including £13.1m of STF. The Board has highlighted the risks to delivery that will need to be managed with support from NHS improvement, these include:

- Delivering an additional £3.7m of savings will provide a substantial challenge for the Trust. The total savings target for the year will now be £28m (6.4% of gross cost). The key to delivering this will be transformational support and reducing agency expenditure further. The Trust has made good progress on reducing agency expenditure but further significant reductions in medical agency expenditure will require all Trust's across the patch adhering to capped rates.

- The Trust is confident in delivering the improvement trajectories for most key standards. Whilst we continue to embed new internal processes in line with ECIP recommendations the Emergency Access Standard will continue to be challenging unless the right level of support is forthcoming across the entire local health economy. In particular, the levels of emergency demand need to be better managed, and out of hospital capacity will also need to be enhanced.

- Local commissioners are becoming increasingly financially challenged, which is leading to a greater level of transactional behaviour. We have received £2m (10% of contract value) of data queries for April and are expecting to receive a number of contractual notices imminently. As well as increasing financial risk, responding to these is extremely time consuming and restricts the Trust's ability to engage constructively with commissioners on QIPP delivery and service redesign and detracts from expediting the delivery of savings across the Trust. We would look to NHSI for help in creating an environment where all parties are focused on collaboration and mutual support.

The Trust awaits further clarity on the administration of the STF, particularly in relation to the applications of penalties.

Title of report	Financial Performance – Month 2 2016/17
Name of director	Rob Cooper

Worcestershire NHS
Acute Hospitals NHS Trust

Finance Report Month 2

Rob Cooper

Interim Director of Finance

6th July 2016

Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

At the end of May the Trust recorded a cumulative deficit of £10.4m broadly in line with the plan. Although overall the Trust is delivering to plan there are significant variances across income and expenditure. The table below provides a summary of the key variances and highlights the following key themes:

- Contract fines and penalties
- Vacancies
- Reduced income and expenditure due to elective activity below plan

Looking forward there are significant challenges to delivering the planned deficit, these include:

- Potential shortfall on CIP of £6.8m
- Unfunded cost pressures of £3.6m
- Further £3.7m improvement to the position required following agreement of new control total of £34.6m.

	YTD Var £m	Variance Analysis
Patient Care Revenue	(2.3)	YTD position includes anticipated fines of £1.7m and below plan inpatient income (£1.3m) offset by favourable variance in other contract income (£0.6m - of which a significant proportion results from the YTD absense of CCG QIPP programmes).
Pay	2.2	Across Nursing and Medics £0.5m of the variance was due to a reduction in additional activity sessions. A further £0.5m is due to vacancies across non clinical and £0.3m ST&T staff groups. The balance was generated by below planned levels of activity.
Non Pay	0.2	Non pay delivered positive variances across most areas due to reduced levels of elective activity and delivery of growth across other PODs at marginal cost.

Key Messages

- The position is benefitting from the back phased CIP with only £2.1m of the £24.3m target phased into the YTD position. Plans need to be formulated and implemented urgently to coincide with the ramp up of the target over the coming months.
- Activity levels have recovered to an extent in May but further improvements are required across a number specialities. particularly in day cases and electives, to achieve contracted levels and reduce fines through improved performance. For Q1, anticipated fines on local CCG contracts have reached the 2.5% cap.
- The expenditure variance to some extent reflects the lower than planned activity levels and reduced expenditure associated with additional activity sessions.
- The Trust will need to deliver another £3.7m of savings to achieve the agreed control total and any new cost pressures will need to be tightly managed within budgets.

Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

Income – Healthcare income was £0.7m under plan in May and is now £2.4m under plan YTD. Both the in month and YTD positions are primarily driven by anticipated fines of £0.8m in May, bringing it to £1.7m YTD after application of the 2.5% quarterly contract cap. The Trust full year plan reflects £5m of notified CCG QIPP schemes and assumes an impact from the beginning of the financial year, primarily in reducing emergency demand. This is not yet evident in the levels of demand seen to date.

Pay – Expenditure increased in month by £0.3m, £0.2m of this was expected due to bank holiday enhancements with budgets phased accordingly to offset the increase. Overall expenditure remained at the reduced levels seen in Q4 of 15/16 reflecting the impact of the £10m full year reduction and the reduced levels of additional activity sessions . Pay under spent by £2.2m driven by reduced additional activity sessions worth £0.5m, vacancies in STT and Non Clinical staff not covered by agency staff (£0.3m and £0.5m respectively). The balance was generated by lower levels of activity than anticipated in Trust plans.

Agency expenditure and cap breaches – Agency expenditure continues to fall and remains below £2m per month for the second month in succession for the first time since March 2015. Despite the reduction in agency expenditure the breaches remain stable at just under 600 per week due to a further reduction of the capped rates and the extension of framework breaches to all staff groups from April. The Trust's agency ceiling of £22.9.m appears achievable considering the anticipated delivery of in-year savings . However, the high level agency forecast , which includes cost pressures , highlights how close the Trust is to its mandated ceiling.

Non Pay – Healthcare related non pay expenditure is in line with lower than planned activity levels including lower than anticipated levels of outsourcing. However, the overall non pay run rate has increased as a result increased IT leasing costs and the presence of non recurrent items including loan interest and external consultancy and legal fees.

Cash - The Trust held a balance of £6.5m at the end of May, which is higher than the £1.9m minimum balance requirement which is a condition of the Trust's cash support loan. An additional loan of £15.4m was secured during May with an interest rate of 1.5% repayable in 2019. The Trust has drawn down £4.1m against this loan in May and a further £5.2m in June. The remaining balance of £6.1m will provide the Trust with cash support until July/August 2016 depending on the timing of the STF. An improved cash position has enabled the Trust to address some of the creditor backlog.

CIP - Performance for M2 was £1.2m. While this shows significant improvement, it does include benefits in M1 only now being realised. YTD, the Trust is £38k ahead of the back-ended phased target, however, against a £25.3m target, the current full year forecast sits at only £18.5m.

Capital - The approved plan is £1.7m over committed compared to the available funding. Finance are working with the work stream leads to reprioritise schemes and review additional opportunities. Options are being worked through for discussion at CPG in July. There will be a mid year review and a revised capital programme presented to the September FPC. In the meantime the Trust will need to commit expenditure at risk ahead of securing the loan funding to progress essential schemes related to the ASR capacity business case.

Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

Financial Risks & Forecast – The Trust has a challenged cancer performance and waiting list position and will need to source additional capacity over the coming months to improve the position. In addition there are a number of new consultant vacancies across medicine and surgery that will increase the agency run rate in the short term. The other key consideration is that the CIP target is back ended so the I&E position is on plan but the run rate is higher than where we need to be. In short, a combination of new cost pressures, the continued shortfall against CIP plans and an additional savings requirement following the agreement of a new control total has led to the current risk of not delivering our planned outturn that is in the region of £13m.

Urgent action is required to address these three key risks.

Control Total and Sustainability & Transformation Fund update

After careful consideration the Board has agreed the revised control total of £34.6m deficit including £13.1m of STF. The Board has highlighted the risks to delivery that will need to be managed with support from NHS improvement, these include:

- Delivering an additional £3.7m of savings will provide a substantial challenge for the Trust. The total savings target for the year will now be £28m (6.4% of gross cost). The key to delivering this will be transformational support and reducing agency expenditure further. The Trust has made good progress on reducing agency expenditure but further significant reductions in medical agency expenditure will require all Trust's across the patch adhering to capped rates.

- The Trust is confident in delivering the improvement trajectories for most key standards. Whilst we continue to embed new internal processes in line with ECIP recommendations the Emergency Access Standard will continue to be challenging unless the right level of support is forthcoming across the entire local health economy. In particular, the levels of emergency demand need to be better managed, and out of hospital capacity will also need to be enhanced.

- Local commissioners are becoming increasingly financially challenged, which is leading to a greater level of transactional behaviour. We have received £2m (10% of contract value) of data queries for April and are expecting to receive a number of contractual notices imminently. As well as increasing financial risk, responding to these is extremely time consuming and restricts the Trust's ability to engage constructively with commissioners on QIPP delivery and service redesign and detracts from expediting the delivery of savings across the Trust. We would look to NHSI for help in creating an environment where all parties are focused on collaboration and mutual support.

The Trust awaits further clarity on the administration of the STF, particularly in relation to the applications of penalties.

Worcestershire NHS
Acute Hospitals NHS Trust

Appendices

Trustwide Position

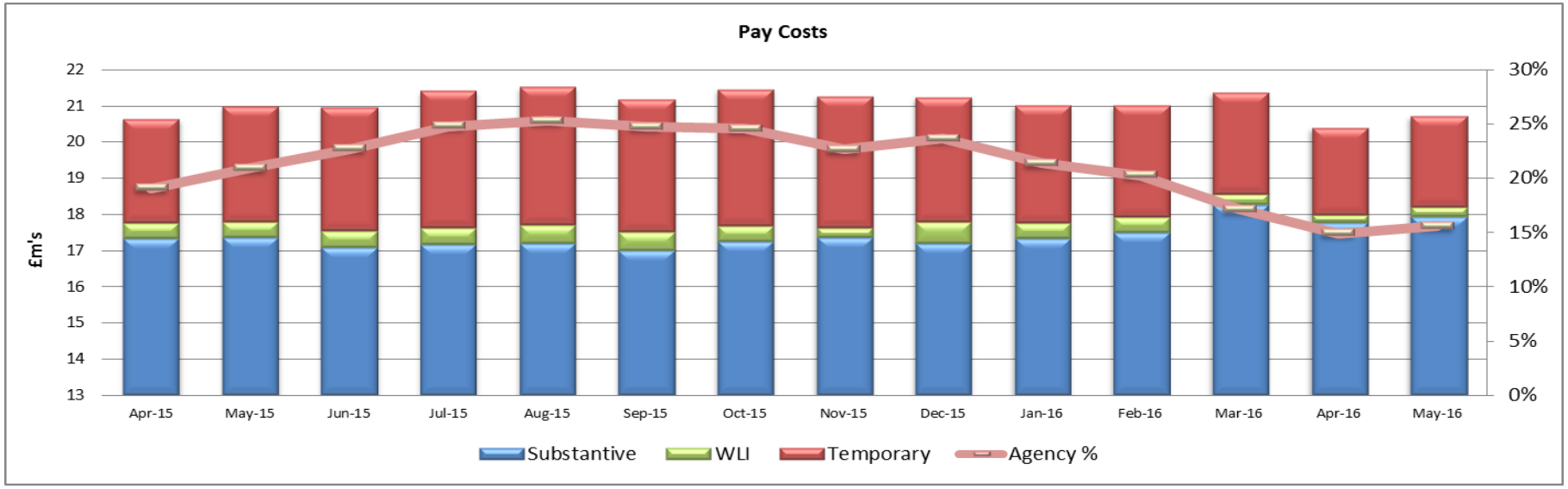
Worcestershire NHS
Acute Hospitals NHS Trust

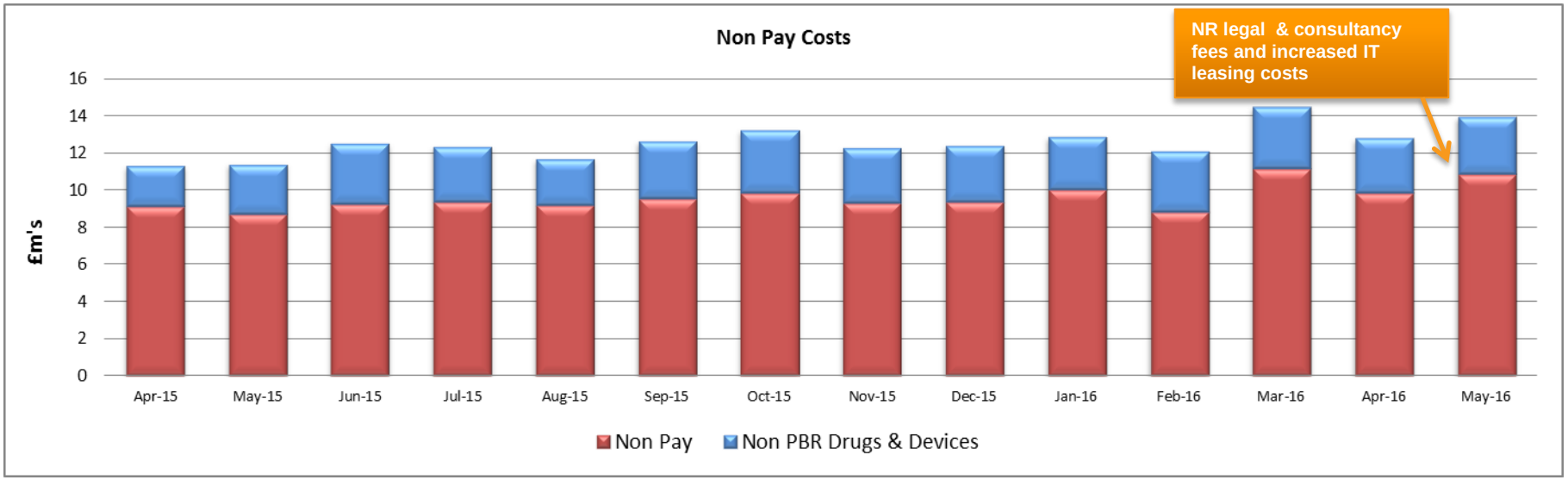
Income & Expenditure	Year to Date			Full Year
	Plan	Actual	Var	Plan
	£000s	£000s	£000s	£000s
Operating Revenue & Income				
Patient Care Revenue	53,795	51,506	(2,289)	317,541
Other Operating Income	4,318	4,296	(22)	25,905
Non PBR Drugs & Devices	6,015	6,015	0	41,319
Total Operating Revenue	**64,128**	**61,817**	**(2,311)**	**384,765**
Operating Expenses				
Pay	(43,314)	(41,127)	2,187	(256,030)
Non Pay	(21,039)	(20,842)	197	(155,351)
Non PBR Drugs & Devices	(6,015)	(6,015)	0	0
Total Operating Expenses	**(70,368)**	**(67,984)**	**2,384**	**(411,381)**
EBITDA *	**(6,240)**	**(6,167)**	73	**(26,616)**
EBITDA %	-9.7%	-10.0%		-6.9%
Depreciation	(1,788)	(1,726)	62	(9,982)
Net Interest, Dividends & Gain/(Loss) on asset disposal	(2,479)	(2,632)	(153)	(14,876)
Reported Total Surplus / (Deficit)	**(10,507)**	**(10,525)**	**(18)**	**(51,474)**
Less Impact of Donated Asset Accounting	12	11	(1)	72
Less Impact of IFRIC 12 adjustments	0	124	124	
Surplus / (Deficit) against Control Total	**(10,495)**	**(10,391)**	**105**	**(51,402)**
Surplus / (Deficit) %	-16.4%	-16.8%		-13.4%

** EBITDA = earnings before interest, tax, depreciation and amortisation*

Pay & Non Pay

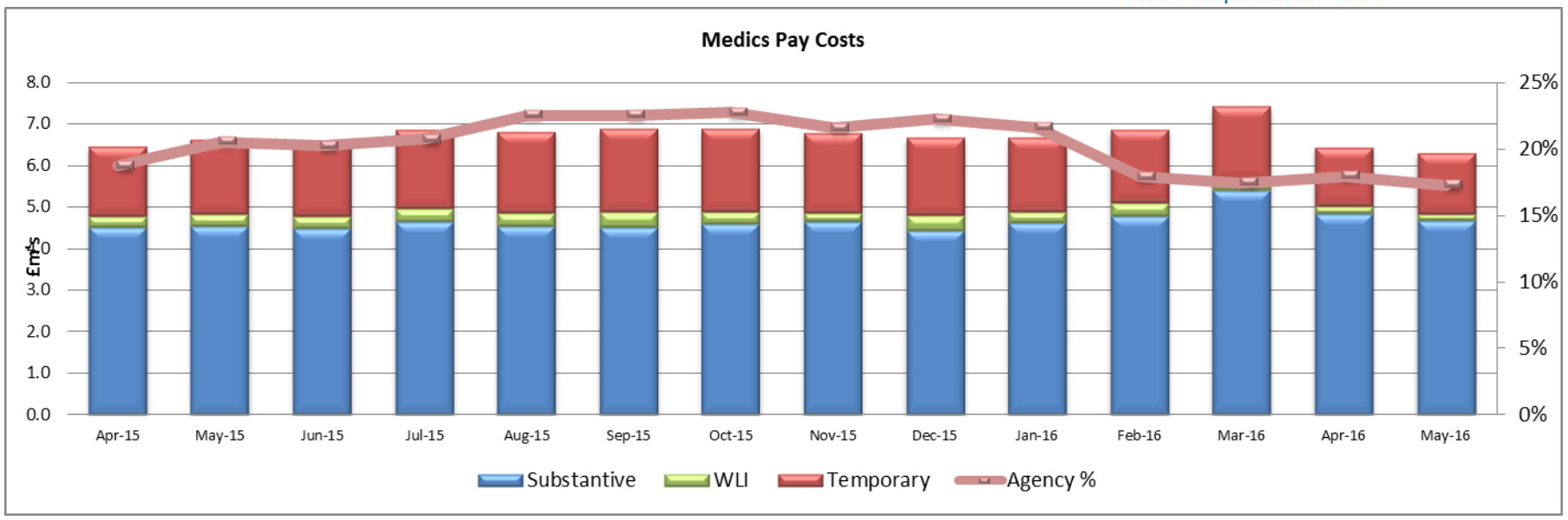
Worcestershire NHS
Acute Hospitals NHS Trust



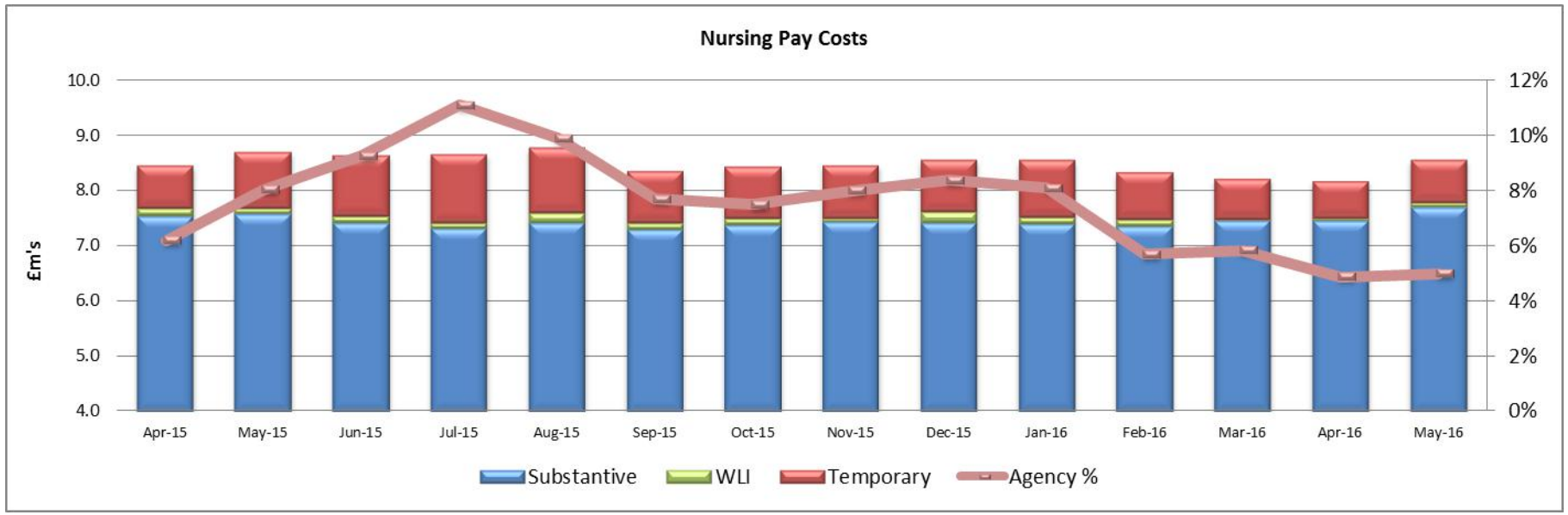


Medics & Nursing Pay

Worcestershire NHS
Acute Hospitals NHS Trust

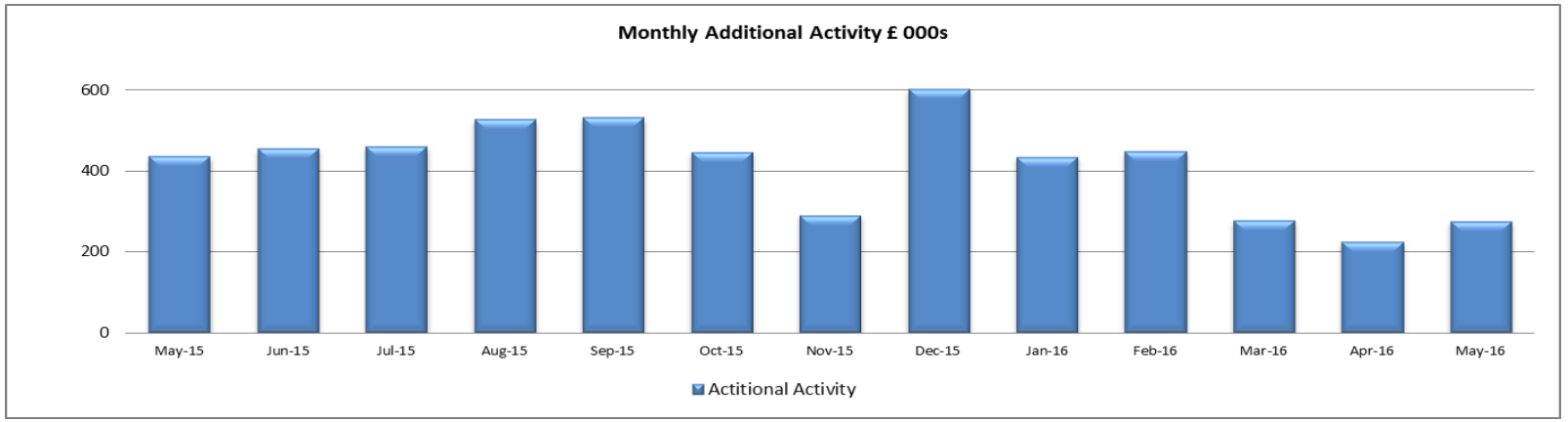


Note. Month 4 contained a YTD change from a net position to a gross position for Consultants sub-contracted to other Trusts.



Additional Activity Sessions

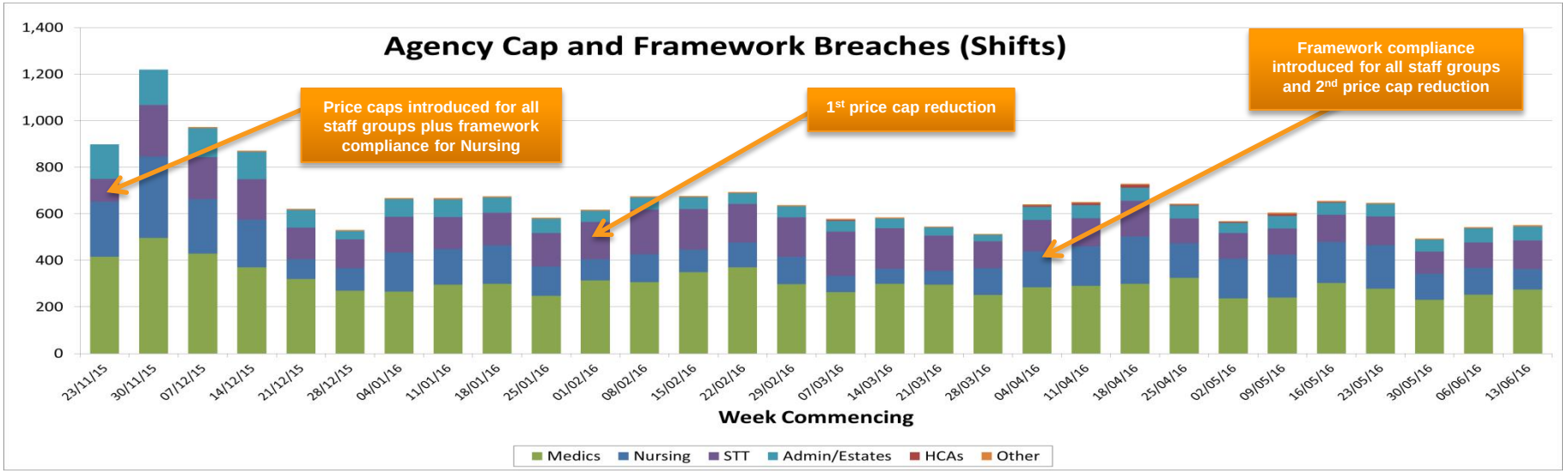
Worcestershire NHS
Acute Hospitals NHS Trust

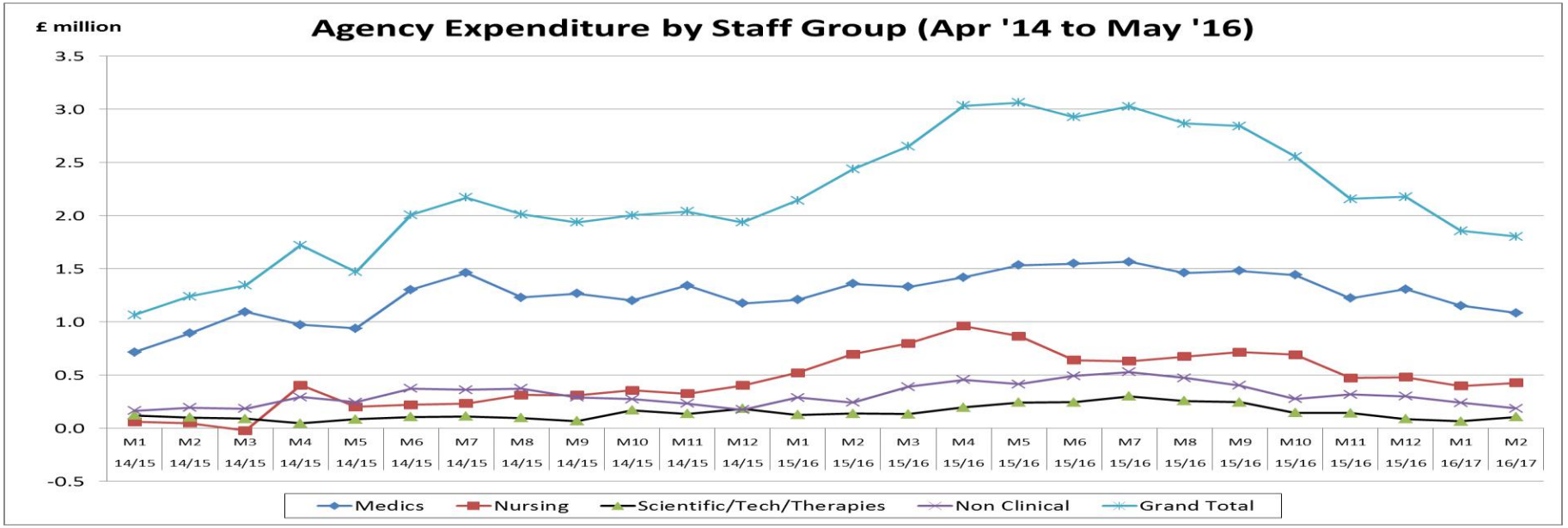


Division	Directorate	YTD values £k					
		OP	IP & Anaesthetics	Endoscopy	Ward rounds	Radiology	Total
SCSD	Anaesthetics	(1)	0	0	0	0	(1)
	C.S.S.D.	0	(2)	0	0	0	(2)
	Endoscopy	0	0	(2)	0	0	(2)
	Opthalmology	(29)	(9)	0	0	0	(38)
	Radiology	0	0	0	0	(139)	(139)
	Total	(30)	(11)	(2)	0	(139)	(183)
Medicine	Cardiology	0	0	0	(11)	0	(11)
	Diabetes	0	0	0	(1)	0	(1)
	Gastroenterology	0	(3)	(40)	0	0	(43)
	Respiratory Medicine	(7)	(8)	(5)	0	0	(20)
	Total	(7)	(11)	(45)	(11)		(75)
Surgery	Dermatology	(3)	0	0	0		(3)
	ENT/Audiology	(1)	0	0	0		(1)
	General Surgery	(52)	(50)	(46)	0		(148)
	Trauma & Orthopaedics	(2)	(68)	0	0		(71)
	Urology	(0)	(31)	(17)	0		(49)
	Vascular	0	(9)	0	0		(9)
	Oral Surgery	0	(10)	0	0		(10)
	Total	(59)	(168)	(63)	0		(289)
W&C	Gynaecology	0	0	(2)	0		(2)
	Obstetrics	(0)	0	0	0		(0)
	Total	(0)		(2)	0		(2)
Grand Total		**(95)**	**(191)**	**(112)**	**(11)**	**(139)**	**(549)**

Agency Expenditure and Cap Breaches

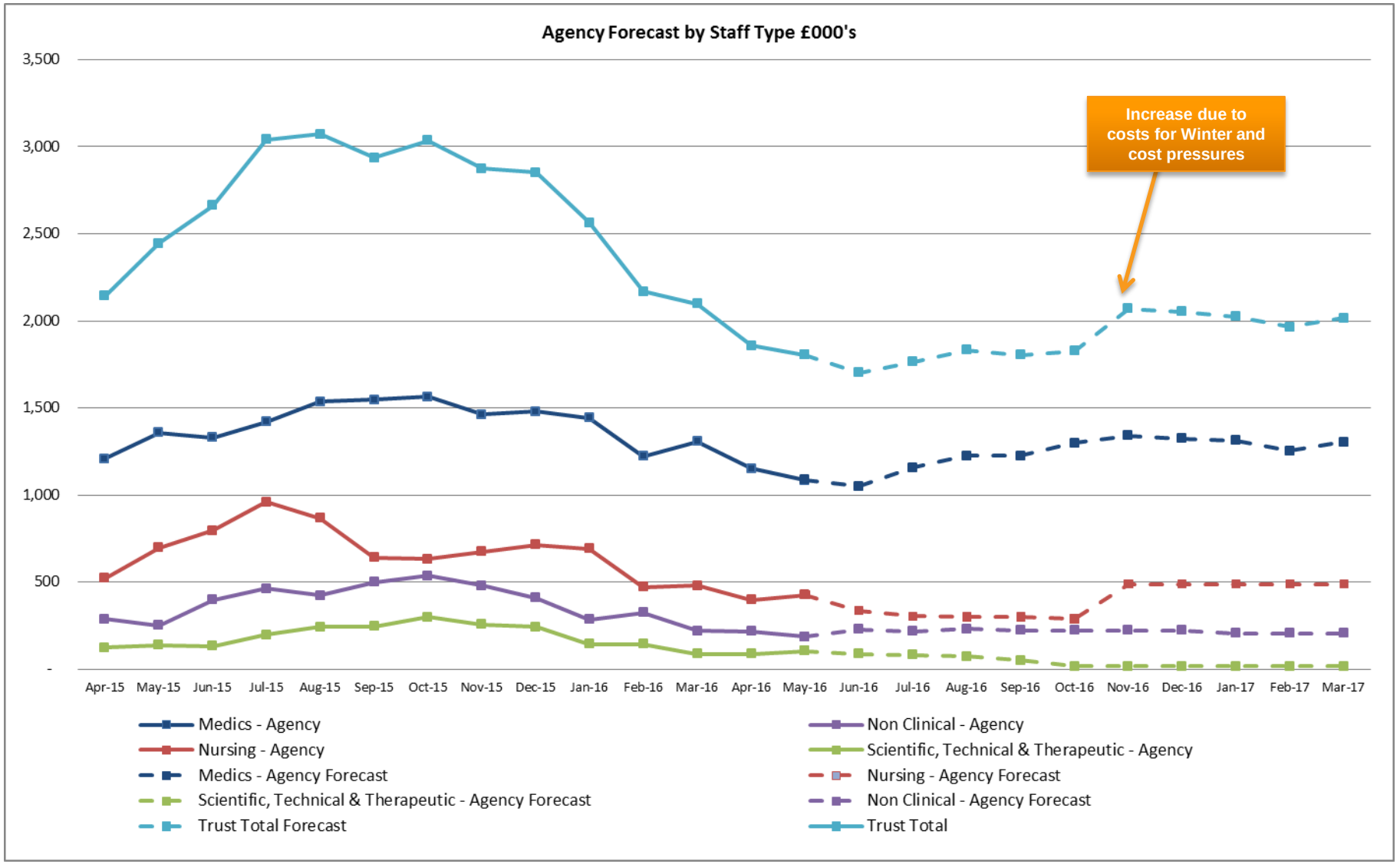
Worcestershire NHS
Acute Hospitals NHS Trust





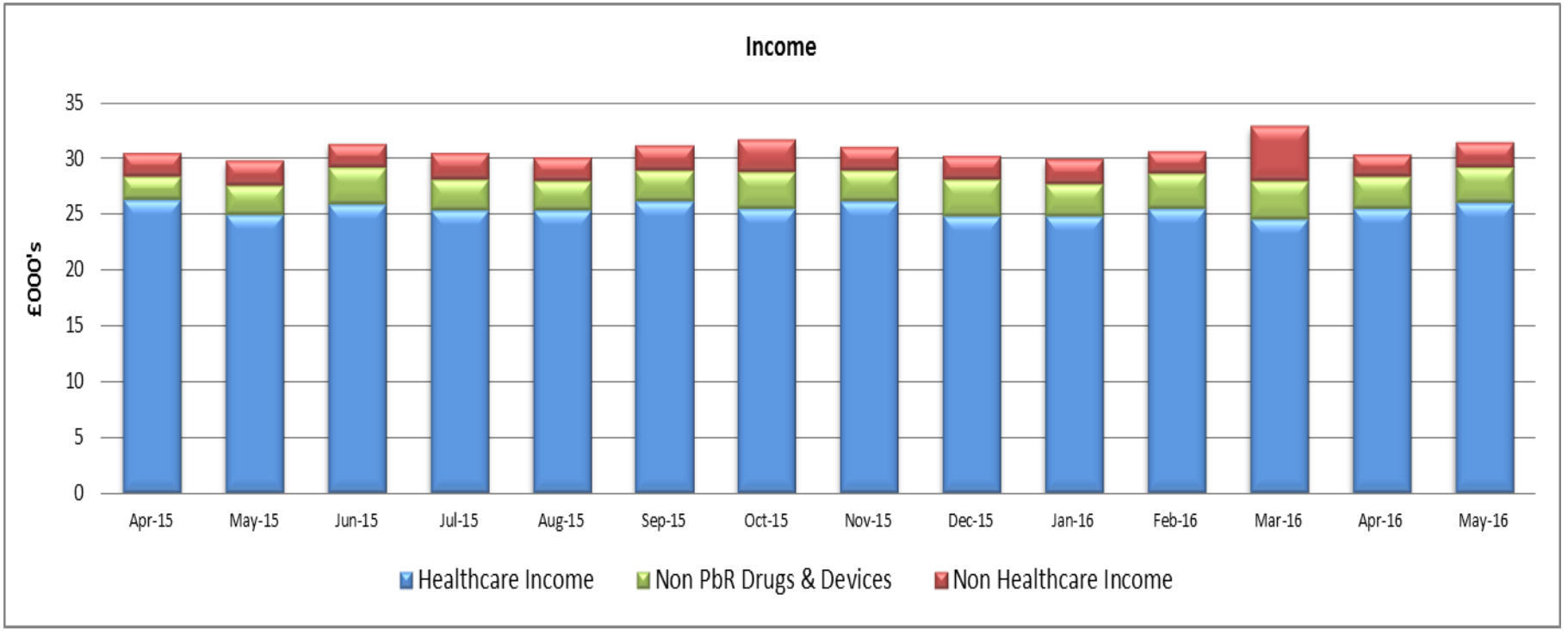
Agency Forecast by Staff Type £000s

Worcestershire NHS
Acute Hospitals NHS Trust



Income

Worcestershire NHS
Acute Hospitals NHS Trust



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	2,240	2,025	(215)	(10%)	4,505	3,910	(596)	(13%)	27,293	27,293
Daycase	2,687	2,890	203	8%	5,590	5,451	(139)	(2%)	35,063	35,063
Non Elective - Emerg	7,485	7,242	(243)	(3%)	14,916	14,362	(554)	(4%)	88,795	88,795
Non Elective - Other	136	139	3	2%	273	237	(36)	(13%)	1,610	1,610
Total Inpatients	**12,547**	**12,296**	**(251)**	**(2%)**	**25,284**	**23,959**	**(1,325)**	**(5%)**	**152,760**	**152,760**
Outpatients New	1,596	1,624	28	2%	3,241	3,082	(159)	(5%)	19,953	19,953
Outpatients F Up	1,538	1,555	17	1%	3,111	3,081	(30)	(1%)	19,312	19,312
Outpatients Procedure	696	758	62	9%	1,383	1,490	107	8%	8,525	8,525
Total Outpatients	**3,830**	**3,937**	**107**	**3%**	**7,735**	**7,654**	**(82)**	**(1%)**	**47,790**	**47,790**
ED Attendances	1,395	1,489	94	7%	2,721	2,817	96	4%	16,645	16,645
Community MIU	181	201	20	11%	352	379	27	8%	2,155	2,155
Total ED/MIU	**1,576**	**1,690**	**114**	**7%**	**3,073**	**3,196**	**123**	**4%**	**18,800**	**18,800**
Maternity - Delivery	1,244	1,063	(180)	(15%)	2,410	2,050	(360)	(15%)	13,267	13,267
Maternity Ante Natal	671	693	23	3%	1,420	1,543	122	9%	8,625	8,625
Maternity Post Natal	137	132	(4)	(3%)	260	245	(15)	(6%)	1,598	1,598
Total Maternity	**2,057**	**1,891**	**(166)**	**(8%)**	**4,102**	**3,842**	**(260)**	**(6%)**	**23,555**	**23,555**
Paed - Daycase/Elective	17	17	0	2%	38	41	3	7%	250	250
Paed - Non Elective	439	475	36	8%	861	896	34	4%	5,527	5,527
Paed - Outpatient	208	221	12	6%	425	461	36	9%	2,645	2,645
Paed - BPT, Drugs, CQUIN	117	161	44	37%	240	271	30	13%	1,501	1,496
Paed - Neonatal Cot Days	354	311	(43)	(12%)	708	706	(2)	(%)	4,250	4,250
Total Paediatrics	**1,137**	**1,185**	**49**	**4%**	**2,273**	**2,375**	**102**	**4%**	**14,174**	**14,169**
Chemotherapy Delivery	**310**	**334**	**25**	**8%**	**634**	**649**	**15**	**2%**	**3,828**	**3,828**
Drugs PBR Excluded	2,082	2,082	0	%	3,840	3,840	0	%	25,700	26,192
Critical Care ITU/HDU	854	850	(3)	(%)	1,707	1,576	(131)	(8%)	10,242	10,242
Other Contract Income	4,809	4,811	2	%	9,765	9,845	81	1%	60,663	60,464
Total Other Contract Income	**7,744**	**7,744**	**(1)**	**(%)**	**15,312**	**15,261**	**(51)**	**(%)**	**96,605**	**96,898**
Contractual Deductions/Penalties	**(135)**	**(1,113)**	**(978)**		**(271)**	**(2,004)**	**(1,734)**		**(1,624)**	**(1,624)**
Commissioner QIPP	(417)	0	417		(833)	0	833		(5,000)	(5,000)
Non Contract Income	498	489	(9)	(2%)	1,076	1,098	22	2%	7,970	7,718
Phasing Adj	704	704	0	%	1,491	1,491	0	%	0	0
	29,851	**29,157**	**(694)**	**(2%)**	**59,877**	**57,521**	**(2,356)**	**(4%)**	**358,859**	**358,895**

- Cost & Volume marginal rates for under/over performance have been applied

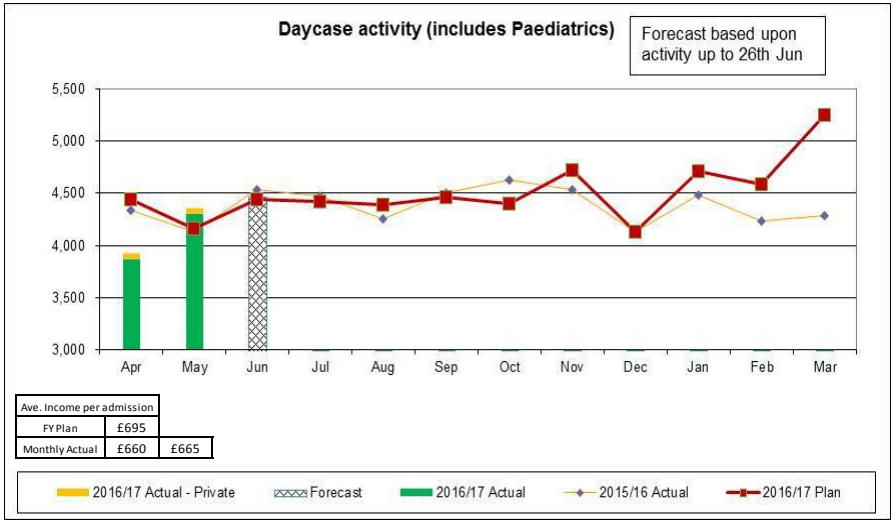
Activity

Worcestershire NHS
Acute Hospitals NHS Trust

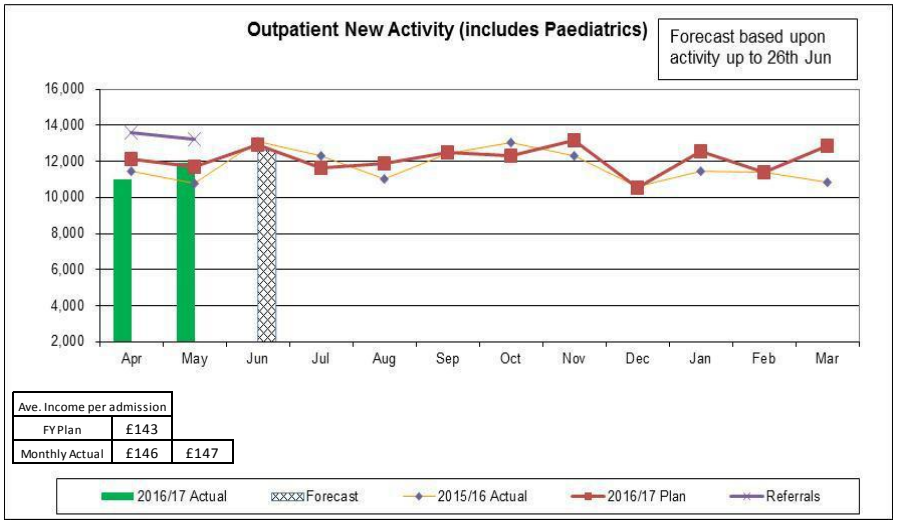
	In Month				YTD				Full Year	
	Plan	Actual	Var	%	Plan	Actual	Var	%	Initial Plan	Current Plan
Elective	795	679	(116)	(15%)	1,608	1,348	(260)	(16%)	9,679	9,679
Daycase	4,135	4,286	151	4%	8,548	8,219	(329)	(4%)	64,901	53,771
Non Elective - Emerg	3,510	3,675	165	5%	7,022	7,071	49	1%	42,403	42,403
Non Elective - Other	49	45	(4)	(8%)	98	88	(10)	(10%)	575	575
Total Inpatients	**8,489**	**8,685**	**196**	**2%**	**17,276**	**16,726**	**(550)**	**(3%)**	**117,559**	**106,429**
Outpatients New	11,161	11,316	155	1%	22,709	21,604	(1,105)	(5%)	138,738	138,738
Outpatients F Up	19,437	19,729	292	2%	39,428	39,245	(183)	(%)	243,400	243,400
Outpatients Procedure	3,949	4,195	246	6%	7,901	8,292	391	5%	48,800	48,800
Total Outpatients	**34,547**	**35,240**	**693**	**2%**	**70,039**	**69,141**	**(898)**	**(1%)**	**430,939**	**430,939**
ED Attendances	12,805	13,676	871	7%	24,971	25,816	845	3%	152,768	152,768
Community MIU	3,063	3,409	346	11%	5,973	6,425	452	8%	36,539	36,539
Total ED/MIU	**15,867**	**17,085**	**1,218**	**8%**	**30,944**	**32,241**	**1,297**	**4%**	**189,307**	**189,307**
Maternity - Delivery	547	473	(74)	(14%)	1,061	909	(152)	(14%)	5,845	5,845
Maternity - Non Delivery	201	189	(12)	(6%)	401	369	(32)	(8%)	2,312	2,312
Maternity - Outpatient	3,497	3,657	160	5%	7,085	7,205	120	2%	44,112	44,112
Maternity Ante Natal	466	480	14	3%	986	1,064	78	8%	5,989	5,989
Maternity Post Natal	496	474	(22)	(4%)	944	882	(62)	(7%)	5,802	5,802
Total Maternity	**5,208**	**5,273**	**65**	**1%**	**10,477**	**10,429**	**(48)**	**(%)**	**64,061**	**64,061**
Paed - Daycase/Elective	27	26	(1)	(5%)	60	65	5	9%	415	415
Paed - Non Elective	574	612	38	7%	1,125	1,125	(0)	(%)	7,220	7,220
Paed - Outpatient	1,274	1,342	68	5%	2,610	2,787	177	7%	16,080	16,080
Paed - BPT, Drugs, CQUIN	37	0	(37)	(100%)	37	0	(37)	(100%)	270	221
Paed - Neonatal Cot Days	738	578	(160)	(22%)	1,473	1,362	(111)	(8%)	8,816	8,838
Total Paediatrics	**2,650**	**2,558**	**(92)**	**(3%)**	**5,304**	**5,339**	**35**	**1%**	**32,801**	**32,774**
Chemotherapy Delivery	**739**	**999**	**260**	**35%**	**1,530**	**1,916**	**386**	**25%**	**11,130**	**11,130**
Drugs PBR Excluded	0	0								
Critical Care ITU/HDU	806	788	(18)	(2%)	1,612	1,521	(91)	(6%)	9,673	9,673
Other Contract Income	0	0								
Total Other Contract Income	**806**	**788**	**(18)**	**(2%)**	**1,612**	**1,521**	**(91)**	**(6%)**	**9,673**	**9,673**
Non Contract Income										
Phasing Adj										

Elective, Day Cases & Outpatients New

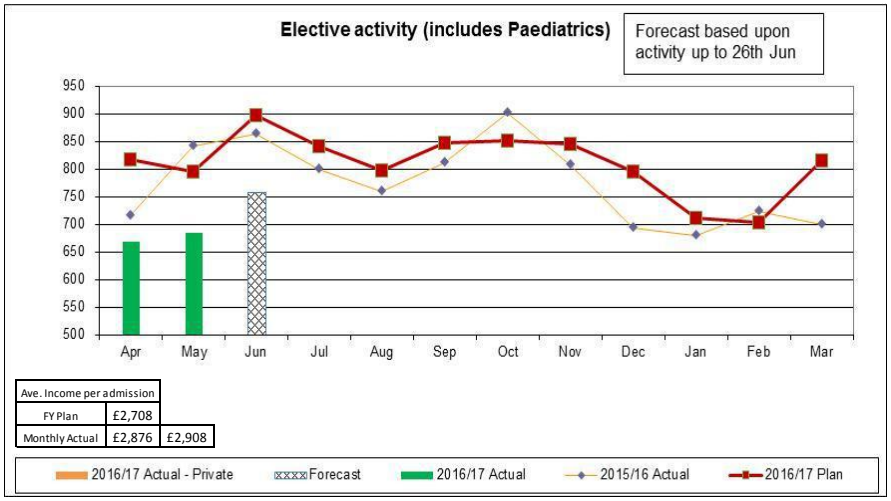
Worcestershire NHS
Acute Hospitals NHS Trust



Ave. Income per admission		
FY Plan	£695	
Monthly Actual	£660	£665



Ave. Income per admission		
FY Plan	£143	
Monthly Actual	£146	£147

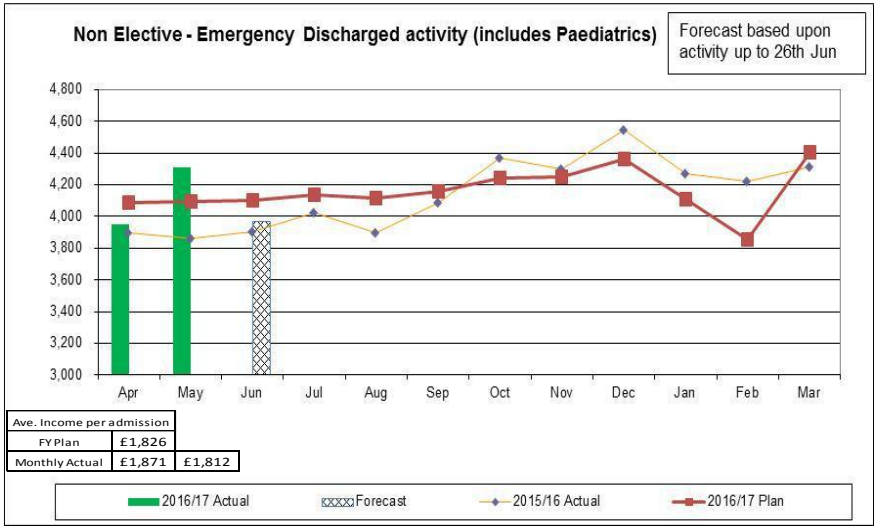


Ave. Income per admission		
FY Plan	£2,708	
Monthly Actual	£2,876	£2,908

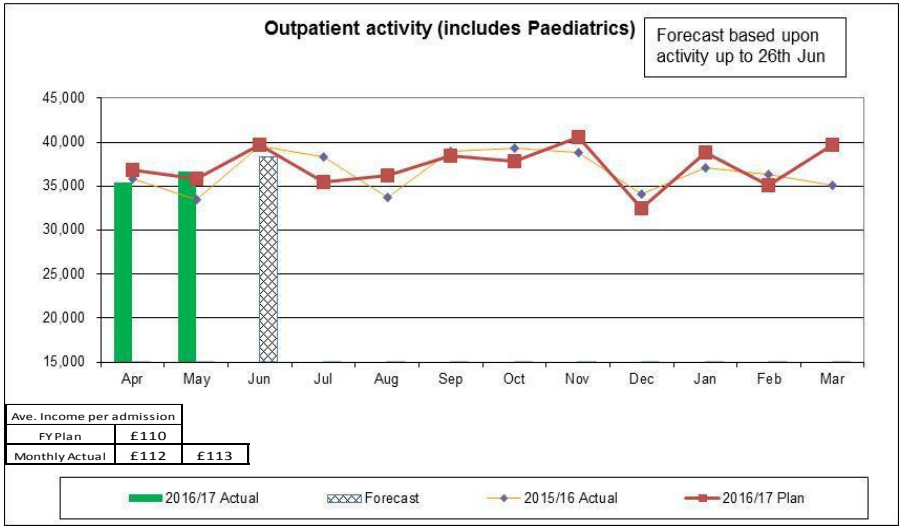
Activity performed within Trust and sent Private				
	Daycase		Elective IP	
	Trust	Private	Trust	Private
Apr	3,871	50	669	0
May	4,311	50	684	0
Jun	0	0	0	0
Jul	0	0	0	0
Aug	0	0	0	0
Sep	0	0	0	0
Oct	0	0	0	0
Nov	0	0	0	0
Dec	0	0	0	0
Jan	0	0	0	0
Feb	0	0	0	0
Mar	0	0	0	0
YTD	8182	100	1353	0

Outpatients, Non Elective and A&E

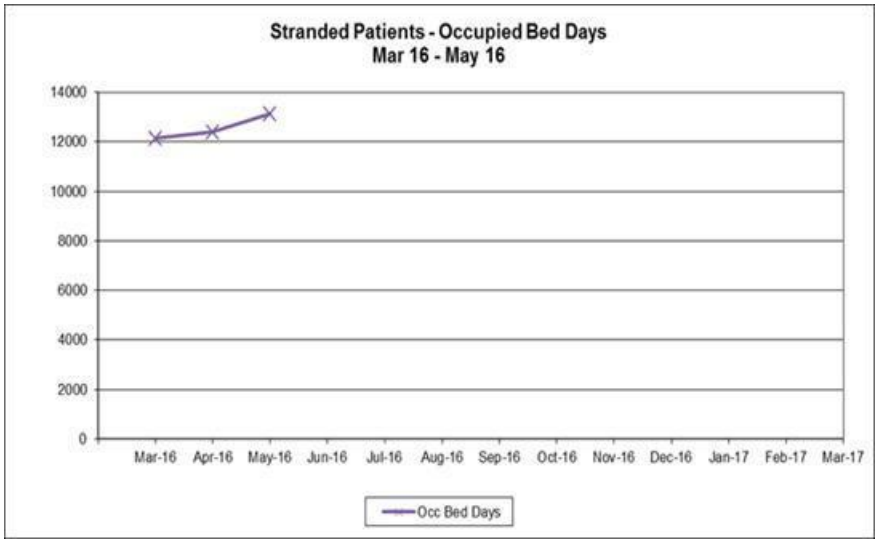
Worcestershire NHS
Acute Hospitals NHS Trust

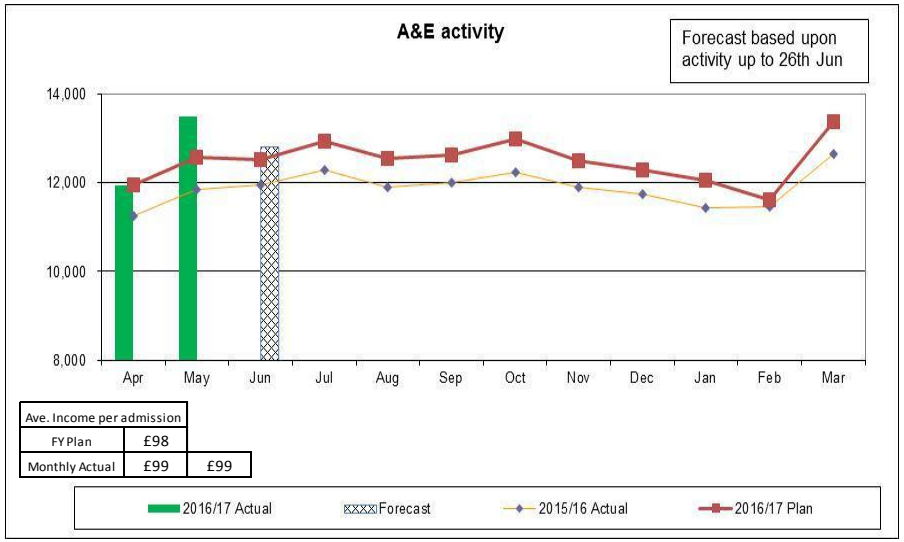


Ave. Income per admission		
FY Plan	£1,826	
Monthly Actual	£1,871	£1,812



Ave. Income per admission		
FY Plan	£110	
Monthly Actual	£112	£113

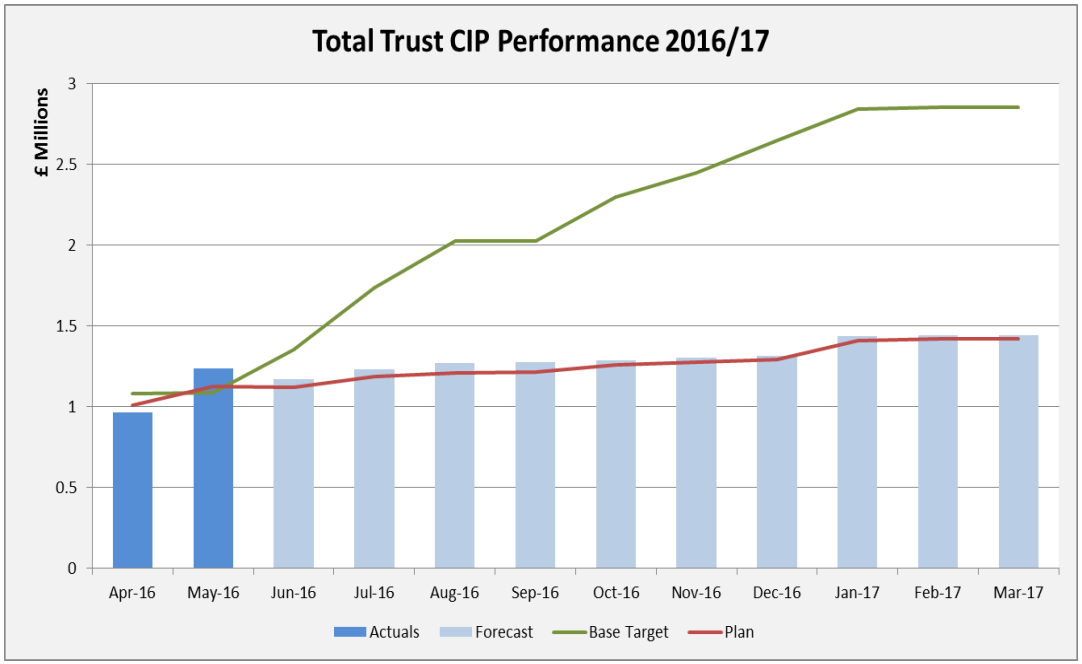




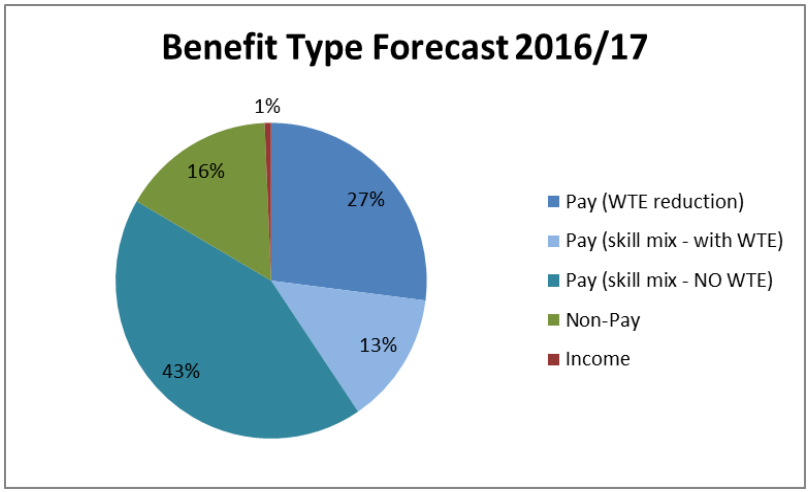
Ave. Income per admission		
FY Plan	£98	
Monthly Actual	£99	£99

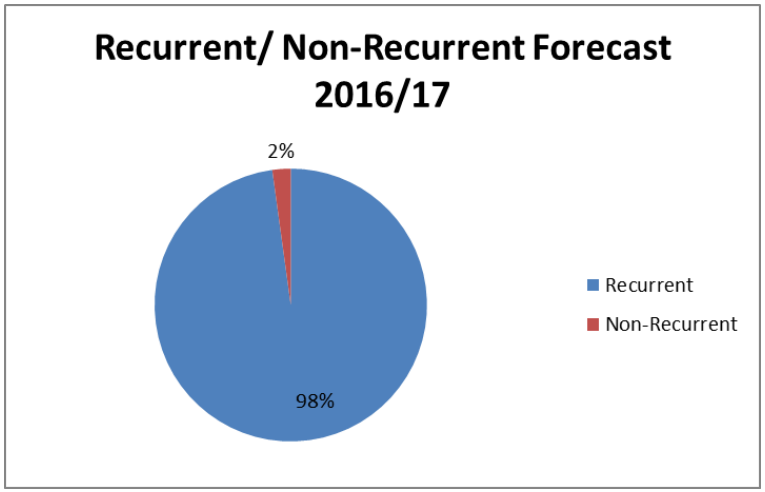
CIP – Target £24.3m

Worcestershire NHS
Acute Hospitals NHS Trust



CIP performance for M2 (£1.2m) shows significant improvement but also includes benefits in M1 only now being realised. YTD, the Trust is £38k ahead of its phased target. However, the full year forecast of planned schemes is only £18.5m against the £25.3m target.

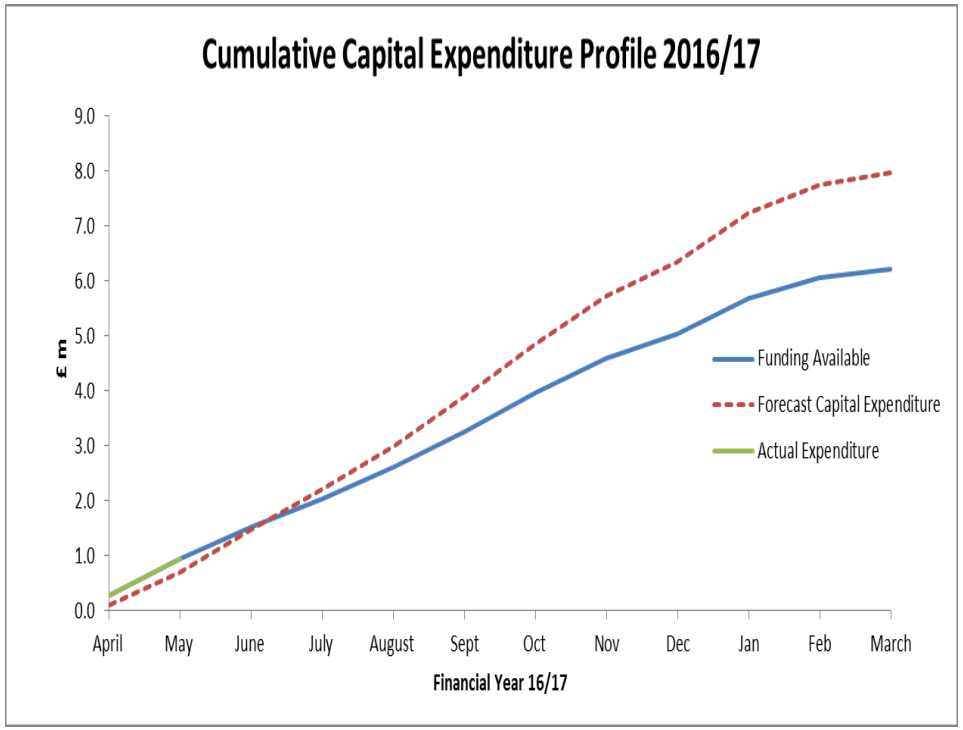




Capital Programme 16/17

Worcestershire NHS
Acute Hospitals NHS Trust

Capital Programme as at May 2016	Expenditure	
Workstream	**In Month Position**	**YTD Position**
Developments	247	321
Property and Works	91	198
Equipment	8	13
ICT	328	427
Total	674	958



- **The Plan is being reviewed to ensure the Trust remains within its available capital funding**
- **The above programme excludes loan applications the Trust intends to make in 2016/17**

Position Overview

Developments **-** ED is the only scheme in progress at present.
Property and Works schemes **-** Main capital expenditure YTD relates to Kings Court £21k, Ophthalmology Flooring £11k, Replacement of RO plant KTC £57k, lifecycle painting £19k and PM staffing costs £24k
ICT schemes - Data Centre £251k and project staffing costs relate to the majority of the capital expenditure.
Equipment **-** 15/16 slippage relating to an ultrasound scanner probe purchased by Maternity and staff costs.

Forecast

The approved plan is £1.7m over committed compared to the available funding. Finance are working with the workstream leads to reprioritise schemes and review additional opportunities. Options are being worked through for discussion at CPG in July. There will be a mid year review and a revised capital programme presented to the September FPC. In the meantime the Trust will need to commit expenditure at risk ahead of securing the loan funding to progress essential schemes related to the ASR capacity business case.

Loans

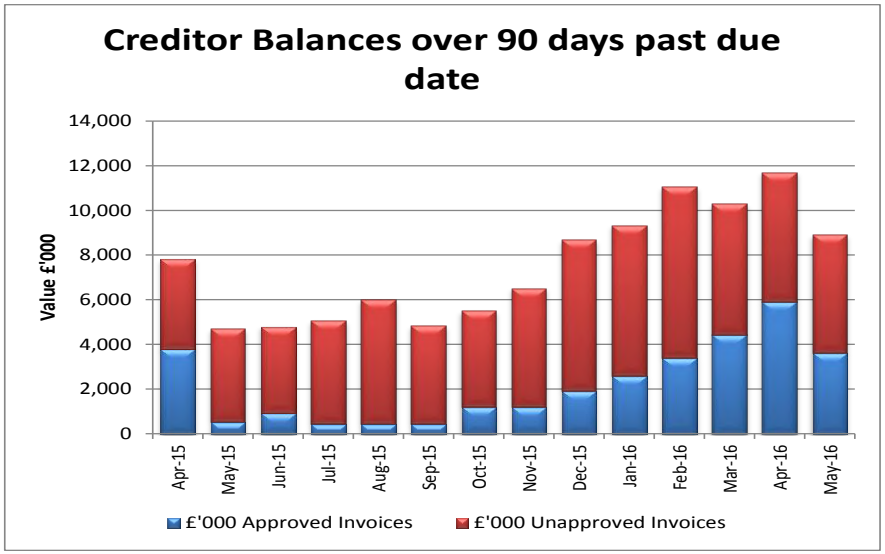
Business cases are being produced for the capital loan applications for 16/17 to support ASR, backlog maintenance and invest to save schemes.

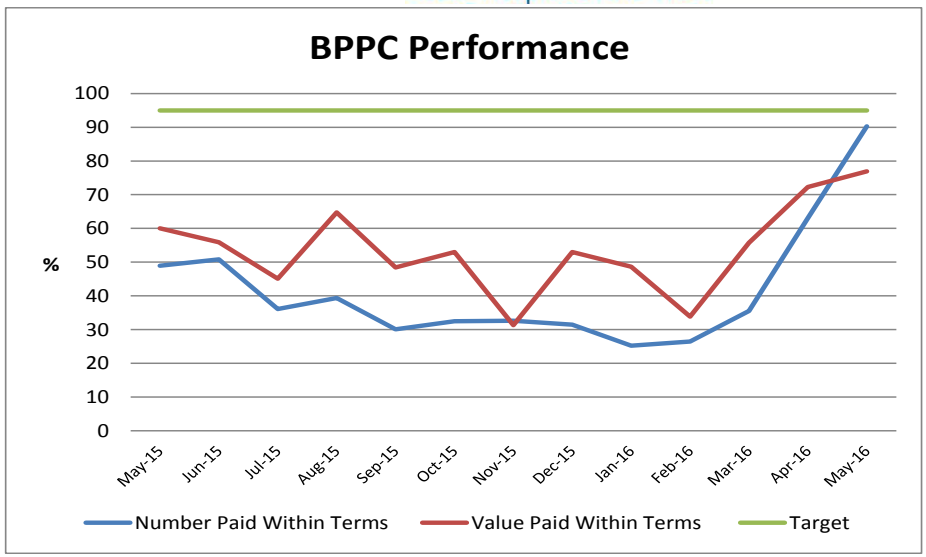
Risks & Mitigations

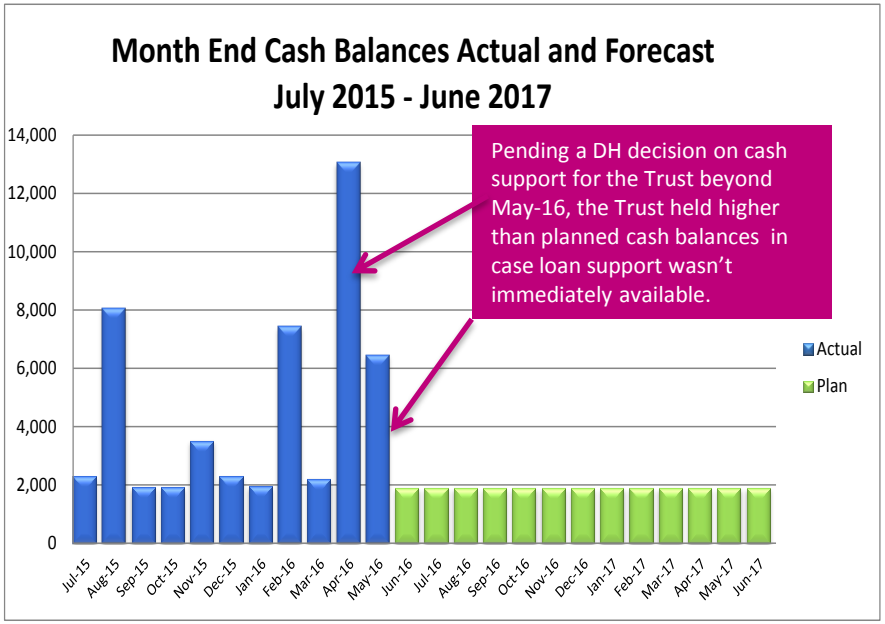
Forecast Overspend - Finance to work with workstream leads to identify savings through reprioritisation and additional funding opportunities for presentation to CPG in July.
ED Overspend - The current profile for the ED expansion indicates the projected total cost is £4.1m against the funding of £3.8m. The Head of Estates is working closely with contractors to keep costs within plans. Opportunities for further VAT recovery are also being reviewed.
Additional Unplanned Expenditure - Additional essential capital expenditure may be required to support performance improvements or essential maintenance. The capital programme would have to be reprioritised to accommodate this.

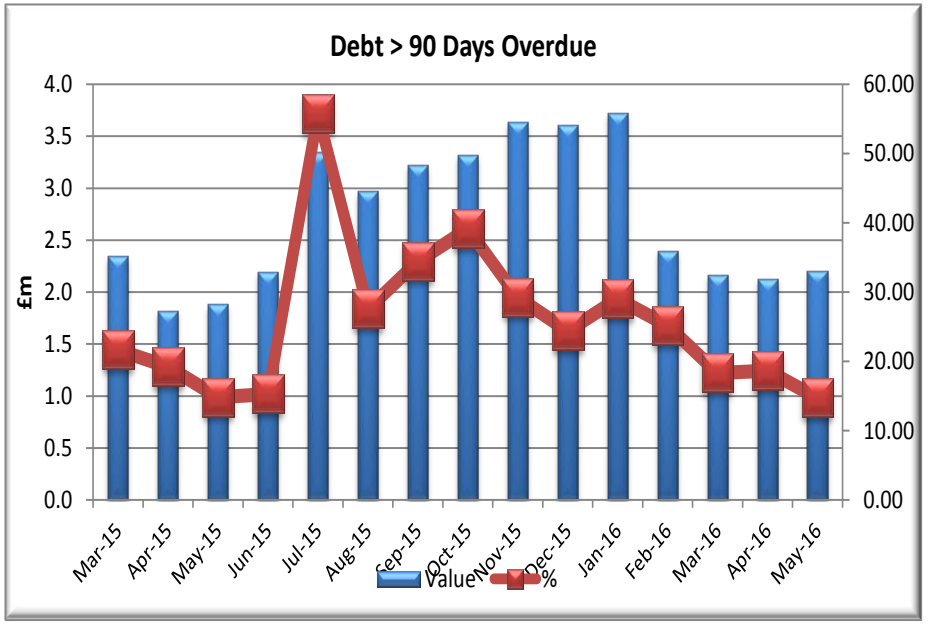
Working Capital

Worcestershire NHS
Acute Hospitals NHS Trust









Balance Sheet

Worcestershire NHS
Acute Hospitals NHS Trust

				Full Year			
Balance at 30th April 2016	Balance at 31st May 2016	Movement in Month	Balance Sheet	Annual Plan	Forecast 31st March 2017	Variance from Plan	Balance at 31st March 2016
£000s	**£000s**	**£000s**	**ASSETS, NON CURRENT**	**£000s**	**£000s**	**£000s**	**£000s**
254,508	250,483	(4,025)	Property, Plant and Equipment and intangible assets, Net	254,467	254,467	0	250,590
4,253	4,562	310	Other Assets, Non-Current	3,238	3,238	0	1,669
258,760	**255,045**	**(3,716)**	**Assets, Non-Current, Total**	**257,705**	**257,705**	**0**	**252,259**
			ASSETS, CURRENT				
8,059	7,733	(326)	Inventories	5,800	5,800	0	7,081
25,927	19,891	(6,037)	Debtors	15,260	15,260	0	25,823
13,059	6,468	(6,591)	Cash and Cash Equivalents	1,900	1,900	0	1,474
47,046	**34,092**	**(12,954)**	**Assets, Current, Total**	**22,960**	**22,960**	**0**	**34,378**
305,806	**289,137**	**(16,669)**	**ASSETS, TOTAL**	**280,665**	**280,665**	**0**	**286,637**
			LIABILITIES, CURRENT				
1,970	**1,970**	0	PFI leases, Current	1,936	1,936	0	1,936
54,862	**41,965**	(12,897)	Creditors < 1 Year	34,679	34,679	0	48,270
56,832	**43,935**	**(12,897)**	**Liabilities, Current, Total**	**36,615**	**36,615**	**0**	**50,206**
(9,786)	**(9,843)**	**(57)**	**Net Current Assets/(Liabilities)**	**(13,655)**	**(13,655)**	**0**	**(15,828)**
			LIABILITIES, NON CURRENT				
110,790	115,135	4,344	Creditors > 1 Year	3,113	3,113	0	95,757
71,860	71,698	(161)	PFI leases, Non-Current	70,055	70,055	0	72,055
0	0	0	Other Liabilities, Non-Current	150,848	150,848	0	0
182,650	**186,833**	**4,183**	**Liabilities, Non-Current, Total**	**224,016**	**224,016**	**0**	**167,812**
66,324	**58,369**	**(7,955)**	**TOTAL ASSETS EMPLOYED**	**20,034**	**20,034**	**0**	**68,619**
£000s	**£000s**		**FINANCED BY :- PUBLIC EQUITY**	**£000s**	**£000s**	**£000s**	**£000s**
184,564	184,564	0	Public Dividend Capital	184,564	184,564	0	184,564
42,729	54,320	11,592	Revaluation reserve	42,729	42,729	0	54,320
(861)	(861)	0	Other reserves	(861)	(861)	0	(861)
(160,108)	(179,654)	(19,547)	I&E Reserve	(206,398)	(206,398)	0	(169,404)
66,324	**58,369**	**(7,955)**	**TOTAL PUBLIC EQUITY**	**20,034**	**20,034**	**0**	**68,619**

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc H1**

Report to Trust Board in public

Title	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR)**
Sponsoring Director	Jan Stevens, Interim Chief Nursing Officer
Author	Justin King, Trust Risk Officer
Action Required	Trust Board is asked to: • Note the changes to the BAF & CRR • Review risk ratings, controls, assurance and mitigating actions and consider if sufficient progress has been made • Approve the updates to the Trust Risk Strategy
Previously considered by	EMT

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 Trust Board with the quarterly update of the full BAF and full Corporate Risk Register.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc H1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JULY 2016

1. Situation

Trust Board is provided with the BAF Risk Register and Corporate Risk Register for assurance, along with an update of the Risk Strategy for endorsement.

2. Background

NHS Trusts are required to have a Board Assurance Framework (BAF). Trust Board review the BAF Risk Register and Corporate Risk Register in full quarterly.

3. Assessment

3.1 Board Assurance Framework (BAF)

The risks recorded on the 2015/16 BAF Risk Register have been reviewed by the responsible Executive Directors, and action plans updated. No risks have been added or removed this month.

An additional index has been provided with this report for the first time. It tracks the movement in risks rating of the risks captured on the BAF over the last 12 months. In summary, of the 22 risks that were on the register during the last twelve months, the risk rating:

- increased for 5 (one of which is now managed at CRR level)
- remained the same for 11
- reduced for 1

and the remaining five were closed and merged with other risks on the BAF.

3.2 Corporate Risk Register (CRR)

There are 36 risks recorded on the Corporate Risk Register, with 15 at a rating of high. The index sheet provided shows the executive lead and monitoring committee of each. Risks have been reviewed by the responsible Executive Directors, and action plans updated.

The risk tracking index has also been provided with the CRR for the first time. In summary, of the 42 risks that were on the register during the last twelve months, the risk rating:

- increased for 4 (two to high, two to moderate);
- remained the same for 20;
- reduced for 17;

and one risk was merged with other risks on the CRR

The Accountable Executive for *Risk 2908 Use and release of information which is inaccurate, false or misleading resulting in patient harm, reputation*

and legal damage has been changed to the Chief Medical Officer.

3.3 Trust Risk Strategy

The Trust Risk Strategy has been updated with the following changes:

- Changed to the new Trust Pathway format
- Tools and templates made simpler to find
- Practical guidance provided for divisions in how to conduct risk register review
- The implementation plan has been completed and further implementation actions are included in the Patient Care Improvement Plan (PCIP) Governance and Safety Action Plan
- The Board reporting process for the BAF has been added, incorporating the process agreed at Trust Board in March 2016, but with a change to the frequency of Board Sub-committee reviews at quarterly (see Enclosure)

The revised strategy is available for review via this link:
http://www.treatmentpathways.worcsacute.nhs.uk/trustwide/risk/

4 Action required

Trust Board is asked to:

- Note the changes to the BAF & CRR
- Review risk ratings, controls, assurance and mitigating actions and consider if sufficient progress has been made
- Approve the updates to the Trust Risk Strategy

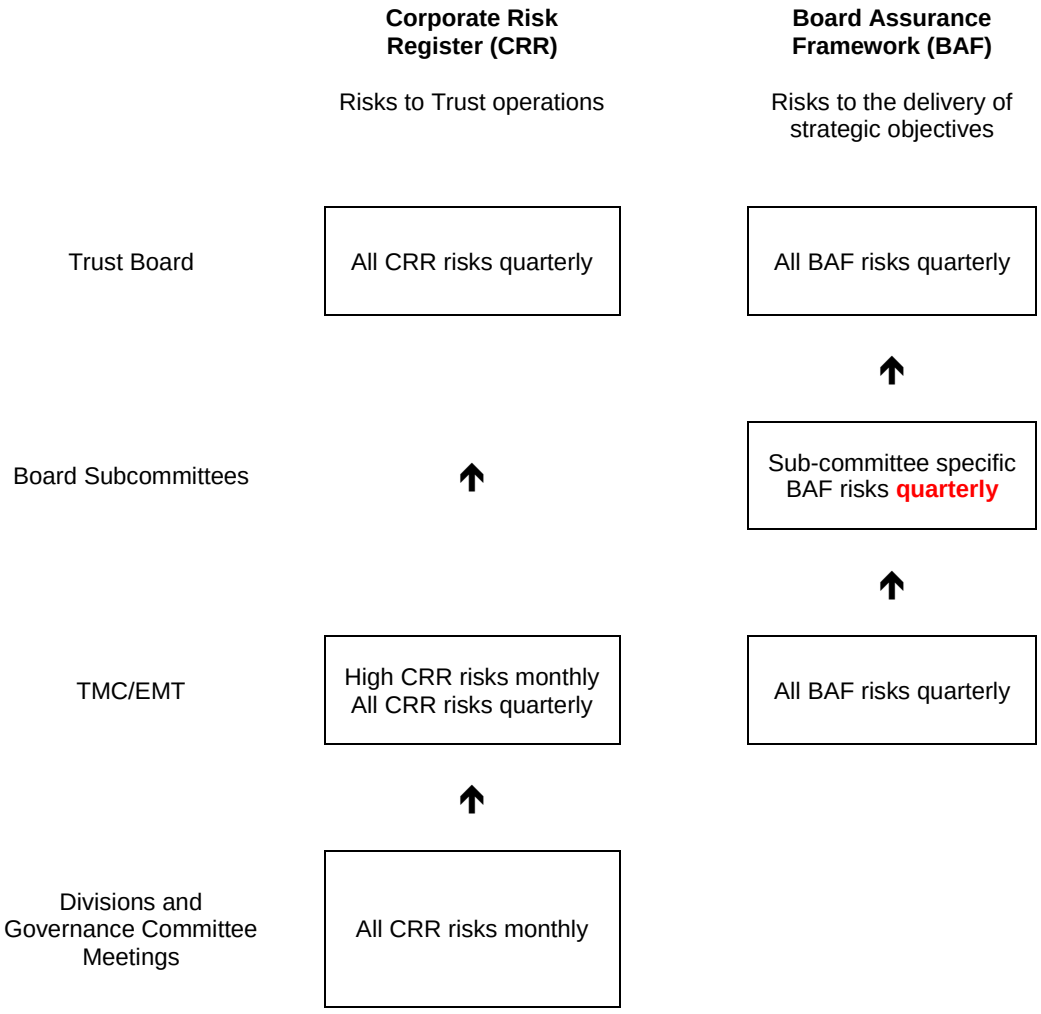
Jan Stevens
Interim Chief Nursing Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc H1**

Enclosure: Reporting process for BAF and Corporate Risk Register

(extract from Trust Risk Strategy to highlight change)



Worcestershire NHS
Acute Hospitals NHS Trust

Board Assurance Framework:

Risk Register 2016/17

All Risks

Trust Board

July 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

Worcestershire NHS
Acute Hospitals NHS Trust

BAF risks mapped to Strategic Goals

	1. Deliver safe, high quality, compassionate patient care	2. Design healthcare around the needs of our patients, with our partners	3. Invest and realise the full potential of our staff to provide compassionate and personalised care	4. Ensure the Trust is sustainable and financially viable and makes the best use of resources	5. Continuously improve our services to provide the best outcomes and experience for our patients
Strategic Goal					
Assurance Committee	**Quality Governance Committee**	**Quality Governance Committee**	**Workforce Assurance Group**	**Finance and Performance Committee**	**Strategy and Transformation Committee**
NED	Bill Tunnicliffe	Bill Tunnicliffe	John Burbeck	Andrew Sleigh	Andrew Sleigh
ED	Chief Medical Officer	Chief Nursing Officer	Director Human Resources	Director of Finance	Director of Strategy & Planning
Risks	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed (COO) 20	3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care 16	2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity (DoC) 20	2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability 20	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
	2902 If the Trust does not achieve safety targets, it will fail to reduce avoidable harm & reported mortality rate to expected levels 16	2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience 12	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels 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 16	2904 If there is inadequate culture and staff development for improvement, the Trust will not be able to continuously improve 12
			2894 Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems 15	3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances (COO) 16	3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected (DoC) 12
			Remuneration Committee Chairman Chief Executive		
			2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services 20		

BAF Risk rating tracking report

BAF Risk	Jul-15	Oct-15	Jan-16	Apr-16	Jul-16	Notes	Change over 12 months
2665 If we do not redesign services in a timely way we will have inadequate numbers of clinical staff to deliver quality care	20	20	20	20	20		→
2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels	20	20	20	20	20		→
2790 As a result of high occupancy levels, patient care may be compromised	20	20	20	20	20		→
2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability	16	20	20	20	20		↑
2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services	12	12	16	20	20		↑
2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity and missed opportunities	12	12	12	20	20		↑
3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care	16	16	16	16	16	July 2015 rating reflects pre-inspection risk 2713	→
2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service	9	12	16	16	16		↑
3193 If the Trust does not achieve patient access performance targets, there will be significant impact on finances			new	16	16		→
2894 Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems	15	15	15	15	15		→
2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience	16	16	12	12	12		↓
2902 If the Trust does not achieve safety targets, it will fail to reduce avoidable harm & reported mortality rate to expected levels	12	12	12	12	12		→
2904 If there is inadequate culture and staff development for improvement, the Trust will not be able to continuously improve	12	12	12	12	12		→
3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected	12	12	12	12	12	managed as risk 2903 until Jan 2016	→
2889 Sufficient access to capital to achieve change and conduct backlog maintenance	15	15	de-escalated			Covered by risk 2888, and managed at CRR level via risk 2856 (rating now 20)	↑
2900 If the Trust does not expand renal services, patients will have to travel further and experience fragmented care	12	12	12	de-escalated		being managed within Medicine Division (no change to risk rating since)	→
2899 Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, reduced clinical outcomes	12	12	12	de-escalated		moved to Corporate risk register (no change in rating since then)	→
2891 If the Trust does not implement mortality review trust-wide then we will have fewer opportunities to improve patient care	16	16	16	closed		closed as it is captured within BAF risk 2902	
2666 Inability to secure sufficient income placing the financial position at further risk and affecting long term sustainability	16	16	closed			closed, merged with 2888	
2667 If expenses are not sufficiently contained and reduced there will be a serious impact on financial position & cash availability	16	16	closed			closed, merged with 2888	
2898 Poor communication with patients resulting in reduced quality of patient experience, complaints and reputation damage	12	12	12	closed		closed, merged with risk 2898	
2905 Failure to create capacity and capability for transformation, resulting in inability to deliver required improvement	12	12	12	closed		closed, risk merged with risk 2665 March 2016	

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	Continuously improve our services to provide the best outcomes and experience for our patients
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. Reputation 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 Future of Acute Hospital Services in Worcestershire (FOAHSW) Project established Sustainability sub-committee of Programme Board Project management contractors employed to support delivery FOAHSW Implementation Group (FIG) established
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 is subject to: consensus of the Clinical Senate, NHSE assurance tests, affordability for all partners, capacity constraints (for more detail see Acute Services Review Project Risk Register) Contingency plan to include appropriate agreed mitigations Public consultation will require consideration and potential subsequent review of plan Commissioners required to submit separate business case to NHSE - uncertainty of outcome The consequences of emergency relocation of services may create unanticipated risks
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	Andrew Short Consultant Paediatrician	15/07/2016	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. Feb 2016 update: Three CCG governance bodies and WAHT Trust Board have approved model. Request submitted to review at clinical senate. May 2016 update: two meetings of clinical senate have taken place, with third to occur on 16th May. Due date updated to July 2016.	
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	Andrew Short Consultant Paediatrician	13/01/2017	Public consultation contingent on endorsement by clinical senate and NHSE. Due date changed again to reflect time required for consultation. June 2016 update: Now scheduled to start in October 2016, due date updated.	

Target Risk Level Major Unlikely 8 Low

BAF Risk Report

Progress	December 2015 update: Back on road to public consultation pending appropriate scrutiny and endorsement by Clinical Senate and NHS England. February 2016 update: When Clinical Senate endorsement achieved, model will progress to NHSE Assurance. May 2016 Draft clinical senate report received, supporting reconfiguration plans June 2016 Paper requesting emergency centralisation of inpatient paediatric services approved at Trust Board. Draft Clinical Senate report has been shared and fully supports proposed model. Due to be published 7th July 2016.

Next Review Date 06/07/2016

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 sustainable and financially viable and makes the best use of resource
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
Continue monthly forecast processes	Rob Cooper Director of Finance	17/08/2016		
Conduct a review of the Trust's risk appetite to reduce expenditure and ensure compliance with the agency caps	Rob Cooper Director of Finance	15/02/2016	Plans agreed to close surge capacity and reduce agency expenditure.	15/02/2016
Deliver revised forecast in order to obtain further cash draw downs	Rob Cooper Director of Finance	15/04/2016	Revised forecast process established	15/04/2016

Target Risk Level Major Possible 12 Moderate

Progress	April 2016 update: Agency costs have reduced from ~3m per month in August 2015 to ~2m per month in March 2016.

Next Review Date 06/07/2016

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	30/06/2016	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. March 2016 update: Workforce Development plan in progress, propose new due date May 2016. April 2016 update: The Divisions have prepared the first draft workforce plans for years 1 - 3 and these are being progressed with a proposed completion date of 30 June 2016	
Medicine Division to review workforce strategy	Andy Phillips Interim Chief Medical Officer	15/04/2016	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. February 2016 update: propose new target date April 2016. March 2016 update: action closed as this is captured within the workforce development plan.	24/03/2016
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. March 2016 update: action closed as engagement strategy covered in risk 2893	24/03/2016

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.

BAF Risk Report

Next Review Date 06/07/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2790 As a result of high occupancy levels, patient care may be compromised**
Date opened	02/02/2015
Strategic goal	Continuously improve our services to provide the best outcomes and experience for our patients
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Major Almost certain 20 High

Director/Committee	Chief Operating Officer / Urgent Care Oversight Team (UrCOT)
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
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	31/12/2016	The actions within the Patient Care Improvement Plan (PCIP) are tracked at UrCOT.	
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.	10/02/2016

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 06/07/2016

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 Continuously improve our services to provide the best outcomes and experience for our patients

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 a recovery plan in conjunction with external advisors and Trust Board	Rob Cooper Director of Finance	31/07/2016	Align recovery plan with STP development plans.	

Develop robust medical workforce plans to support recruitment as well as managing temporary costs	Denise Harnin Director of HR & OD	17/10/2016	February 2016 update: Recruitment strategies to be completed in consultation with divisions by end February 2016. Workforce plans first draft to be developed by 1st March. Centralising medical locum coordinators to be completed by March 2016. Planning to implement an all staff bank. Propose new due date end March 2016. Update March 2016: Draft Workforce plan presented to WAG. To be endorsed by WAG April 2016. Centralised medical locum coordinators to be established on 4th April 2016. All staff bank will take approximately six months to establish. In light of this, proposed new due date October 2016.	
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 Update Feb 2016: Schemes developed to a value of £9.9m, to be presented to Finance & Performance Committee on 26/2/16.	18/02/2016
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. Update Feb 2016: Superseded by schemes developed to date. Need to maintain delivery of existing CIP schemes.	22/02/2016
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. April 2016 update: Target reduction achieved New medical agency authorisation process established.	12/04/2016
Target Risk Level	Catastrophic	Unlikely	10	Low
Progress				

Next Review Date 06/07/2016

BAF Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity and missed opportunities**
Date opened	18/05/2015
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	Moderate	Likely	12	Moderate

Director/Committee	Director of Human Resources / Workforce Assurance Group
Description/Impact	Employees need to be able to raise concerns, offer suggestions for improvement and be involved in decision making across the trust. Engagement during times of change is vital to inform decision making and to ensure buy-in of employees in the process. This ensures realisation of potential for innovation for safer more effective and efficient services. A growing body of evidence links staff engagement to employee wellbeing, patient satisfaction and clinical outcomes.
Key Controls	Staff communications such as CEO brief and Daily Brief Chief Executive feedback breakfast sessions Trust Board Surgeries 'How was it for you' sessions with Chief Nursing Officer Staff surveys- annual National Staff Survey, quarterly Friends and Family scores to provide an engagement score Intranet resources for staff Whistleblowers policy and reporting process Divisional staff engagement plans wirtten Chief Executive feedback breakfast sessions The Big Conversation engaging staff in changes and improvements
Sources of Assurance	Management Assurance-Workforce Assurance Group reporting

Performance Monitoring	Friends and Family test conducted quarterly and reported trust-wide and to Divisions highlighting an overall engagement score Staff absenteeism and turnover data reviewed at TMC and Trust Board Staff exit questionnaires
Gaps in Control	Lower than national average for staff scores to questions "I am involved in deciding on changes introduced that affect my work area / team / department", "My immediate manager asks for my opinion before making decisions that affect my work", "Senior managers here try to involve staff in important decisions", and "Senior managers act on staff feedback" Consistent high turnover and failure to attract the numbers of new recruits required.
Gaps in Assurance	

Current Risk Level	Major	Almost certain	20	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop new infrastructure for delivery of engagement plan	Lisa Thomson Director of Communications	15/07/2016	Plan is contained within Improvement Priority Plan (PCIP)	
Trust engagement plan to be reviewed	Lisa Thomson Director of Communications	15/03/2016	Update Jan 2016: Draft plan developed to be discussed at WAG and Executive. Update being taken to the Board in March. Includes the development of a staff engagement group. Update March 2016: Staff engagement plan presented to Trust Board 23/03/2016. This work will be picked up by staff engagement group.	24/03/2016

Target Risk Level	Moderate	Unlikely	6	Very Low

Progress	Annual staff survey underway. Awaiting results for an updated staff engagment score.

Next Review Date 06/07/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2894 Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems**
Date opened	18/05/2015
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	Moderate	Almost certain	15	Moderate

Director/Committee	Director of Human Resources / Workforce Assurance Group
Description/Impact	Trust leadership and managers need to be visible and approachable throughout the organisation. They need to coach and support employees helping remove barriers that get in the way of teams doing their jobs. Trust leadership and management need to support a culture, particularly with clinical teams, of partnership working based on trust, engagement and involvement.
Key Controls	A range of accredited leadership development programmes including ILM A range of accredited coaching programmes with coaches available for staff to access and a coaching skills programme Clinical Leadership programme in place
Sources of Assurance	Internal Audit-Job planning audit

Performance Monitoring	Annual staff survey includes numerous questions relating to management and leadership. It is reported to Workforce Advisory Group and Trust Board.
Gaps in Control	Lower than national average for staff scores to questions: "My immediate manager encourages those who work for her/him to work as a team", "My immediate manager can be counted on to help me with a difficult task at work", "I know who the senior managers are here", "Communication between senior management and staff is effective", "Senior managers where I work are committed to patient care"
Gaps in Assurance	

Current Risk Level	Moderate	Almost certain	15	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop aspirant leaders development programme	Denise Harnin Director of HR & OD	11/05/2016	Update Dec 2015: Programme drafted and with DCNO. Initial plan will be completed by mid-March 2016. March 2016 update: programme drafted. Improvement Director scoping nursing leadership requirements.	
Implement Organisational Development Strategy	Denise Harnin Director of HR & OD	31/12/2016	Update April 2016: The initial strategy presented to WAG 21st March 2016. A communications plan and staff leaflet to be developed to include the Trust Values and additional actions agreed to support the strategy focusing on Staff Engagement including Chatback, Listening into Action. And a range of workforce metrics has been developed to support the OD Strategy.	
Create HR strategy for learning and development, including leadership for senior management	Denise Harnin Director of HR & OD	15/02/2016	Update Dec 2015: Organisational Development strategy developed and presently with Executives for review. Propose new date mid-February 2016. Update March 2016: Organisation Development Strategy re-written and presented to WAG 21/03/2016 and at Trust Board Development day 23/03/2016. Action closed.	24/03/2016

Target Risk Level	Moderate	Possible	9	Low

Progress	Staff survey underway, awaiting further results regarding support and reliability of management. Update Jan 2016: A bid is being developed to access special measures money to take this forward.

Next Review Date 06/07/2016

BAF Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience**
Date opened	18/05/2015
Strategic goal	Design healthcare around the needs of our patients, with our partners
Strategic objective(s)	Provide excellent patient experience
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Nursing Officer / Patient & Carer Experience Group
Description/Impact	One of the most important aspects of monitoring complaints is to ensure that the Trust learns from complaints received and takes action to ensure that the situation that led to the complaint is not repeated. If we do not adequately understand & learn from complaints and patient feedback we will be unable to deliver and demonstrate excellent patient experience.
Key Controls	Complaints & PALS policy and procedure Ace With Pace customer service training Training for Healthcare Assistants in patient experience Patient experience incorporated into preceptorship for newly qualitfied nurses Patient and Public Forum ward visits and action plans Established system for recording compliments Patient experience dashboard provided routinely to divisions 'How was it for you' sessions with Chief Nursing Officer Ace With Pace customer service training
Sources of Assurance	Internal reports to the Board-Patient and Public Forum ward visits and action plans Care Quality Commission-Care Quality Commission (CQC) inspection Review-External-Parliamentary and Health Service Ombudsman Management Assurance-Quality Review Visits and mock inspections Management Assurance-Divisional Quality Governance Teams

Performance Monitoring	Numerous performance indicators, including: - Complaints numbers, response times & themes - Friends and Family test - National inpatients survey - CQC survey - Hospedia - Carer Feedback Survey - Cleanliness polls - PPF action plans - PALS reports - NHS Choices/Patient Opinion
Gaps in Control	Patient experience data spread across numerous surveys and reports and therefore themes may be difficult to identify No standardised method of disseminating learnings from feedback, innovations or good practices Improvements from complaints not tracked centrally
Gaps in Assurance	Planned actions provided by divisions in response to complaints sometimes unclear or unsubstantiated

Current Risk Level Moderate Likely 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Development of Outpatient Strategy to incorporate outpatient feedback from National Survey 2015 and quick wins	Tessa Mitchell Associate Director of Patient Experience	15/08/2016	An Outpatients Group has been established to develop Strategy	
Implement new complaints investigation template across Trust following pilot	Tessa Mitchell Associate Director of Patient Experience	15/02/2016	rolled out Trust wide in January with staff briefing	02/02/2016
Meet with NED's to review presentation of patient experience data	Tessa Mitchell Associate Director of Patient Experience	26/02/2016	PE Event held 1.2.16 to review current position and data and set priorities to improve patient experience moving forward.	02/02/2016
Improve presentation and triangulation of data - collaboration between Patient Experience and Information Teams	Tessa Mitchell Associate Director of Patient Experience	31/01/2016	New FFT script has been completed and going live in February. New Complaints DATIX Report now available to all via DATIX reports system. Further development and tweaking taking place. Regular meetings with Informatics and PE managers.	02/02/2016

Develop method for disseminating learnings from complaints and patient experience data	Tessa Mitchell Associate Director of Patient Experience	15/03/2016	Reviewing areas for improvement and ensuring these are captured in action plans. Update Dec 2015: Actions to be taken following complaints being added to Datix. New Datix report template set up by Information Team. update Jan 2016: New Monthly Complaints update to go on weekly Brief from February. Looking at format used by other hospitals. PE Event 1.2.16 helped set scene and establish priorities going forward. New PE Lead starts in March. Regular Complaints & PALS and Patient Experience Newsletters introduced Feb 16. These promote info, activities and share learning.	03/03/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	The objectives of the 2013-17 Patient, Public and Carer Experience Strategy aim for clearer accountability, focussed support to our Divisions and to reflect our commitment to ensuring that public, patient and carer voices remain central to our healthcare services. Significant improvements have been made to our complaint handling processes during the last year and the revised template will fill many of the process gaps identified in our recent internal audit. Liaison with informatics are improving data presentation and understanding. Ward Dash Boards will greatly assist. Update Jan 2016: Trust Board downgraded risk to moderate

Next Review Date 06/07/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2902 If the Trust does not achieve safety targets, it will fail to reduce avoidable harm & reported mortality rate 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 Single weekly Operational Governance meeting to coordinate patient safety forums Corporate Clinical Governance Team and Divisional Quality Teams to support implementation
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) - Hip Fractures – Time to Theatre within 36 hours (QEF3.1) - 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 Mortality review process requires embedding 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 Clear definition and description of safety metrics - check inclusion in reporting processes Performance management processes that include these.

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Launch safety culture campaign with highlighted themes	Lisa Thomson Director of Communications	17/06/2016	A new safety campaign is being developed with input of the CNO which will encompass safety culture and the major elements of the Governance and Safety action plan.	
Check definitions of patient safety targets / metrics and inclusion in the Divisional Qulaity Governance Report / Dashboards	Chris Rawlings Head of Clinical Governance & Risk Management	30/06/2016	Review of Divisional Quality Governance Report on 1st April.	
Actions regarding improvement in patient safety and mortality review are contained within the Trust Improvement Programme (prev. PCIP)	Chris Rawlings Head of Clinical Governance & Risk Management	31/12/2016	Improvement Plan in place with KPIs. Refer to this for detail on actions and performance.	
Review performance management framework	Sarah Smith Director of Strategy, Planning and Improvement	31/01/2016	December 2015 update: Review of performance management framework being presented to Trust Board January 2016. February 2016 update: Now working to new framework	31/01/2016

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	Incorporated into existing PCIP work streams and as necessarypatient safety workstreams.	12/02/2016

Target Risk Level	Major	Possible	12	Moderate

Progress	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. Brainstorming meeting on sharing / feedback from learning held in February. 1st April - review of Divisional Quality Governance 'deep dive' report at OGM after first cycle of reports. Trajectory set for mortality review performance at QGC in April 2016 Update June 2016: PCIP work progressing. CNO recruiting external support and getting input from Oxford University Hospitals NHS Foundation Trust.

Next Review Date 06/07/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk **2904 If there is inadequate culture and staff development for improvement, the Trust will not be able to continuously improve**

Date opened 26/05/2015

Strategic goal Continuously improve our services to provide the best outcomes and experience for our patients

Strategic objective(s) Get better every day

Initial Risk Level Major Possible 12 Moderate

Director/Committee	Director of Human Resources / Trust Management Committee
Description/Impact	If there is insufficient culture and capability for improvement, the Trust will not be able to continuously improve. Key clinical and non-clinical staff need to be supported with training and tools to enable innovation and improvement. In order to achieve the objective Get better every day, the Trust needs to create a 'can-do' culture.
Key Controls	Training delivered by Transformation team to project teams, including: 5S, Improvement Methodology and Six Sigma, Change Agent, Measurement for Improvement by Transformation team Training in principles of customer service and communication by Organisation Development Suite of training in aspects of quality and safety by Clinical Governance
Sources of Assurance	Management Assurance-Transformation project reporting processes Management Assurance-Complaints and patient feedback reporting Management Assurance-Quality and safety reporting via clinical governance structures and processes

Performance Monitoring	Trust performance monitoring dashboard Annual Staff Survey regarding culture, and management responsiveness to change and improvement
Gaps in Control	Interventions to improve the culture of improvement
Gaps in Assurance	

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Implement OD and engagement improvement plan	Denise Harnin Director of HR & OD	31/12/2016	Updates captured within the Trust Improvement Programme (PCIP) for Organisational Development & staff engagement	
Development of the three year Organisational Development Program to support staff by providing the right conditions for innovation and creative thinking	Denise Harnin Director of HR & OD	15/03/2016	Update Feb 2016: the ODP is captured in the PCIP Update Mar 2016: the Organisational Development and engagement plan agreed by the Improvement Board in March 2016. Action closed	24/03/2016

Target Risk Level Major Unlikely 8 Low

Progress	April 2016: Resource plan for organisational development being developed

Next Review Date 06/07/2016

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 / Remuneration 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, the Trust being placed in Special Measures, recruitment difficulties and historical 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 five Non-Executive Directors (NEDs) including the Acting Chair, two Associate NEDs and a Board Advisor; 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 December 2016. This creates a business continuity risk for the governance of the organisation. 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 NHSI who are responsible for the appointments, however this has not yet been accepted. NHSI have stated that they will now only appoint for two year periods. Furthermore, as a result of the departure or absence of several Executive Directors, the five voting Executive posts are either acting or 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 and experienced acting or interim staff, endorsed by NHSI 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 Clear deputizing arrangements in operation, and or swift action to bring in interim support where required The Chief Executive is the substantive Deputy CEO and the acting CMO is a substantive Divisional Medical Director
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 NHSI self-certification Independent Assurance-NHSI have commenced a Board Capability & Capacity review in line with the special measure regime

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 NHSI and decision on NEDs currently delayed pending new Chair appointment
Gaps in Assurance	The Trust is not presently aware of the NHSI'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	30/09/2016	Strong interim posts in place for 2016. Chief Nursing Officer, Chief Medical Officer and Director of Finance posts to be advertised from Sep 2016. Due date updated to September 2016.	
Following recruitment of new chair, Chairman to discuss with NHSI, agreeing appointment programme and business continuity arrangements for Trust Board		21/10/2016		
Develop a NED recruitment programme	John Burbeck Interim board chair	15/07/2016	Associate NEDs appointed to supplement Board capacity through transition period. Former NED role extended as Board Advisor.	27/06/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	NHSI have commenced a Chair Recruitment Process and interviews are scheduled for late July 2016. In the meantime, the Deputy Chair has agreed to act as chairman. Plans are in place to commence recruitment of key Executive posts, following the appointment of a new Chair. In the meantime, the Executive will remain in place, providing continuity and stability through the transition period.

Next Review Date 06/07/2016

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 Divisional QUality Governance Reports are provided monthly for Exec Review and quarterly to the Quality Governance Committee as 'deep dive' reports.
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
Implement changes outlined in the review of quality	Chris Rawlings Head of Clinical Governance & Risk Management	30/06/2016	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. March 2016 - Deputy Director post offered with an expected start date in June. Deadline date moved to end of June to allow for this.	
Ensure that the "must do's" contained within the Final Report are acted on.	Lisa Miruszenko Deputy Chief Nursing Officer	16/09/2016	The PCIP has been populated with the "Must Do's" from the Final report. All "Should Do's" have been reviewed and those identified as good practice for the organisation have also been moved across into the PCIP reports. The remainder have been cascaded to the divisions who have developed action plans that are being monitored through the Divisional Quality Meetings. Progress against the PCIP, which is currently being underpinned with updated project documentation, is being monitored through the Improvement Board (Est 9th March 2016). June 2016 update: due date extended to capture continued work of Improvement Board in addressing the Must Do's.	
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 for 11th February 2016 and will be conducted monthly thereafter.	01/02/2016

Target Risk Level Major Unlikely 8 Low

BAF Risk Report

Progress	Must do's and selected should do's are incorporated into the PCIP, which is being monitored by the Improvement Board. Quality Review Visits are being used to test assumptions and provide assurance that improvmements are being sustained. Risk areas are being communicated to Quality Champions so that they can cascade good practice and other messages throughout the Trust. Hot Topics are being developed to facilitate communication of key messages throughout the Trust.

Next Review Date 06/07/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected**
Date opened	18/01/2016
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Moderate Likely 12 Moderate

Director/Committee	Chief Executive /
Description/Impact	Media interest, external reports and delays in reconfiguration all have the potential to damage Trust reputation. If these and other issues are not proactively managed commissioners may look to other organisations to provide services; political interference may inhibit and slow critical decisions required to deliver the Trust's plans; and requests for funding and to be part of any national initiatives would be restricted. All of this could lead to a lack of confidence from patients and difficulties with recruitment if the Trust is seen to be a less desirable place to work or be treated. It will also adversely affect the ability to raise funds and support for fundraising activities.
Key Controls	Director of Communications & Communications Team Communications strategy for handling the publication of any reports about the Trust and any changes made under emergency measures
Sources of Assurance	Review-External-TDA and CCG Communications teams provide assurance regarding the communications strategy and approach

Performance Monitoring	Yearly stakeholder survey to be initiated. Media monitoring (including social media) in place and reported
Gaps in Control	Social media under-utilised Relationships with stakeholders insufficiently formal
Gaps in Assurance	Insufficient information available regarding stakeholder views & opinions of the Trust

Current Risk Level Moderate Likely 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Test staff advocate programme	Lisa Thomson Director of Communications	15/07/2016	Testing in progress.	
Implement Stakeholder Brief (for Commissioners, Council Leaders, MP's etc)	Lisa Thomson Director of Communications	15/02/2016	Brief used to communicate progress on FOASH externally. Internal weekly brief a team brief used as opportunities to update staff on progress on the FOASH programme. Update March 2016: first stakeholder brief distributed	24/03/2016
Increase utilisation of social media	Lisa Thomson Director of Communications	15/03/2016	Draft Media Policy produced and available. Submitted to WAG in February 2016 and now needs to be presented to the policy group. Update March 2016: media policy signed off, action closed.	24/03/2016
Create an integrated Communications Strategy	Lisa Thomson Director of Communications	15/04/2016	Staff engagement group formed. First meeting to take place in early March. National staff survey results known in March. Both of these will be used to inform the communications strategy.	15/04/2016
Conduct the first annual stakeholder survey	Lisa Thomson Director of Communications	16/05/2016	Survey drafted for consideration by the executive team	16/05/2016
Implement Media Policy	Lisa Thomson Director of Communications	15/07/2016	Developed, tested and approved	31/05/2016
Promote and develop staff and patient roles as advocates for the Trust to improve confidence amongst colleagues and the community	Lisa Thomson Director of Communications	15/06/2016	Staff engagement group formed. ToR for patient advocates under development.	15/06/2016

Target Risk Level Minor Unlikely 4 Very Low

Progress	

Next Review Date 06/07/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk [3193 If the Trust does not achieve patient access performance targets, there will be significant impact on finances]

Date opened 23/03/2016

Strategic goal Ensure the Trust is sustainable and financially viable and makes the best use of resource

Strategic objective(s) Use resources wisely

Initial Risk Level Major Likely 16 High

Director/Committee	Chief Operating Officer / Finance and Performance Committee
Description/Impact	As part of the Sustainability and Transformation Plan (STP) process, approximately £14m of Trust income is dependent on delivery of the four main access standards, that is: - 4 hour Emergency Access Standard (EAS) - 18 week Referral to Treatment (RTT) standard - 62 days from urgent GP referral for suspected cancer to first treatment - Cancer diagnosis rates (one year survival) The amount of money provided is scaled depending on the degree to which these access targets are achieved. This will be challenged by a number of factors, including: changing terms and conditions for delivery of additional clinical activity; staffing; high occupancy levels; delayed transfer of care.
Key Controls	Weekly access meetings Additional activity through theatres Waiting list management Somerset Cancer Registry to monitor cancer waiting times & escalation reports Patient level tracker for all cancer standards Monthly review of capacity and utilisation at senior level across system Full capacity protocol Monitoring of patients >10 days LOS on a weekly basis
Sources of Assurance	Management Assurance-Plan and trajectory provided in regular reports at Finance & Performance Committee Management Assurance-Monthly performance review with divisional teams

Performance Monitoring	CAE1.1 % of patients waiting less than 4hrs in A&E PW4.0 Backlog > 18 weeks (Outpatients + Day Case + Elective Inpatients)
Gaps in Control	Demand management plan with commissioners Finalised workforce and recruitment contract for 2016 with commissioners Consultant workforce numbers
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Implement training and development for staff and a validation resource for RTT data	Inese Robotham Deputy COO	15/06/2016		
Introduce outsourced support for imaging to enable a 24/7 service	David Burrell Divisional Director of Operations	31/07/2016	Up-date 24/6/16 - Radiology overnight reporting was outsourced from 11 April 2016. This has provided additional reporting sessions per week, however the improvement expected in reporting times has been negated by Consultant Radiologists leaving the service or reducing hours. The outsourcing initiative will be reviewed in 3 months' time. Expected completion date – 31 July 2016	
Urgent Care and Patient Flow Trust Improvement Programme contains the full action plan for this risk	Rab McEwan Chief Operating Officer	31/12/2016		
Centralise pathology services to improve efficiency of diagnostics	David Burrell Divisional Director of Operations	15/06/2016	Up-date 24/6/16 - Complete. Most pathology services were already centralised. Histopathology was centralised at WRH from 8 June 2016. This was a financial and quality initiative. Data will be monitored to determine if this initiative has improved turnaround times.	24/06/2016

Target Risk Level Moderate Possible 9 Low

BAF Risk Report

Progress	

Next Review Date 06/07/2016

Worcestershire NHS
Acute Hospitals NHS Trust

Corporate Risk Register Summary

June 2016

ID	Opened	Title	Executive Lead	Monitoring Committee	Rating (current)	Risk level (current)
3097	27/11/2015	If managers do not adhere to financial controls, there will be excess expenditure and financial recovery plan not met	Finance Director	Finance and Performance Committee	20	High
3041	16/10/2015	If the Trust does not increase efforts to save money, it may not realise the CIP target, worsening the financial position	Finance Director	Finance and Performance Committee	20	High
2856	07/04/2015	Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury	Chief Executive		20	High
2664	22/04/2014	Insufficient out of hospital capacity to meet the needs of patients with on-going healthcare needs	Chief Operating Officer	Trust Management Committee	20	High
1941	29/06/2010	Lack of available bed capacity may cause overcrowding in ED which can lead to suboptimal care & a poor patient experience	Chief Operating Officer		20	High
2649	11/04/2014	Workforce shortages affecting the consultant on-call rota for emergency surgery at AGH	Chief Operating Officer	FoAHSW - Sustainability Subcommittee, TMC	16	High
2661	22/04/2014	Increased pressure in emergency demand may impact on the safety of patient care & failure to meet performance standards	Chief Operating Officer	Trust Management Committee	16	High
2709	19/08/2014	Risk to critically ill patients having delayed admission to ITU due to lack of bed spaces (spaces occupied by wardable patients)	Chief Operating Officer		16	High
2711	29/08/2014	Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	Chief Nursing Officer	Trust Management Committee, WAG	16	High
2746	24/10/2014	If W&C Division are unable to sustain safe staffing levels it will be unable to provide safe patient care at all sites	Chief Medical Officer	FoAHSW - Sustainability Subcommittee, TMC	16	High
2791	04/02/2015	If the Medicine Division is unable to sustain appropriate staffing levels it will be unable to provide safe patient care	Chief Operating Officer	FoAHSW - Sustainability Subcommittee, TMC	16	High
2908	28/05/2015	Use and release of information which is inaccurate, false or misleading resulting in reputational and legal damage	Chief Medical Officer	Data Quality Group	16	High
3078	23/11/2015	Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner	Chief Operating Officer		16	High
3079	23/11/2015	Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care	Chief Medical Officer	Workforce Assurance Group	16	High
3018	15/09/2015	As a result of the care models on the Wyre Forest GP unit, medicines are not managed safely	Chief Operating Officer		15	Moderate
3019	15/09/2015	As a result of the care models on Ward 1, medicines are not managed safely resulting in sub-optimal care	Chief Operating Officer		15	Moderate
2736	13/10/2014	Lack of Section 12 approved doctors to act as Responsible Clinician prevents legal detentions under Mental Health Act	Chief Medical Officer	Trust Management Committee	15	Moderate
2396	15/01/2013	Poor quality clinical record keeping may lead to a variety of harms to patients and organisation	Chief Medical Officer	Electronic Patient Record Programme Board (HRC)	15	Moderate
2662	22/04/2014	Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT	Chief Operating Officer	Trust Management Committee	15	Moderate
2663	22/04/2014	If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets.	Chief Operating Officer	Cancer Board, Trust Management Committee	12	Moderate
2774	15/01/2015	Failure to provide resilient IT infrastructure resulting in system unavailability which negativity impacts patient care	Chief Executive	Trust Management Committee	12	Moderate
2857	07/04/2015	Failure to manage water system resulting in transmission of harmful pathogens to patients or staff	Chief Nursing Officer	TIPCC	12	Moderate
2864	20/04/2015	Failure to follow pressure ulcer prevention procedures (risk assessments, position changes, correct equipment) resulting in harm	Chief Nursing Officer	Patient Harm Group, Safe Patient Group	12	Moderate
2899	19/05/2015	Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, poor clinical outcomes	Chief Operating Officer	Trust Management Committee	12	Moderate
2994	03/08/2015	Failure to meet the NHS England Serious Incident Framework resulting in failure to learn and potential regulatory action	Chief Nursing Officer	Safe Patient Group	12	Moderate
2995	03/08/2015	If Patient Safety Incidents are not managed in a timely way there will be missed learning and preventable harm	Chief Nursing Officer	Safe Patient Group	12	Moderate
3044	21/10/2015	If the Trust does not manage CCG QIPPs the financial plan will not be realised	Finance Director	Finance and Performance Committee	12	Moderate

CRR Risk rating tracking report

CRR risk	Jul-15	Oct-15	Jan-16	Apr-16	Jul-16	Notes	Change over 12 months
2664 Insufficient out of hospital capacity to meet the needs of patients with on-going healthcare needs	20	20	20	20	20		→
3041 If the Trust does not increase efforts to save money, it may not realise the CIP target, worsening the financial position	15	15	20	20	20		↑
1941 Lack of available bed capacity may cause overcrowding in ED which can lead to suboptimal care & a poor patient experience		escalated	20	20	20		→
2856 Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury		escalated	20	20	20		→
3097 If managers do not adhere to financial controls, there will be excess expenditure and financial recovery plan not met		new	20	20	20		→
2908 Use and release of information which is inaccurate, false or misleading resulting in reputational and legal damage	16	16	16	16	16		→
2791 If the Medicine Division is unable to sustain appropriate staffing levels it will be unable to provide safe patient care	16	16	16	16	16		→
2746 If W&C Division are unable to sustain safe staffing levels it will be unable to provide safe patient care at all sites	16	16	16	16	16		→
2711 Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	12	12	16	16	16		↑
3079 Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care		new	16	16	16		→
3078 Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner		new	16	16	16		→
2709 Risk to critically ill patients having delayed admission to ITU due to lack of bed spaces (spaces occupied by wardable patients)	16	16	16	16	16		→
2661 Increased pressure in emergency demand may impact on the safety of patient care & failure to meet performance standards	16	16	16	16	16		→
2649 Workforce shortages affecting the consultant on-call rota for emergency surgery at AGH	20	20	16	16	16		↓
2396 Poor quality clinical record keeping may lead to a variety of harms to patients and organisation	20	20	15	15	15		↓
3018 As a result of the care models on the Wyre Forest GP unit, medicines are not managed safely	12	15	15	15	15		↑
2736 Lack of Section 12 approved doctors to act as Responsible Clinician prevents legal detentions under Mental Health Act	15	15	15	15	15		→
2662 Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT	15	15	15	15	15		→
3019 As a result of the care models on Ward 1, medicines are not managed safely resulting in sub-optimal care	new	15	15	15	15		→
2995 If Patient Safety Incidents are not managed in a timely way there will be missed learning and preventable harm	new	16	12	12	12		↓
2857 Failure to manage water system resulting in transmission of harmful pathogens to patients or staff	15	15	15	16	12		↓
2774 Failure to provide resilient IT infrastructure resulting in system unavailability which negativity impacts patient care	12	12	12	12	12		→
2663 If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets.	12	12	12	12	12	Replaced risk 1800	→
3044 If the Trust does not manage CCG QIPPs the financial plan will not be realised	new	12	12	12	12		→
2994 Failure to meet the NHS England Serious Incident Framework resulting in failure to learn and potential regulatory action	new	15	12	12	12		↓
2864 Failure to follow pressure ulcer prevention procedures (risk assessments, position changes, correct equipment) resulting in harm		escalated	12	12	12		↑
2899 Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, poor clinical outcomes			de-escalated from BAF	12	12	Moved from BAF to CRR in March 2016	→
2372 Failure to address the causes of falls resulting in patient harm and financial penalties	12	12	12	12	de-escalated to SPG		→
2463 Failure to reduce number of preventable cases of C.difficile due to lapses in care, resulting in adverse patient outcomes	12	12	16	12	de-escalated to TIPCC	Now rated 9	↓
2747 Failure to prepare for serious new or emerging pathogens (eg Ebola, MERS) leading to exposure of public, patients and staff.	20	16	12	9	de-escalated to TIPCC		↓
2565 Delay or failure to act upon clinical diagnostic test results leading to patient harm	12	9	9	9	de-escalated to SPG		↓
2461 Problems with the functionality, reliability and timeliness of eznotes system, negatively impacting patient care	12	9	9	9	de-escalated	Manged by EPR Programme Board	↓
2732 If the Trust does not adequately prepare for emergencies, there may be an uncoordinated response and subsequent adverse events	20	20	12	8	de-escalated	Managed by Emergency Planning, Resilience and Response group	↓
2770 If a staff member uses an overdue key document, patients may not receive best practice care, or corporate process not followed	12	12	8	8	de-escalated		↓
2957 Breaching hygiene code due to inadequate or ineffective assurance around environmental cleaning	20	20	12	6	de-escalated to TIPCC & PEOG		↓
2464 Risk of Norovirus outbreaks resulting in adverse patient outcome and impact on patient flow	20	20	12	6	de-escalated to TIPCC		↓
2462 Failure to prevent MRSA bacteraemia due to lapse in care resulting in adverse patient outcomes and reputational damage	6	6	12	6	de-escalated to TIPCC		→
2764 Fire Code non-conformance potentially resulting in reduced capability to achieve timely progressive horizontal evacuation	20	20	5	5	de-escalated	Related to WRH site - managed by E&F risk register	↓
2554 Insufficient staff and fire compartmentation to safely evacuate silver ward resulting in patient/staff injury	12	12	15	closed		Avon 5 closed Feb 2016 risk removed	↓
2822 As a result of the care models on ward 1 and the GP unit, medicines are not managed safely resulting in suboptimal care	15	closed				GP unit closed, so new risk created just for Ward 1	↓
2730 If the structure for managing patient property is not robust patients may lose valuables & the trust is financially liable	9	closed				Risk closed following implementation of controls	↓
2433 Increases in emergency demand may compromise capacity and flow resulting in poor patient experience & failing the 4hr standard	16	closed				Closed as covered by risks 2661 and 1941	

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**1941 Lack of available bed capacity may cause overcrowding in ED which can lead to suboptimal care & a poor patient experience**
Date opened	29/06/2010
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Major Almost certain 20 High

Director/Committee	Chief Operating Officer /
Description/Impact	If there is insufficient bed capacity at times of high Emergency Department (ED) demand, the ED becomes overcrowded, patient flow is adversely affected and patients are nursed in inappropriate areas such as corridors. In the corridors there is a lack of privacy, no call buttons or suction which results in poor patient experience, increased clinical risks and stress for staff whilst working in these conditions. Patients have to be continually moved to be seen and be treated making it difficult to keep track of where patients are physically located together with their notes. The overcrowding also means that the Trust cannot meet the 95% target for 4 hour waits or ambulance handover times for which the trust is fined. This situation is resulting in increased complaints and incidents.
Key Controls	Escalation Policy when the department reaches capacity Additional equipment PCIP/UrCOT for monitoring and service improvement plan in place Corridor Policy Additional corridor nursing staff to manage patients Use of rapid triage where nursing staffing numbers allow GP's working in ED at WRH Use of Locum doctors to fill gaps in rota Additional equipment Joint statement management of patients in the corridor/cohorting patients by WMAS and WAHT Full Capacity protocol
Sources of Assurance	External Audit-CCG have undertaken an audit of the GP function Management Assurance-Monitored monthy through UrCOT Management Assurance-Monitored through PCIP

Performance Monitoring	EAS targets ED harm reviews 15 minute triage validation
Gaps in Control	Availability of Agency staff to fill shifts for both the transfer team and corridor GP gaps in rota Clinical staff vacancies/ middle grade cover/use of locums and risks associated Varying skill mix with regard to GP's Ability to fill locum shifts for Doctors and last minute sickness Lack of beds/patient flow within the trust thus restricting flow out of the A&E department
Gaps in Assurance	

Current Risk Level Major Almost certain 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done

Expansion of ED and improve patient flow	Randeep Kular Deputy Director of Operations	27/06/2016	Business case and building plan was produced and submitted to the TDA to request funding for expansion of ED. Capital support application was submitted which was supported in AUG 15. Progress is being monitored through UrCOT work stream and ED expansion group. The work programme includes best practice ward rounds workstream to assist with early discharges and improve patient flow and enhance patient experience. Meetings with all ward managers at AGH and WRH have been led by the CNO to ensure the roll out of best practice ward rounds. Further work around a discharge lounge with increased capacity has begun and will also suppport improvements to patient flow 24/9/15 Delays to progress due to factors outside of the Trust's control. Expected by Dec 15.Expected delivery date Now Feb 2016 4/12/11 expansion work has commenced; completion expected March 2016 Due to slippage in ground work the proposed opening dates is now May 2016. Operational and planning meetings have been commenced on weekly basis. 6/5/16 phase 2 of the project will be completed by the end of May.	
Improvement programme for patient flow for ED and the Trust.	Randeep Kular Deputy Director of Operations	30/06/2016	Monitoring of programme to improve patient flow is being undertaken by SRG (system resilience group for urgent care) This includes external agencies who have been allocated actions to deliver. Internally the Urgent Care Programme Board is responsible for the urgent care component of the Patient Care Improvement Plan (PCIP). This is where progress on the actions to improve urgent care and patient flow is tracked. The PCIP work is on-going with a focus on base wards to improve flow. A robust action plan has been developed by WAHT in conjunction with external partners and ECIP and this includes the urgent care concordat. Delayed transfers of care numbers have reduced in line with SRG requirements. On going work with ECIP team continues to focus on the SAFER care bundle on the base wards and ED/MAU/ AEC.	
Delivery of Workforce Plan for Medical and Nursing Staff at WRH in preparation for expansion to ED	Randeep Kular Deputy Director of Operations	27/01/2017	Business case for nursing establishment has been submitted to the executives and is awaiting approval. 6/5/16 Exec approval has been given for increasing numbers of nurses per shift from 11 to 13 to allow for the ED expansion and also SIAN (Senior Intial Assessment Nurse)nurses. Recriutment has commenced. The medical workforce plan is currently being written New weekly operational group set up led by Sarah Smith and Randeep to put in place operational plans associated with the ED expansion. Includes workforce and equipment issues Up-date 24/6/16 - Nursing Workforce Plan has been reviewed to accommodate increased nursing resource. This will allow for 14, 14, 14 cover as of October 2016 as recruitment is ongoing. Recruitment process for Consultants has commenced with expected completion date of January 2017.	
Extra equipment purchased for ED	Clare Bush Senior Sister/Department Manager	20/05/2014	All equipment now received in the ED	04/06/2014
UCIP plan in place	Paul Bytheway General Manager		Actions are progressing - progress reports are submitted to EAST on a monthly basis	25/06/2014

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Deliver frality unit summer 2014	Caroline Lister Directorate Manager		Frailty Unit - now named 'Silver' is established with clinical leadership provided by Elderly Care. AMU have dedicated nurse leader (Donna Kruckow) and the unit on AMU reconfigured to provide a higher standard of care.	20/09/2014
Daily review of nursing staff in order to plan additional nursing staff for corridor	Clare Bush Senior Sister/Department Manager		All shifts escalated. Do not always fill. Matron/band 7 nurses work in numbers. Some training has been cancelled early 2014	30/09/2014
New Departmental escalation policy for ED in progress	Clare Bush Senior Sister/Department Manager		Edited and now completed and approved via EAST	30/09/2014
Additional Capacity Summer 2014	Paul Bytheway General Manager		Additional capcity was opened as and when required on Avon 5	10/10/2014
Workforce plan agreed for Nursing	Clare Bush Senior Sister/Department Manager	04/05/2015	The Workforce plan was completed and presented to EAST. This is now being refined and updated to include immediate requirements. This will be represented on 22/10/14 for agreement at relevant committee as agreed by Ann Carey;. Workforce plan has been agreed and recruitment process has begun 16/12/14	25/05/2015
Winter capacity plans	David Allison Directorate Manager		Report completed. Awaiting approval through governance route.	30/06/2015
Implementation of Urgent Care Centre at Alex	Michael Dobb Operations Manager		Fully functional project steering group in place with all supporting processes, such as risk log, action plan, leadership etc. This led by the CCG. All actions are on track.	30/06/2015
Implementation of Urgent Care Centre at WRH	Stuart Cannonier Directorate Manager for Medicine	31/07/2015	GP's now working in ED at WRH. A rota is in place	30/06/2015
Focus on workforce model for AMU	James Young Consultant - Diabetes and Endocrinology	31/08/2015	A 5 day rota has now been agreed. The 7 day AEC and Acute recruitment plan will incorporate how we move towards 7 day service. This is currently being worked through.	24/09/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	Current bed remodelling planning underway within the acute trust this will look to repatriate a larger bed base to the medicine take which will realign the medicine demand for ED. Currently the medicine division are working on an AEC plan which will look to reduce attendances through ED, thus reducing the footfall into ED and reduce the number of patients admitted to the hospital. this will help with patient flow.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2396 Poor quality clinical record keeping may lead to a variety of harms to patients and organisation

Date opened 15/01/2013

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

Strategic objective(s) Develop and sustain safe services

Initial Risk Level Catastrophic Possible 15 Moderate

Director/Committee	Chief Medical Officer / Electronic Patient Record Programme Board (HRC)
Description/Impact	Quality of clinical record is on occasion too poor to facilitate good quality care. Sometimes illegible, info missing or omitted. Potential causes are workload pressures, including interruptions. As a result staff may not complete the record to the standard required. This leads to a variety of potential harms to patients and organisation. Such as: error in care due to poor communication, harm to patients, reputation damage, possibility of receiving an Article 24 letter, litigation, failure of CQC outcomes, financial penalties, reduced income due to poor coding.
Key Controls	Clinical record keeping policy Clinical record keeping training as part of induction Improvement in data capture forms such as Comorbidity form Monthly clinical record keeping audit - feedback on performance to clinical teams Performance management of record keeping standards through Health record committee
Sources of Assurance	Clinical Audit-Monthly clinical record keeping audit

Performance Monitoring	Monthly record keeping audit - Quarterly reports reviewed at Clinical Health Records Committee
Gaps in Control	No robust monitoring of creation of action plan and implementation of action plan following audit No competency testing or manadatory training for clinical record keeping policy
Gaps in Assurance	Lack of improvement plan(s) following highlighting of gaps on annual audit

Current Risk Level Catastrophic Possible 15 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Update clinical record keeping policy and re-launch	Steve Graystone AMD Patient Safety	29/06/2016	HW drafted, SG and SM updated. HW to submit to clinical leads prior to TMC approval.	
Agree new process for reporting and oversight of improvement plans	Steve Graystone AMD Patient Safety	30/06/2016	Process drafted by HW,professional Dev team and Clinical Audit team to present to Dr Graystone. New process to be presented to Lisa Miruszenko.	
Introduce e-forms (direct entry) to eZnotes to address issues such as legibility, time and date.	Steve Graystone AMD Patient Safety	30/06/2016	In IT Workplan, currently at initiation stage. training on how to build eforms has taken place. Awaiting IT developer resources to commence building of the forms.	
Results of clinical record keeping audit reviewed at HRC. Clinical teams not completing the audit have been instructed to complete within 3 months. Those with poor (<60% compliance) to devise actions and reaudit within 3 months.	Steve Graystone AMD Patient Safety	28/10/2013		31/10/2013
Introduce new health records audit methodology - monthly audit of smaller numbers with reports to Directorates	Steve Graystone AMD Patient Safety	31/10/2014	Audit method and tool developed. Divisional/Directorate audit to commence December 2014.	31/10/2014
Establish mechanism for raising issues to program board and feed back to Divisions	Steve Graystone AMD Patient Safety	30/04/2015	Monthly audit process piloted in Feb 2015 and found acceptable. Routine monthly audits commmenced April 2015 with quarterly reporting schedule to EPR programme Board	30/04/2015
Enhance monthly documentation audit to include clinical appropriateness	Rabia Imtiaz Consultant Obstetrician	29/02/2016	New questions added to documentation audit regarding content of notes.	29/02/2016
Review completion of record keeping e-learning	Steve Graystone AMD Patient Safety	06/05/2016	Update of league table requested from Sandra Berry Feb 2016 Information provided as a % only. No league table available. To be presented to HRC	29/04/2016

Target Risk Level Catastrophic Unlikely 10 Low

Corporate Risk Report

Progress	Review of action plans to improve performance scheduled on clinical HRC agenda. Completion will be monitored through this committee and exceptions reported to SPG.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2649 Workforce shortages affecting the consultant on-call rota for emergency surgery at AGH**
Date opened	11/04/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care
Initial Risk Level	Major Possible 12 Moderate

Director/Committee	Chief Operating Officer /
Description/Impact	Delay in introduction of countywide on call rota is leading to workforce shortages and recruitment challenges, resulting in vulnerability of the emergency general surgery service at AGH which may affect patient outcomes. Maintaining full emergency general surgery services across both WRH and AGH is challenging. As a response to concerns generated by HSMR data in late 2013, a cohort of emergency general surgery patients was transferred to WRH from AGH in February 2014. This has led to improved HSMR at AGH with no accompanying decline at WRH, demonstrating a positive clinical impact due to the change. However, it has led to increased emergency surgical patient admissions on the WRH site, leading to increased pressure on the CEPOD theatre list and the general surgery wards. Conversely, emergency admissions on the AGH site have reduced. The reduction in general surgery admissions and complexity of work on the AGH site could lead to nursing and medical staff becoming de-skilled, and is resulting in recruitment challenges. Nursing recruitment is a particular challenge across surgical wards at AGH, and this is thought in part to be connected to the current uncertainty regarding reconfiguration. The consultant and middle grade on call rotas at AGH are vulnerable due to gaps and ongoing recruitment challenges. Recent middle grade and consultant resignations have led to difficulties in providing substantive cover, resulting in multiple locum cover. A high proportion of sessions covered by locums can involve issues regarding of continuity of care. In addition, consultants on the AGH on call rota have varying sub-speciality interests. Whilst recent and ongoing 'general surgery' experience is appropriate for some ambulatory services, contemporaneous experience would be required for surgeons undertaking higher risk procedures which should be within their sub-speciality area. The potential risks associated with failing to reconfigure emergency general surgery toward a countywide model include: • Inability to maintain consultant and middle grade on call rotas at AGH • Inability to recruit satisfactorily to nursing posts at AGH, leading to potential patient safety concerns on the surgical wards • Inability to provide out of hours care for emergency surgery patients at AGH • Inability to support patients in ED that require surgical intervention at AGH out of hours Inability to support other patients being treated by other specialties (medicine, urology, ITU) at AGH with surgical input out of hours
Key Controls	Constant monitoring of surgical on call rota Constant monitoring of ward staffing levels and intervention where required Ongoing recruitment campaigns for middle grade and consultant staff Ongoing recruitment campaigns for nursing staff and use of agency staff where possible Triggers developed for action if service deteriorates
Sources of Assurance	Self-assessment against standards-On-call rota – frequency / gaps Self-assessment against standards-Consultants in post to participate in the on-call rota Self-assessment against standards-Ratio of permanent consultants Vs locums Self-assessment against standards-Performance data such as HSMR, unplanned return to theatre, delayed emegrency surgery Self-assessment against standards-Ratio of permanent Middle Grades v Locums Self-assessment against standards-Nurse staffing levels on AGH wards in accordance with workforce plan.

Performance Monitoring	Please see attached draft Sustainability Dashboard
Gaps in Control	Service is susceptible to further sickness or retirement
Gaps in Assurance	no known gaps

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Countywide rota being scoped to mitigate potential issue with AGH rota	Graham James Consultant Oral and Maxillo-facial Surgeon	31/08/2016	Rota scoped - awaiting implementation delayed due to delays in reconfiguration. Due date changed to end of October. Rotas available and ready for implementation. Update Dec 2015: Alternative rota models being reviewed. Due date updated to Feb 2016. Update April 2016: New group FoAHSW Implementation Group (FIG) established with role in developing a plan for countywide rota	

New trust grade surgical posts being developed to increase attractiveness of positions	Val Doyle Surgery	30/01/2015	adverts completed	15/04/2015
Establishment of a Task and Finish Group set up from 14/05/2015	Val Doyle Surgery	14/05/2015	Group established, ongoing weekly meetings underway.	14/05/2015
Ongoing review of workforce on the Alex site by operational team	Val Doyle Surgery	31/12/2015	Full complement of fully trained surgeons at AGH, all are GI surgeons	16/12/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	The acute Trust is unlikely to be in a position to maintain 2 separate consultant on call rotas in emergency general surgery, and additional actions may be required to maintain quality. Plans are being drawn up to instigate a county-wide consultant on call rota. This would require the movement of more emergency surgery work from AGH to WRH. It is thought that countywide rotas will allow rotation of consultant and middle grade posts and help improve recruitment potential, thus enabling the Trust to stabilise the rotas and attract good quality candidates. The general surgery department is working on a clinical model to develop a countywide ambulatory emergency general surgery service at AGH, which would redirect patients from WRH to create more capacity for emergency admissions on that site. Direct access to a consultant for GP's is part of the proposal for the ambulatory emergency general surgery service at AGH. 24/7 dedicated middle grade surgical cover would be maintained at AGH, which is the appropriate level suggested by national guidance. This would also allow the continued support for other departments (including Trauma and ED) at AGH out of hours. It would also allow more utilisation of theatre and ward facilities on the AGH site, and allow for rotation of both nursing and medical staff between sites. This would potentially help with recruitment and retention of staff. Discussions have taken place between clinical stakeholders regarding level of surgical provision required on each site if a countywide rota was introduced. An options apraisal has been completed with partners and current and future risks assessed against the proposals. 12/05/2015 A Task + Finish Group – Implementation of a Single County-wide Acute Surgical Model for Emergency and Ambulatory Care Pathways has been set up. First meeting being held on 14th May 2015" 13/07/2015 Work being undertaken with both internal and external stakeholders includes - Options appraisal - Capacity and workforce analysis modelling - Quality impact assessment - Operation plans have been drawn up - Risk assessments undertaken - Interim on-call rota has been agreed and is ready for implementation - Patient pathways have been agreed 10/11/15 - Confirm and challenge meeting completed with the executive team - All Rota's are available and ready to go live - Agreement in principal to go live on the 23rd November 2015 - Pre implementation checklist developed - Work being over seen by the safer services task and finish group - Communication strategy developed 03/11/2015 - Service model adapted to minimise impact on WMAS and site bed occupancy - Aiming to implement in December 2015

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2661 Increased pressure in emergency demand may impact on the safety of patient care & failure to meet performance standards

Date opened 22/04/2014

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 Operating Officer / Trust Management Committee
Description/Impact	Description: If emergency demand continues to increase and there is a lack of downstream flow in the local health economy then EAS performance will be compromised. This is an indicator on safety, quality of care and patient experience. Impact: - Sick people wait too long to be seen in the ED - Total LOS is increased with associated safety issues for the elderly - Hospital mortality rate increases - Patients leave ED without being seen - Medical errors and incidents increase
Key Controls	Escalation management system PCIP implementation Senior Immediate Assessment Nurse (SIAN)
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-Ambulance handover and EAS reporting audits

Performance Monitoring	CAE1.1 % of patients waiting less than 4hrs in A&E CAE1.1a 4 Hour Waits (%) - Trust inc. MIU - from September 14 Ambulance handover incidents in ED
Gaps in Control	WMAS conveyances have increased significantly since introduction of NHS111. Fully implemented admission avoidance schemes Patient flow centre not integrated with ward processes Emergency demand increases ahead of forecast due to service reconfiguration
Gaps in Assurance	Further information and assurance being sought through the Systems Resilience Group (SRG).

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Implement SIAN service	Rab McEwan Chief Operating Officer	28/10/2016	Feb 2016 update: Partially implemented SIAN service. Due date extended to April 2016. Up-date 24/6/16 - SIAN nurses have been implemented in the WRH ED department 7 days a week. These nurses are specifically assigned to manage their initial assessment of patients within 15 minutes and ensure prompt handover of patients arriving by ambulance within the same 15 minute timeframe. The next step for the SIAN nursing role is to continue with additional recruitment of nurses into their WRH ED so that service can be fully covered 24/7. Expected completion date October 2016.	
Trust Clinician formal review of final CCG QiPP Schemes including evidence of plans and PIDs.	Mark Wake Chief Medical Officer	30/06/2014	Overdue - Sufficient detail has not been received - DoR has contacted counterparts in CCGs	22/12/2014
Increase in bed capacity implemented.	Stewart Messer Chief Operating Officer	30/09/2014	The Divisions are currently working through the final schedules for the site reconfiguration for the specialities which will take place in September	22/12/2014
It is proposed that a Local Health Economy Action Plan is to be developed and monitored through Systems Resilience Group.	Stewart Messer Chief Operating Officer	28/02/2015	System wide action plan complete. Protocol introduced around risk assessment for patients presently being managed in the corridor of the ED	31/07/2015
Develop plan for winter 2015/16	Rab McEwan Chief Operating Officer	31/10/2015	Submitted to Trust Board in October 2015	07/10/2015

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	30/11/2015	Actions have been implemented to achieve compliance with 15 minute assessment standard in place. Further actions required, as contained within the PCIP.	13/11/2015
Create Full Hospital Capacity protocol	Rab McEwan Chief Operating Officer	31/10/2015	Full Capacity Protocol implemented 30/11/2015	30/11/2015
Reconfigure beds across sites to improve patient flow	Rab McEwan Chief Operating Officer	29/02/2016	Proposed new due date end December 2015. Update Dec 2015: new due date Feb 2016	31/03/2016

Target Risk Level	Major	Possible	12	Moderate

Progress	

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2662 Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT

Date opened 22/04/2014

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

Strategic objective(s) Deliver effective care

Initial Risk Level Catastrophic | Possible | 15 | Moderate

Director/Committee	Chief Operating Officer / Trust Management Committee
Description/Impact	Description: If emergency demand continues to increase it will result in insufficient elective capacity to deliver the 18 week RTT admitted target and to reduce the in-patient backlog. Impact: Compromised care and patient experience with patients waiting longer for planned procedures.
Key Controls	Waiting list management with PTL daily. Somerset Cancer Registry to monitor cancer waiting times & escalation reports to Operational teams to act upon Weekly access meetings Additional activity through existing theatre capacity and WLI's.
Sources of Assurance	Management Assurance-Divisional monitoring waiting lists Management Assurance-Surgery Division monitoring medical outliers daily Management Assurance-Monitoring backlog weekly. Internal Audit-Divisional Governance Structures Audit Internal Audit-Waiting List Initiative (WLI) Expenditure Audit

Performance Monitoring	PW4.0 Backlog > 18 weeks (Outpatients + Day Case + Elective Inpatients) PW4.1 Backlog > 18 weeks (Day Case + Elective Inpatients)
Gaps in Control	The Trust lacks clarity and control of the management of new referrals to the waiting list The Urgent Care Strategy is not delivering the expected benefits as described in BAF No. 2661 and a system-wide action plan is still in development The Trust has little control of the commissioning of independent sector capacity.
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).

Current Risk Level Catastrophic | Possible | 15 | Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Acute Trust to work with CCG to support the improved uptake of independent sector capacity where clinically appropriate.	Stewart Messer Chief Operating Officer	28/02/2015	Independent sector uptake has increased by 33%	28/02/2015
Patient pathways review by Transformation Team. Assertive recycling of theatre lists. KTC realignment plan (Jan15)	Stewart Messer 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
CCGs to agree plans with the Trust for management and reduction of GP referrals.	Rab McEwan Chief Operating Officer	30/09/2015	Agreed key specialities with CCG, where there is a significant backlog, GP's are to refer to alternative providers. Trust has developed speciality level action plans to achieve 92% incomplete standard by September 2015. Due date changed to reflect this.	31/12/2015
Acute Trust to plan additional activity through existing theatre capacity	Rab McEwan Chief Operating Officer	15/02/2016	Action updated, WLI removed due to Trust financial position. Existing capacity being used. Due date updated.	31/03/2016

Target Risk Level Catastrophic | Unlikely | 10 | Low

Progress

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 2663 If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets.

Date opened 22/04/2014

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

Strategic objective(s) Deliver effective care

Initial Risk Level Catastrophic | Likely | 20 | High

Director/Committee	Chief Operating Officer /
Description/Impact	Description: If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets. Impact: Failure to achieve these targets impacts patient care, potentially affecting clinical outcomes. This may also damage Trust reputation
Key Controls	Daily cancer waiting list management Somerset Cancer Registry to monitor cancer waiting times & escalation reports to Operational teams to act upon. Implemented new patient level tracker for all cancer standards Bi-weekly performance management regime Monthly reports provided to Board with speciality breakdown Recovery action plans for site level breaches of 62 day standard
Sources of Assurance	Management Assurance-Monitoring PTL daily. Management Assurance-Monitoring medical outliers daily. Management Assurance-Monitoring backlog weekly. Internal Audit-Data Quality- Cancer Waits Internal Audit

Performance Monitoring	CCAN1.0 31 Days: Wait For First Treatment: All Cancers CCAN2.0 31 Days: Wait For Second Or Subsequent Treatment: Surgery CCAN5.0 62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers CCAN6.0 62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers CCAN7.0 62 Days: Wait For First Treatment From Consultant Upgrades: All Cancers CCAN8.0 2WW: All Cancer Two Week Wait (Suspected cancer) CCAN9.0 2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)
Gaps in Control	The Trust lacks prior warning of national Cancer Awareness Campaigns The Urgent Care Strategy is not delivering the expected benefits as described in BAF No. 2661 and a system-wide action plan is still in development
Gaps in Assurance	Further information and assurance being sought through the CCG Contract Monitoring Board and Systems Resilience Group (SRG).

Current Risk Level Major | Possible | 12 | Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Outsourcing to both NHS and private sector	Stewart Messer Chief Operating Officer		Closed in Dec 2014 update	22/12/2014
KTC Utilisation plan	Stewart Messer Chief Operating Officer	30/06/2014	Closed in Dec 2014 update	22/12/2014
Assertive recycling of theatre lists	Stewart Messer Chief Operating Officer	30/06/2014	Closed in Dec 2014 update	22/12/2014
Recruitment to consultant gaps	Stewart Messer Chief Operating Officer	28/02/2015	Added to Trust action plan action	22/12/2014
CCGs and NHSE to alert the acute Trust to upcoming National Cancer Awareness campaigns	Stewart Messer Chief Operating Officer	28/02/2015	Information on upcoming National Cancer Awareness campaigns recieved.	28/02/2015
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
Appoint Head of Elective Performance and Patient Access	Rab McEwan Chief Operating Officer	14/03/2016		04/01/2016

Corporate Risk Report

Target Risk Level	Catastrophic	Possible	15	Moderate

Progress	

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2664 Insufficient out of hospital capacity to meet the needs of patients with on-going healthcare needs**
Date opened	22/04/2014
Strategic goal	Design healthcare around the needs of our patients, with our partners
Strategic objective(s)	Get better every day
Initial Risk Level	Major Almost certain 20 High

Director/Committee	Chief Operating Officer / Trust Management Committee
Description/Impact	If there is insufficient out of acute hospital capacity to meet the needs of patients with on-going healthcare needs then patients will be forced to stay in an acute hospital bed for longer detrimentally affecting their clinical outcomes, ongoing independence and experience of care.
Key Controls	System wide Capacity Plan sets out the required service capacity by pathway to menu of out of hospital care. Capacity meets normalised flow and peak pressure flow requirements. Commissioners have agreed resource plan with all relevant providers. Monitoring of patients +10 days on a weekly basis with H&CT/ASS. Weekly monitoring of patient list and +10 day cases with partners with actions taken as appropriate
Sources of Assurance	Management Assurance-Monthly review of capacity and utilisation at senior level across system. Management Assurance-Urgent Care Strategy Group, Review-External-Commissioner QIPP programme Internal Audit-Temporary Staff Booking Audit

Performance Monitoring	PIN3.1 Delayed Transfers of Care SitRep (Patients) - Acute PIN3.2 Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute Acute bed days occupied by patients 'Fit to Go'
Gaps in Control	Patient Flwo Centre not integrate with ward processe and challeneg on assessment of patient need
Gaps in Assurance	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
Patient Flow Centre to be re-organised	Rab McEwan Chief Operating Officer	31/07/2016	WAHT is hosting PFC to ensure multi-agency teams provide support for wards to support discharge Up-dated 24/6/16 - In reach pilot commenced 16 May 2016. Introduction of electronic discharge notification planned for end of June 2016. PFC hosting arrangement will change on 31 July 2016 and an integrated patient flow team will be in place by 31 July 2016.	
Act on report recommendations across local county.	Stewart Messer Chief Operating Officer	30/06/2014	Complete	31/08/2015
Commission an economy wide capacity review and report	Chris Tidman Acting Chief Executive	30/06/2014	Complete	31/08/2015
As a last resort, open up winter surge capacity and limit elective workload	Stewart Messer Chief Operating Officer	31/08/2015	Closed	31/08/2015
Commission a Discharge to Assess Pathway via Nursing Homes using Operational Resilience Funding	Stewart Messer Chief Operating Officer	31/08/2015	Commissioned pathways in place however capacity remains an issue i.e. DTA pathway 1 - struggling to recruit the carers required to deliver this outcome and the roll-out to the base wards within the Acute has been delayed (trying to use the Community beds in the short term). DTA 3 has been delayed as the beds have yet to be commissioned. There are system wide issues with the three pathways - this will be discussed at SRG.	31/08/2015
Elect to fine Social Care based on Section 2 and Section 5 notifications	Stewart Messer Chief Operating Officer	31/08/2015	Not pursuing this action.	31/08/2015
Close collaboration with CCG and County Council on reconfiguration of Trust bed base to include nursing home beds as part of winter resilience plan	Rab McEwan Chief Operating Officer	31/10/2015	Commissioned as pathway 3 capacity	01/11/2015

Weekly review of DTOC's led by SWCCG to speed up discharge	Rab McEwan Chief Operating Officer	29/02/2016	Weekly review implemented and ongoing.	18/02/2016
Obtain health economy sign off of the Worcester wide choice policy	Rab McEwan Chief Operating Officer	20/05/2016	Choice policy agreed	12/04/2016

Target Risk Level	Major	Possible	12	Moderate

Progress

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2709 Risk to critically ill patients having delayed admission to ITU due to lack of bed spaces (spaces occupied by wardable patients)

Date opened 19/08/2014

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

Strategic objective(s)

Initial Risk Level Major Likely 16 High

Director/Committee	Chief Operating Officer /
Description/Impact	There is risk of potential harm to critically ill patients requiring admission to critical care. Transfer of patients ready for ward step-down is often delayed due to capacity pressures across the site. Guidelines for the Provision of Intensive Care Services (GPICS). Standard 2.11 states that Discharge from Critical Care to a general Ward must occur within 4 hours of the decision. Standard 2.12 states that Discharge from Critical Care must occur between 0700hrs and 2159hrs. These standards are not currently being met by the Trust.
Key Controls	Representation at bed meetings Patient flow managed via PCIP urgent care plan
Sources of Assurance	Internal Audit-On-going monthly monitoring of delayed discharges Review-Internal-Daily escalation and monitoring of patients suitable for ward stepdown at bed meetings

Performance Monitoring	Daily escalation of wardable patients by the Divisional representative at the daily bed meetings. On-going monthly monitoring of delayed discharges Delayed discharges DATIXd and referred to bed management team for investigation
Gaps in Control	
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Improve clinical site coordination at AH and WRH through Hospital at Night and Clinical Site Coordination Team	Rab McEwan Chief Operating Officer	19/08/2016	New team appointed. Agreeing SOPs and performance management process.	
Risk to be included in Exception report to QGC	Faye Rafferty Quality Governance Manager	08/02/2016		08/02/2016

Target Risk Level Major Unlikely 8 Low

Progress	Currently there are on-going delays of stepping down level 1 patients to their respective wards due to emergency/capacity pressures across the sites. It is anticipated that re-establishment of assessment areas and improved patient flows will resolve these delays. There has been no progress made by the Trust in addressing failure to step down from the intensive care units. This is highlighted in the July 2015 critical care dashboards. The Trust is a National outlier in intensive care discharge performance. 02.03.2015. High level of patients remaining on ITU but ready for discharge to ward highlighted to Division at QG meeting.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 2711 Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.

Date opened 29/08/2014

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

Strategic objective(s) Develop and sustain safe services

Initial Risk Level Moderate Likely 12 Moderate

Director/Committee	Chief Nursing Officer /
Description/Impact	There are national shortages in some particular nursing/midwifery specialitities which means that the Trust is unable to recruit sufficient qualified nurses to maintain agreed safe staffing levels. There are site specific recruitment difficulties afffecting some areas possibly to percieved uncertainty over services e.g. Alexandra Hospital
Key Controls	Use of flexible staffing via NHSP and third party agencies Re-deployment of staff as appropriate Monitoring of daily staffing levels by shift and escalation where staffing falls below minimum agreed staffing levels Existing staff offered zero hours contracts Quarterly recruitment events Weekly and monthly monitoring of nursing and midwifery vacancies Enhanced exit interview process Surveys of student finalist employment intentions/influences Re-deployment of staff as appropriate Agreement to over recruit to posts where possible.
Sources of Assurance	Internal reports to the Board-Monthly Board reports on safe staffing levels

Performance Monitoring	Vacancies for registered nurses and health care support workers. Registered Nursing staff and health care support worker turnover.
Gaps in Control	There is a national shortage of nurses. There continues to be high use of external agencies in some clinical areas.
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
To liaise with local educational providers to recruit staff to the Trust	Sarah Needham Lead for Workforce and Education	31/08/2016	To identify and recruit staff into the organisation via educational providers and this will also take place prior to the last placement for nursing students at Worcester University.	
Trust to consider potential of recruiting abroad	Sarah Needham Lead for Workforce and Education	31/08/2016	European market has now been saturated and English language skills make it a challenge for them to achieve ILETS course level 7. Recruiting from the Phillipines also results in the same challenges. Therefore consideration and funding is required for looking at nurses in India.	
Implemenation of new roles	Lisa Miruszenko Deputy Chief Nursing Officer	30/09/2016	Job Descriptions for 3 new Roles, Ward Administrator, Ward Housekeeper and Assistant Practitioner have been agreed and recruitment. to the Ward Administrator role in the first instance has commenced Update 17/06/2016: shortlisting for ward administrator and ward housekeeper has taken place and interviews will take place on first week of July 2016. Nursing associate training for fast track program have been shortlisted and commence on 21st June 2016. This consists of 26 members of staff. A further 32 members of staff have been identified for a two year foundation degree and will commence in September 2016. The remainder of applicants have been sent a letter specifying the educational requirements required to be successful in the future and funding has been identified for this. Seven nurses from this cohort have been identified for nurse training and will commence in September 2016.	
To identify funding for the organisation to attend local recruitment fairs	Sarah Needham Lead for Workforce and Education	30/09/2016	Identify the most appropriate recruitment fairs Develop a promotional video highlighting the opportunities to work at the hospital and life living in Worcestershire, links to University, and promotional products.	

Specific Nursing & Midwifery Recruitment & Retention Strategy to be agreed. Reviewing Nursing & Midwifery recruitment pocesses to reduce timescales	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	31/12/2014	Centralised recruitment processes are in place for Bands 2 and 5 to minimise recruitment time.Nursing and Midwifery Recruitemnt & Retention Strategy has been approved by the Board.	16/01/2015
Growing Nursing & Midwifery NumbersDeveloping un-registerd workforce through apprenticeships. Implementing and delvering a Return to Practice Programme with University of Worcester. Developing new roles such as Emergency Nurse Practitioners	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	30/01/2015	New cohort of health Care Apprentices recruited. Return to Practice Programme recruited to with some candidates offered HCSW posts prior to commencement of and during course to facilitate completion and retention post completion.ENP programmes ongoing.	16/01/2015
Implement tighter monitoring of vacancies and attrition to the Nursing & Midwifery Workforce Action Group	Lisa Miruszenko Deputy Chief Nursing Officer	28/02/2015	Vacancies reported monthly via workforce group and traingulated with HR and Finance information.	24/03/2015
Development of Neonatal Workforce.Targeted recruitment events. Discussion with University of Worcester to create pre-registration neo-natal pathway. Raising profile of Neonatal Nursing as a career pathway for qualified Adult Nurses. All nurses rescrui	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	31/03/2015	Recruitment events have seen recruitment to vacant posts posts and additional staff have been enrolled on specialist courses with extra places on course continuing to be purchased.	26/05/2015
Recruitment Activity Targeted recruitment events for specific specialities. General recruitment events for newly qualified and experienced staff. Attendance at local jobs and careers fairs. Recruitment abroad (Europe)	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	30/11/2015	Action closed as overtaken by work of Task and finish group	14/10/2015
Task and Finish Group to implement Nurse Recruitment Action Plan	Lisa Miruszenko Deputy Chief Nursing Officer	31/12/2015	T&F group established, action plan developed, including multiple actions in the following categories: Recruitment Process, Agency Spend, Additional Capacity, Attraction &Retention, Working with University, New Roles	17/12/2015
Establishment of new roles subgroup to look at roles supplementary and complementary to nursing.	Lisa Miruszenko Deputy Chief Nursing Officer	31/03/2016	Group has met and agreed terms of reference. Scoping of current and possible future roles being undertaken. Action plan to be developed once scoping complete to track progress..	18/02/2016

Target Risk Level	Insignificant	Possible	3	Very Low

Progress	The Trust is seeing slight upward trend in recruitment to registered nurse posts. Vacancies for Health Care Support workers are reducing. A case for overseas recruitment initially in the Phillipines and or India has been submitted to the Executive Team for consideration. Quarterly Trust Recruitment Events are taking place. Trust representatives attend local and regional recruitment events. Proactive measures are being taken to actively newly qualified nurses from local HEIs.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2736 Lack of Section 12 approved doctors to act as Responsible Clinician prevents legal detentions under Mental Health Act**
Date opened	13/10/2014
Strategic goal	Design healthcare around the needs of our patients, with our partners
Strategic objective(s)	Deliver effective care

Initial Risk Level	Moderate	Almost certain	15	Moderate

Director/Committee	Chief Medical Officer / Trust Management Committee
Description/Impact	WAHT hospitals are registered with the Care Quality Commission to provide regulated activities, including "Assessment or medical treatment for persons detained under the Mental Health Act 1983" (MHA). Each time a patient is made subject to Section 2 or 3 of the Act, the Act and its code of practice require that a Responsible Clinician is identified. The Trust does not have any Section 13 approved doctors to act as Responsible Clinician to coordinate detentions under MHA. Inevitably some patients with acute medical conditions will also have acute mental health conditions that need detention under the MHA. There is no formal process for accessing a Responsible Clinican for these patients, without this any detention is unlawful
Key Controls	Negotiations lead by Lindsey Webb are taking place with Worcestershire Health and Care Trust for the provision of Responsible Clinician cover. Negotiations are taking place on a case by case basis to get agreement from consultant psychiatricst to undertake the Responsible Clinician role whenever a detention takes place uner the MHA Mental Health Act detentions are recorded on DATIX
Sources of Assurance	Management Assurance-Monitoring of Mental Health Act detentions reported on DATIX and checking that these have had a responsible clinician appointed

Performance Monitoring	
Gaps in Control	If a detention takes place outside office hours it will be very difficult to gain agreement with WHCT for a Responsible Clinician
Gaps in Assurance	Not all detentions are recorded as detentions on DATIX at the time so do not come to the attention of the Lead Nurse, Safeguarding Adults in a timely manner and some may never be known outside the Division.

Current Risk Level	Moderate	Almost certain	15	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Ensure roles are covered with suitable medical staff	Andy Phillips Interim Chief Medical Officer	16/05/2016	Chief Executive is commissioning a peer review of the specifications with a Mental Health Trust. Due date updated. Update March 2016: CMO is in discussion with Health and Care Trust CMO regarding service provision. Propose new due date May 2016	
To be escalated to the February Risk Executive Committee	Lindsey Webb Chief Nursing Officer	10/02/2015	Risk was accepted onto the Corporate Risk Register at REG on 10th February.	10/02/2015

Target Risk Level	Moderate	Rare	3	Very Low

Progress	CMO has met with the H&CT Company Secretary and they plan to work together to develop a business case to support funding for 2 FTE posts to be presented to commissioners. The Trust is providing a regular update at Clinical Quality Review meeting with CCGs.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**2746 If W&C Division are unable to sustain safe staffing levels it will be unable to provide safe patient care at all sites**
Date opened	24/10/2014
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 Operating Officer /
Description/Impact	In the event that Women and Childrens Services are unable to sustain safe staffing levels and an appropriate level of trained /skilled Paediatric, Obstetric, Maternity, Neonatal and Gynaecology staff, we will be unable to continue to provide safe patient care at all in-patient sites. The risk is that in the absence of appropriately trained and consistent safe staffing rotas, the division will be unable to safely operate two fully functioning in-patient maternity and paediatric units. If the staffing rotas are not covered adequately by skilled and competent staff on both sites, patient safety and quality of care will be compromised. The risk to patient safety and quality of care significantly increases with rapid turnover of short term locum staff. If the quality of staff skills and competency is not of a high standard, morbidity and mortality rates will rise, affecting outcomes for women, babies and children. This overarching risk covers the following key areas: • O&G Middle Grade Medical Staffing rotas • Neonatal Trained in Speciality Nursing staff rotas • Paediatric Middle Grade Staffing rotas • O&G Consultant rotas • Adherence to national and local guidelines to ensure safe patient care • Inability to maintain Deanery training status • Maintenance of high quality Maternity, Paediatric and Gynaecology care The above issues are all interlinked and the inability to maintain parts of the above may lead to disruption to the provision of maternity, paediatric, gynaecology and neonatal services.
Key Controls	Robust monitoring of morbidity and mortality rates Task & Finish groups implemented as individual risks heighten Robust communications with other departments that affect the daily working of the services (anaesthetics/ surgery etc.) Develop and test Contingency plans Maintenance of Deanery training status Monitoring of adherence to national and local guidelines Monitoring of adherence to governance processes and patient safety standards Constant monitoring of staffing rotas with escalation to bank and agency staff. Task & Finish groups implemented as individual risks heighten Weekly meetings with executives to review staffing and query indicators
Sources of Assurance	

Performance Monitoring	Please see attached draft Sustainability Dashboard Weekly ratings and escalation of agreed triggers to Exec team
Gaps in Control	National shortage of these key staff groups
Gaps in Assurance	Performance data trended over time

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Weekly safety risk meeting review medical rotas and trigger points.	Cathy Garlick Director of Operations - Women & Children	29/06/2016	Weekly review of rotas see attached 29/4/16, meeting structure amended with weekly monitoring of medical and nursing rotas continuation	
Temporary closure of Alex Special care unit on 18th Feb	Cathy Garlick Director of Operations - Women & Children	14/07/2015	RCA report completed	18/02/2015
Emergency plans accepted	Cathy Garlick Director of Operations - Women & Children	07/08/2015	Emergency plans accepted and shared with wider health partners	07/08/2015

Tansfer of Emergency Gynae activity form Alex to WRH from 6/8/15	Cathy Garlick Director of Operations - Women & Children	04/09/2015	Temp transfer of all emergency gynae activity to WRH from Alex due to inability to adequately staff O&G medical rotas	07/08/2015
Communication with Deanery	Cathy Garlick Director of Operations - Women & Children	22/04/2015	Completed and ongoing	31/08/2015
Monitoring of risk matrix indicators	Cathy Garlick Director of Operations - Women & Children	22/04/2015	Risk indicators established. Thresholds for Executive escalation agreed at Trust Board.	31/08/2015
Full Contingency Plan should service change be required on safety grounds	Cathy Garlick Director of Operations - Women & Children	29/05/2015	Contingency plan developed	31/08/2015
O&G Middle Grade Task & Finish Group	Cathy Garlick Director of Operations - Women & Children	30/06/2015	Task and finish group presently closed but may need to be re-instated at a future date.	31/08/2015
Paediatric Middle Grade task & finish group to be established	Andrew Short Consultant Paediatrician	30/06/2015	Task and finish group operational	31/08/2015
External SI, Neonatal Near Misses weekend of 2/3/4 May 2015	Cathy Garlick Director of Operations - Women & Children	08/06/2015	External SI process commenced due to Near Miss x2 over the weekend due to staffing difficulties due to short term sickness. Awaiting final report. D/W Fay Bailey 30-9-2015 - The action can be closed. The contingency plan for short staffing and safe services has been agreed with commissioners.	30/09/2015
temporary closure of NNU at Alex on 15/8/15	Mari Gay Interim Chief Nursing Officer	30/10/2015	round table to review incident held, report awaited	30/10/2015
temporary suspension of maternity and neonatal in patient service at Alex site due to inability to safely staff neonatal nurse rotas	Cathy Garlick Director of Operations - Women & Children	06/11/2015	Services transferred safely Extensive Internal and external comms Staff induction and orientation review of gynae envirnoment and ability to meet 18 week RTT standards	06/11/2015
Initiate temporary suspension of maternity and neonatal in patients on Alex site until Feb 16	Cathy Garlick Director of Operations - Women & Children	29/02/2016	Review of temporary closure, staff meeting held Jan 2016. Andy Phillips executive updated W&C staff regarding the extension of temporary relocation of services.	09/02/2016
review of emergency changes submitted to trust board for consideration	Cathy Garlick Director of Operations - Women & Children	28/12/2015	Paper submitted to board and external partners. Accepted that trust cannot revert to 2 site opertions for maternity and neonatal care. internal consultation with staff to commence	15/02/2016
flexible reduction of in patient beds on ward 1 (Paeds) at Alexandra hopsital	Dana Picken Modern Matron-Paediatrics	31/03/2016	Agreed flexible reduction of numbers of beds on ward 1, 10 to 12 beds to meeting nurse staffing levels and seasonal variations in activity	04/04/2016
Development of paediatric emergency centralisation plan	Andrew Gallagher Consultant	18/03/2016	Draft plans in development including staffing should emergency centralisation be required. V4 draft plan being reviewed by DoP 10/3/16	27/04/2016

Target Risk Level	Moderate	Possible	9	Low

Progress	Forecast / horizon scanning for potential future issues: Neonatal Nursing staffing Risk, being monitored within Directorate, The rota remains fragile with the notification of further maternity, adoption leaves and additional resignation. One new starter. Unable to offer posts at Julys interviews. Re-advertise posts. 2 locum junior consultants are in post. The sickness/absence rate in the O&G consultant body has improved, however, 3 consultants remain on redistricted duties (for differing reasons). O&G Middle grade rotas remain difficult to manage due to the inability to fill all vacant shifts. In order to keep 2 fully operational maternity sites, the temporary move of emergency Gynae activity form Alex to WRH will remain in place until February 2016 (next doctors rotation date). We have had to move a number of antenatal clinic appointments to evenings/weekends to ensure that women with risk factors receive the appropriate maternal and fetal monitoring they require. Paediatric medical staffing remains RED for Alex, however we have been successful in attracting short and long term locum doctors. The Deanery has not consented to a county wide rotation for this speciality, therefore the risk sits mainly on Alex site. Summary / Comments: The medical staffing rotas are increasing difficult to manage. Staff are working additional hours and acting down as able. This is not sustainable. The emergency measures taken to transfer all emergency Gynae activity to WRH site has allowed the retention of 2 in patient maternity sites at the current time. Paediatrics medical rotas are becoming increasingly fragile on the Alex site. Consultant are acting down in order to maintain a safe service. This is not sustainable. Update 13/11/2015: temporary suspension of maternity and neonatal in patients on Alex site from 6th Nov until Feb 16 Update Jan 2016 Maternity and Neonatal services remain located at WRH Gynae emergency care located at WRH. Major elective activity compromised due to bed capacity. Minor elective work at Alex, evesham and KTC Paediatric medical and nursing staffing rotas remain fragile, weekly monitoring continues Update 22/2/16. review of emergency centralisation of maternity and neonatal services presented to trust bpard. Accepted that division cannot operate a safe and sustainable 2 site model, thereofre service to remain centralised for foreseeable future. internal staff consultation to commence

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2774 Failure to provide resilient IT infrastructure resulting in system unavailability which negativity impacts patient care**
Date opened	15/01/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and support staff

Initial Risk Level Major | Almost certain | 20 | High

Director/Committee	Chief Executive / Trust Management Committee
Description/Impact	Power - there is an inherent risk of the power being overloaded and causing the systems located in the hub rooms to shut down unexpectedly. There is also exisiting trustwide power issues that are affecting the stability of the power in the existing hub rooms. Environmental - The exisiting hub rooms are not maintained to a sufficient level to provide manageable support for the hardware located within them. Data loss/security - Room access is not controlled or monitored and there are no procedures in place to minimise the number of staff members that have access to them. There is no limited resilience in place for the majority of the systems. Topology - The system resilience is not to a standard where there can be confident business continuity.
Key Controls	Rephase the power in the exisiting hub rooms to enable better power distrubition to ensure systems are kept up for a longer period of time. Map all applications to determine their dependancies, ensure that whole systems are not affected by environmental issues. Reduce the number of staff that have access to exisiting hub rooms to minimise any unplanned outages for systems. Recable the existing hub rooms to minimise any hazards and unplanned outages. Design and build two resilient datacentres to house all system sotrage and servers Upgrade existing systems to a supportable level and provide a baseline on the support for these systems Migrate the systems across to the new datacentres and pass the management and access control of the datacenters to Computacentre
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level Major | Possible | 12 | Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Move to the new data centre	Stephen Asante-Boakye ICT Service Delivery Manager	20/06/2016	Data Centre implementation consists of several key stages: the build of the physical rooms, equipping the rooms, and moving our current IT systems onto the new platform. It was intended that the new platform would be ready to start accepting the move of systems from December 2015. However, at the time of writing, delays in building the physical rooms due to planning permission issues have resulted in a 4 month delay, and the complexities of the ICT design work by Computacenter have added a further month. Systems migration is now due to begin in May 2015 with the project tentatively expected to end in November 2016. The ICT team have been working with Computacenter to evaluate any impacts resulting from the delay and to mitigate against them by implementing either interim measures or some elements where possible ahead of schedule.	
Complete the discovery activities for current applications	Computacenter IT Contractors	31/03/2015	The discovery activities have been completed and any follow-on actions are being built into the data centre or the existing systems programme of work.	31/03/2015
Work with Oncology Centre staff, UHCW, and vendors to ensure a resilient radiotherapy IT infrastructure	Stephen Asante-Boakye ICT Service Delivery Manager	30/06/2015	A back-up Virginlink fibre network has been commissioned and is in use to connect the applications (MOSAIQ & Raystation) to UHCW. The cabinet on the 1st floor is being repatched to add resilience if anything happens to the ground floor hub room.	14/09/2015
Develop an project plan to deliver the data centre at KC	Computacenter IT Contractors	31/12/2015	Completed but project under review due to slippage. See implementation action entry.	14/09/2015

Target Risk Level Major | Unlikely | 8 | Low

Corporate Risk Report

Progress	Data centre project is progressing

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk [2791 If the Medicine Division is unable to sustain appropriate staffing levels it will be unable to provide safe patient care]

Date opened 04/02/2015

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

Strategic objective(s) Develop and sustain safe services

Initial Risk Level Major Likely 16 High

Director/Committee	Chief Operating Officer /
Description/Impact	If the Medicine Division is unable to sustain staffing levels and an appropriate level of trained /skilled Consultants specialising in Emergency Medicine, Acute Medicine, Respiratory, Gastroenterology, Geriatrics, Stroke and general Nursing staff, it will be unable to continue to provide safe patient care at all relevant in-patient sites. The risk is that in the absence of appropriately trained and consistent safe staffing rotas, the division will be unable to safely operate two fully functioning Emergency Departments, Respiratory, Gastroenterology, Acute Medicine, and Stroke services. If the staffing rotas are not covered adequately by skilled and competent staff on both sites, patient safety and quality of care will be compromised. The risk to patient safety and quality of care significantly increases with rapid turnover of short term locum staff and/or an over-reliance on locum staff. If the quality of staff skills and competency is not of a high standard, morbidity and mortality rates will rise, affecting outcomes for patients. This overarching risk covers the following key areas: • ED, Acute Medicine, Respiratory, Gastroenterology, Geriatric and Stroke Consultant rotas • ED Middle Grade Medical Staffing rotas • Gastroenterology Speciality Nursing staff rotas • Adherence to national performance indicators and local guidelines to ensure safe patient care • Inability to maintain Deanery training status • Maintenance of high quality Emergency, Acute Medicine, Respiratory, Gastroenterology, Stroke and Geriatric care The above issues are all interlinked and the inability to maintain parts of the above may lead to disruption to the provision of unscheduled care services. See also risks: 1719, 2516, 2558, 2692, 2714, 2766, 2785, and BAF risk 2829
Key Controls	Robust monitoring of morbidity and mortality rates Task & Finish groups implemented as individual risks heighten Robust communications with other departments that affect the daily working of the services (diagnostics/ surgery etc.) Develop and test Contingency plans Maintenance of Deanery training status Monitoring of adherence to national and local guidelines Monitoring of adherence to governance processes and patient safety standards Constant monitoring of staffing rotas with escalation to bank and agency staff. Task & Finish groups implemented as individual risks heighten Monitoring of risk matrix indicators (ED and Acute Medicine) Development of a workforce plan document Weekly meeting now held with deputy director of ops and HR to discuss/monitor and progress any issues.
Sources of Assurance	

Performance Monitoring	0. 1+The following measures are used to evaluate performance: ED Middle grade medical staff rotas ED and Acute Medicine Consultant rotas Base ward nursing rotas Respiratory Consultant rotas Geriatric Consultant rotas Gastroenterology Consultant rotas WRH Stroke Consultant rotas Please see attached performance report
Gaps in Control	Regional competition UK labour market shortages
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Action	Responsibility	Expected Completion	Progress	Date Done
Development of a Nursing Pool	Julie Kite Divisional Director of Nursing Medicine	27/06/2016		
Gastroenterology - Business case being prepared for additional 2 WTEs (1 on each site). High use of waiting list initiatives to attempt to meet targets for RTT, services struggling on both sites.	Robin Snead Divisional Director of Operations	27/06/2016	This has been delayed due to the current financial controls within the trust.Business case has been approved and x1 Gastroenterologist has been appointed.Further posts to be advertised shortly.	
Review of medical workforce	Robin Snead Divisional Director of Operations	27/06/2016		
Due to Acute Medical Consultant leaving shortly back up plan to be developed.	Gary Ward Emergency Medicine	30/06/2016	Dr Jenkins will move from Diabeties and provide support to MAU. Plan still being formulated	
Geriatrics – progressing recruitment of integrated physicians with CCG/WHCT	Robin Snead Divisional Director of Operations	25/07/2016	Currently working with external head hunting agencies to target recruitment for specific consultant posts across the division.At present there are x6 vacant posts.Consideration is being made within the Divisison regarding recruitment from overseas.	
Job Planning	Nick Hudson Consultant Physician	25/07/2016	Dates have been scheduled for job planning to occur .28/04 the Division is currently at 70% with job planning further dates have been scheduled.	
Recruit Consultant Medical Staff in Stroke services, Respiratory services and Emergency Medicine	Robin Snead Divisional Director of Operations	25/07/2016	Currently working with external head hunting agencies to target recruitment for specific consultant posts across the division	
ED Workforce Review Task & Finish Group	Robin Snead Divisional Director of Operations	12/10/2015	Stuart Cannonier is currently writing the business case to be produced by 8th October 2015	22/10/2015
Medical Workforce Plan	Anthony Scriven Consultant Cardiologist	30/11/2015	This is being progressed with Nicky Callaghan in line with the trusts central workforce strategy group, chaired by denise Harnin	30/11/2015
Acute Medicine Consultants – job plans to be written, funding to be secured	Robin Snead Divisional Director of Operations	18/04/2016	Shared jobs are at present being advertised through NHS jobs,await till closing date and short listing has occoured.	28/04/2016

Target Risk Level	Moderate	Possible	9	Low

Progress	Currently out to recuitment for consultant medical staff in Stroke services, respiratory services and emergency medicine. Currently working with Nicky Callaghan to complete a complete workforce strategy document for Medicine by April 2015 Respiratory consultant jobs had two candidates who both withdrew from the process days prior to interview, posts back out to advert. Stroke consultant posts currently out to advert. Elderly care posts out to advert by 7th June 2015 See controls above Currently working with Hunter Healthcare to target consultant level recruitment for Acute medicine, Respiratory, Elderly Care posts. Interviews are expected to take place in February 2016. Jo Kenyon(Deputy Director of Operations) is now the divisional lead for medical staffing and is co-ordinating the recruitment of all the vacant posts. Furthedr posts are currently out to advert for specialty and acute medicine hybrid job plans. Active recruitment to stroke consultant physicians posts is also ongoing.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 2856 Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury

Date opened 07/04/2015

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

Strategic objective(s) Develop and sustain safe services

Initial Risk Level Catastrophic Likely 20 High

Director/Committee	Chief Executive /
Description/Impact	Plant and equipment failure resulting in loss of service.
Key Controls	Increased reliance on specialist contractors Increased holding of stock and spares Emergency arrangements in place with contractors (e.g. Heating, Fire and Air Con) Use of comprehensive specialist contractors
Sources of Assurance	

Performance Monitoring	We are proceeding cautiously with operating and maintaining critical plant and equipment throughout the estate to keep vital services on line, planned maintenance shut downs are traditionally difficult to arrange but as services age, the need becomes more acute to allow proactive identification of failing equipment. Mean time between failures has inevitably increased and there's a significant burden on our workforce and revenue budget as a result Until there is certainty in the Estates Strategy, it would be extremely difficult to effectively target funds without running the risk of abortive or nugatory costs
Gaps in Control	
Gaps in Assurance	

Current Risk Level Catastrophic Likely 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Funding being sought through CPG	Ray Cochrane Directorate support manager	04/07/2016	Ongoing, due date updated to April 2016. Final adjustments being made to Capital Programme mtg between CT, Jl & HK w/c 21 March with view to being considered at next CPG April 2016. Note this is an ongoing risk and will remain for many years to come. It is wholly dependant on receipt of sufficient funds to clear down estates backlog. Due date updated to reflect this.	
Salix Funding sourced for major equipment replacement	Ray Cochrane Directorate support manager	04/07/2016	Ongoing, due date updated to April 2016	
Detailed capital and backlog plans developed for 2015/16	Ray Cochrane Directorate support manager	30/06/2015		31/12/2015
Distressed capital bid being prepared	Ray Cochrane Directorate support manager	30/06/2015	Bid complete and requested	31/12/2015

Target Risk Level Catastrophic Unlikely 10 Low

Progress	Paper presented to Risk Executive Group 7th December 2015

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2857 Failure to manage water system resulting in transmission of harmful pathogens to patients or staff

Date opened 07/04/2015

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

Strategic objective(s) Deliver effective care

Initial Risk Level Catastrophic Possible 15 Moderate

Director/Committee	Chief Nursing Officer / Trust Infection Prevention & Control Committee
Description/Impact	Failure to manage water system resulting in transmission of harmful pathogens to patients or staff. The Trust is required to have a board approved water safety policy in place and a requirement for a water outlet flushing process that can be demonstrably audited.
Key Controls	Supervision of Estates actions and responses by dedicated Trust microbiologist and water safety group Governance via monthly Water Safety Group meetings Authorising Engineer (Water) appointed Flushing process developed and implemented - Augmented care areas flushed daily and audited by infection control. AHR and KTC have flushing process, flushing folders have been distributed to wards, training sessions ongoing at all sites. WRH Flushing folders have been isssued to WRH 17th and 18th March 2016. latest audit of KTC and AHR gave a compliance score of approximately 90% - trialling compass IT based flushing records in AHR & KTC WRH flushing Audit 20% compliance Water Policy Finalised and Water Safety Plan developed final version being reviewed by SN / MA for approval by WSG and TIPCC- staff working to draft plan Hard FM Contractor being directly managed by the Trust to ensure compliance with Water Safety Plan, Trust Contractor being managed by RP / WST will report monthly on PPM KPIs to WSG LL Construction and SPC engaged to resolve perceived design failures of Worcestershire Oncology Centre (Biocide system now fitted to oncology building and SPC are looking to change Water Tank location to prevent build up of heat Dedicated water quality technician appointed to manage water systems across county. Standardised log book in use Governance via monthly Water Safety Group meetings Water treatment plant installed in the radiotherapy building dosing the system with active chlorine results now improving, engineering controls now also in place to increase water usage and prevent temperature rise Looking at a water treatment plant for new breast building 220 Newtown
Sources of Assurance	Management Assurance-Auditing of flushing records Management Assurance-Authorising Engineer audit Management Assurance-Auditable Estates water log book External Audit-Authorising Engineer carries out annual audit External assessment against standards-Legionella risk assessment carried out every two years and Pseudomonas risk assessment carried out by independent consultants to assess Trust compliance against applicable standards
Performance Monitoring	Performance reporting process for flushing in place. Water supply testing results monitored by Water Safety Group Positive patient test results in augmented care areas investigated to determine whether hospital attributable WSG reports to TIPCC
Gaps in Control	Potential for gaps in the flushing regime - will be audited in KTC / AHR by water quality Technician - need to finalise arrangements for WRH Presence of sub-optimal plumbing in augmented care areas eg flexible hoses - A DAF has been raised to remove all flexible hoses from augmented care work due to be completed in January Water tank storage temperature has improved due to engineering works in Radiology building - high cold water temperatures are being found at the outlets due to low usage and lack of turnover. The system does not rely on temperature control alone as a means of Legionella control as system is now being dosed with a biocide plant sub optimal response from hard services provider re actions to mitigate risks e.g. installation of PAL filters (Avon 4 and Silver)
Gaps in Assurance	

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Complete Water Safety Plan with ratification at TIPCC	Simon Noon Principal Engineer & Statutory Standards Manager	30/06/2016	Water Safety Plan in progress, but requires further modification.	
Carry out Risk Assessment	Simon Noon Principal Engineer & Statutory Standards Manager	31/07/2015	Legionella assessment complete, Pseudomonas ongoing, interviews presently completed, awaiting issue of risk assessment	16/09/2015
Daily / weekly flushing of all outlets in augmented care / ward areas	Simon Noon Principal Engineer & Statutory Standards Manager	07/09/2015	Flushing in each unit requested in accordance with HTM 04 -01. Kidderminster, Alexandra Hospitals and WRH implemented, Flushing log books issued will be improved with rollout of compass.	16/09/2015

Point of use filters fitted to outlets	Simon Noon Principal Engineer & Statutory Standards Manager	07/09/2015	Filters fitted and are replaced monthly and as required resulting from positives sampling results. Filters fitted to all clinical areas in Radiotherapy and a protocol for removing filters based on HTM04-01 addendum has been agreed based on agreed clear results.	16/09/2015
Enhanced testing regime implemented	Simon Noon Principal Engineer & Statutory Standards Manager	18/12/2015	In Radiotherapy and Laurel monthly tesing continues until 3 clear test results are obtained after which frequency can be extended to every 6 Months at agreed sentinel test points. Additional samples have been agreed at AHR but the final test programme is still to be agreed by Trust Microbiologist, AE and Estates department. 04/12/2015 At the Alex we are testing 20 points per month for legionella and we are testing 100% of augmented care areas for pseudomonas six monthly at KTC and the Alex. Kidderminster we are testing seven points per month for legionella. New testing schedule has been agrees for AHR and Kidderminster and a UKAS acredited lab has been appointed to take the samples new sampling programme to start in August	18/12/2015
Cascade water safety training to stakeholders	David Shakespeare Infection Control	25/02/2016	Being planned, dates received from Hydrop, these are being cascaded to maximise attendance at sessions which will be held at each site. 10/12/2015 - Dates for training at WRH 23/12/2015 and ALEX 15/12/2015. 24/12/15 - First training session low attendence; more sessions to be planned Feb/Mar 2016.	26/02/2016
KPIs for water safety to be developed and reporting process established	Simon Noon Principal Engineer & Statutory Standards Manager	31/03/2016	Reporting process is in place, via regular monthly water quality testing and a monthlyy water report. Discussions about further developing this report are underway including performance indicators, including flushing performance, PPMs and aggregate of high risk pathogens identified. 04/11/2015 New contractor has started. Will report on PPM completed against target at December TIPCC.	23/03/2016
Establish and embed revised system of undertaking and recording water flushing trustwide	Simon Noon Principal Engineer & Statutory Standards Manager	29/04/2016	Augmented care areas - flushing is undertaken and recorded by clinical staff. There remains a gap in assurance around flushing for non-augmented care areas. 07/03/16 Outstanding issues continue with regard to nursing and housekeeping responsibility for flushing.	23/03/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	Records and processes being improved significantly and subject is regularly discussed at Water Safety Group, TIPCC, Quality Governance Committee. Water is regularly tested and the results subject to actions agreed in the Trust Water Safety Plan as required by HTNM04-01 addendum Flushihg log books distributed, adherance to requirements to be monitored. there is a concern to buy in to flushing this to will be monitored the WSP requires microbiologist sign off(estates and SE water have already approved the document. there is an ongoing issue wiht microbiology to achieve sign off based on availability of resource. A meeting to disucuss furhter is planned to resolve.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2864 Failure to follow pressure ulcer prevention procedures (risk assessments, position changes, correct equipment) resulting in harm

Date opened 20/04/2015

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

Strategic objective(s) Deliver effective care

Initial Risk Level Moderate Possible 9 Low

Director/Committee	Chief Nursing Officer /
Description/Impact	Pressure ulcers can occur as a result of a variety of factors. Immobility is the primary contributing factor in the development of pressure injuries. The majority of RCA investigations find patients that have developed a pressure injury were not moved (or not documented as having been moved). The most common concerns are reduced awareness of those patients at risk. This may be caused by insufficient pressure ulcer risk assessments and/or re-assessments. Pressure re-distributing mattresses are available, but are not always used in a timely manner for the patients that require them.
Key Controls	Pressure area risk assessments on admission Intentional care and comfort rounding Repositioning in beds and chairs
Sources of Assurance	Self-assessment against standards-Monthly Matrons PUP Audits.
Performance Monitoring	Patient Safety Thermometer - point prevalence, reported Via CQUIN group for 2014/15. Not a CQUIN for 2016. To be reported via contracting. Monthly incidence reported on Trust Dashboard. Patients who develop hospital acquired PU's have a root cause analysis to determine cause and if avoidable or unavoidable.
Gaps in Control	Staff knowledge of policy and procedures Staff time available to conduct rounding and attend to repositioning Staff documentation of pressure relieving activities
Gaps in Assurance	

Current Risk Level Moderate Likely 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Replace chairs not fit for purpose	Elaine Bethell Tissue Viability	31/05/2016	Audit by mid-January to identify chairs that are not fit for purpose due to ingress and/or tearing. Report expected by end February 2016. Divisions to then replace identified chairs. 18/2/16 Audits carried out, results to be analysed and presented at the March TIPCC meeting. Divisions to replace chairs within their own Divisions. Unsure of progress to date.	
Discuss opportunities for improving risk assessment paperwork to increase likelihood of completion	Elaine Bethell Tissue Viability	12/07/2016	22/3/16 - Jo Logan is to meet with Service point to update the amended C and C to include A and E trolleys and Repose. A and E WRH were using a different chart to the rest of the hospital. This amended chart will ensure standardisation across the Trust. TV Lead to discuss with interim CoN re SKIN Bundle and revision of care and comfort charts to remove PU element and have a separate SKIN bundle. Due to unexpected sickness of the Senior members of the TV team - this has been delayed.	
Discuss opportunities to ensure staff are prompted to turn patients	Elaine Bethell Tissue Viability	12/07/2016	Exploring possibility of using electronic whiteboard to prompt staff and to explore ideas using Datix as an automatic prompt with the Trust Risk Officer.	
Implement 'react to red skin' pathway with 2 hourly repositions	Elaine Bethell Tissue Viability	12/07/2016	24/12/12 - To be trailled alongside care and comfort documentation by end January 2016. This has now been rolled out and is being implemented within T&O on both sites. Aim being to roll out to rest of Trust over the next couple of months. TV Lead to discuss with Interim CoN re strategy for React to Red and tools that need funding.	

Corporate Risk Report

Target Risk Level	Minor	Unlikely	4	Very Low

Progress	June 2016 update: Accountability meetings held by Deputy CNO have been implemented for grade 3 and 4 pressure ulcers.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 2899 Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, poor clinical outcomes

Date opened 19/05/2015

Strategic goal Design healthcare around the needs of our patients, with our partners

Strategic objective(s) Deliver effective care

Initial Risk Level Major Possible 12 Moderate

Director/Committee	Chief Operating Officer / Trust Management Committee
Description/Impact	If the Trust does not provide full clinical services seven days per week (eg consultant cover, nursing and therapy staffing, access to imaging and theatres) quality of care will be inconsistent. This could lead to increased length of stay and reduced performance in clinical outcomes such as morbidity and mortality.
Key Controls	Cover provided during weekends, variable across services On-call arrangements in many areas
Sources of Assurance	Clinical Audit-Benchmarking, clinical audit, and peer review conducted against professional standards and guidelines in various specialities Care Quality Commission-CQC inspections

Performance Monitoring	Length of stay performance data Numbers of complaints Mortality data split by day and time, site, etc (eg HSMR)
Gaps in Control	Potential difficulties recruiting in light of regional/national shortages in some groups Cost required to implement
Gaps in Assurance	Presently no data/scorecard available indicating performance against seven day working (eg proportion of service providing weekend consultant ward rounds)

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Establish seven day per week working group	Denise Harnin Director of HR & OD	31/07/2015	Group has formed and is reviewing consultant staffing required for seven day working	31/07/2015
Conduct baseline assessment on 7 day services assessment tool and agree action plan	Rab McEwan Chief Operating Officer	31/03/2016	Self assessment complete. Awaiting further information from the Department of Health regarding the future of the national audit. Due date updated to reflect this.	31/03/2016

Target Risk Level Major Unlikely 8 Low

Progress	Risk transferred from BAF to Corporate Risk Register following Trust Board meeting 2nd March 2016.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2908 Use and release of information which is inaccurate, false or misleading resulting in patient harm, reputation and legal damage

Date opened 28/05/2015

Strategic goal Ensure the Trust is sustainable and financially viable and makes the best use of resource

Strategic objective(s) Deliver effective care

Initial Risk Level Major Likely 16 High

Director/Committee	Chief Medical Officer / Data Quality Group
Description/Impact	The Trust depends on accurate data to ensure sound decision making for quality of care and to make best use of resources. If the Trust does not exercise due diligence on its data, it may utilise inaccurate data, affecting decision making and public records. The Care Act 2014 has put in place a new criminal offence applicable to care providers who supply, publish or otherwise make available certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation (False or Misleading Information Offence or FOMI). A further offence applies to the 'controlling minds' of the organisation, where they have consented or connived in an offence committed by a provider. On conviction organisations can be subject to an unlimited fine and be compelled to take remedial action and to publicise the conviction and the action taken to remedy the situation. Clearly there will also be reputational consequences for the organisation involved and these may be greater than the financial consequences. The possible consequences for individuals are very serious. Individuals can be subject to an unlimited fine, a custodial sentence of up to two years or both.
Key Controls	Training for staff about data quality Automated data quality checking for key data sets When problems identified with information systems, a project is undertaken to rectify
Sources of Assurance	Internal Audit-Data quality is included in the Internal Audit Calendar

Performance Monitoring	
Gaps in Control	Due to system update of Oasis to include RTT clocks, data has to be manually validated Some gaps in mandatory fields and data validation at point of entry
Gaps in Assurance	Internal Audit forward plan may not include all FOMI datasets

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Establish A&E dataset reporting	Rebecca Brown Head of Information	19/08/2016		
Address audit recommendations around training for VTE data entry	Jan Stevens Interim Chief Nursing Officer	30/09/2016	Work underway via Divisional Directors of Nursing to ensure accurate data entry.	
Check and assure rules to create VTE data	Mark Crowther Consultant Haematologist	31/10/2016	Group established with ToR and meeting regularly.	
Complete assurance process for all key data items	Rebecca Brown Head of Information	30/06/2017		
Seek legal advice around suitable caveats to apply to reports	Rebecca Brown Head of Information	30/06/2015	Action split 25/8/15. Legal advice and further clarification sought. Legal briefing to Executives and NEDs scheduled for Board Development event in September 2015.	15/06/2015
Review all relevant datasets to ensure compliance with minimum standards	Rebecca Brown Head of Information	30/06/2015	Initial review completed. Further detailed work required for all key systems to establish risks and caveats. Outline for required FOMI assurance work written. Bring forward into a further more detailed action.	26/06/2015
Strategic ownership of data quality enhanced by nomination of a senior or executive level Data Quality Champion	Rebecca Brown Head of Information	31/05/2015	Executive Lead: CMO. Trust Clinical Data Quality Lead: Consultant Obstetrician /Associate Medical Director Clinical Effectiveness	07/08/2015

Re-establish Trust Data Quality Group, and ensure senior level representation is included	Rebecca Brown Head of Information	30/06/2015	Trust Strategic Data Quality Lead and Head of Information working on Terms of Reference and attendance for group. First meeting scheduled for October, then monthly for remainder of 15/16.	14/08/2015
Inclusion of FOMI dataset areas in the Audit and Assurance Committee forward plan	Michael White Finance	30/06/2015	Proposed for inclusion on the November Audit and Assurance meeting agenda.	25/08/2015
Create project plan for roll out of data quality kitemark	Rebecca Brown Head of Information	23/10/2015	Complete	16/10/2015
A&E dataset review	Rebecca Brown Head of Information	29/01/2016	Mapping complete. Engagement with A&E ongoing. Visualisation of new reporting being scoped. (note: updated delivery date on 15/12)	16/02/2016
Identify all modes of external distribution of FOMI related data	Rebecca Brown Head of Information	18/02/2016	Project resource allocated. Ongoing. Date for completion changed from 30/9/15 as scope of this action has been extended, and project resource as been lost. ACTION CHANGED TO ROLL OUT OF DATA QUALITY KITEMARK ACROSS TRUST DASHBOARD. RESOURCE NOT AVAILABLE FOR FULL ANALYSIS. Date changed - project support still not in place.	16/02/2016
New clinical lead required for DQSG	Rebecca Brown Head of Information	04/03/2016	This role is currently held by Alex Blackwell, O&G Consultant.	20/05/2016
Provide assurance mechanism around 'due dilligence'	Rebecca Brown Head of Information	25/03/2016	Project resource allocated to this work. Scope of work includes writing caveats for high level systems, relevant CDS's, then more specific data fields. Work completed on reviewing all business logic in A&E, and awaiting clinical sign off. (date altered to reflect new deadlines) Schedule established for quality indicators. Process and governance established for all indicators. New action - to complete assurance for all key data items.	31/05/2016
A&E dataset roll out	Rebecca Brown Head of Information	11/03/2016	Information specialist to ensure roll out by end of contract. Dataset available. Being managed by Business Intelligence Project Board.	23/06/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	Further gaps and actions may be identified following the review of relevant datasets. Update June 2016: Trust recieved a qualified audit opinion for Completion of VTE prophylaxis proforma. New action added regarding this.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2994 Failure to meet the NHS England Serious Incident Framework resulting in failure to learn and potential regulatory action

Date opened 03/08/2015

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

Strategic objective(s) Develop and sustain safe services

Initial Risk Level Major Possible 12 Moderate

Director/Committee	Chief Nursing Officer / Safe Patient Group
Description/Impact	The Trust's processes for the identification, management, investigation and learning from serious incidents must meet the requirements of the NHS England SI framework and produce evidence of learning with improvement in safety for patients. While a process of improvement has commenced, incident investigations need to continue to improve so that investigations are completed in the time required; the causes are determined; recommendations relate to the causes; and the resulting actions to achieve improvement are SMART, owned by the management teams and implemented effectively.
Key Controls	Policy for incident reporting and investigation Patient Safety Team resources Training in investigation for incidents & complaints Serious Incident Review Group - review and approval of investigations - chaired by Executives, monitor new SIs and current investigation process Divisional Quality Governance Team management of investigations Commissioner (CCG) review and sign-off for SI investiagtion reports in STEIS
Sources of Assurance	Internal Audit-Internal audit of SI process

Performance Monitoring	SI investigations open >60 days
Gaps in Control	Effective Divisional control of SI investigations - appointing investigators, monitoring progress with incidents and producing reports that are fit for first-time approval. Effective application of investigation training to the investigation process Availability of trained investigation leads / chairs Phase 2 / sustainable training in investigation methods Effective performance management - to include managers responsible for implementing actions arising from SIs - with escalation to Executives
Gaps in Assurance	Application of the Duty of Candour for SIs

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Job planning to allow senior clinical staff to lead on investigations to be completed	Andy Phillips Interim Chief Medical Officer	30/04/2016	Job planning is in progress. This action is also recorded in the Internal Audit report on the SI system received in December 2015 March 2016 - confirming progress with CMO	
Revise incident reporting and investigation policies to match the revised process & disseminate the changes effectively	Chris Rawlings Head of Clinical Governance & Risk Management	31/07/2016	Policies are still in revision - several additional changes to process have been made through the work Consequence UK have been undertaking with the W&C Division and these need to be included in the final versions. They will be completed before the December SPG meeting and will include actions taken in response to the Internal Audit of the SI process. Further, smaller amendments will need to be made as the SI investigation process evolves. Target date for review moved to allow for review and revision to take place in early 2016 - the changed processes are starting to settle and a move to the new weekly Governance Operational Meeting on 15th January needs to be included. SI policies remain under review. New expected completion date end July 2016.	

Develop and agree phase 2 training for investigations & workshops for trained staff	Chris Rawlings Head of Clinical Governance & Risk Management	30/09/2016	December 2015 - Method of training staff agreed. Arrangements for external training provider to deliver and train our staff to continue in progress. Expressions of interest for internal trainers to be sought. Target date moved to February to allow for provider to a respond and arrange training. March 2016 - Scoping of training need will be completed this week. Discussion with Oxford regarding provision of training will be undertaken when they engage as our 'buddy' trust. Deadline therefore moved. Funding for training secured from HEWM. Veritas booked for training in July and September 2016 for more than 60 staff, with a review following that. Due date moved to end September 2016.	
Review SI meeting terms of reference	Chris Rawlings Head of Clinical Governance & Risk Management	30/09/2016		
Develop and agree ToRs for the SI Group	Steve Graystone AMD Patient Safety	31/08/2015	Draft ToRs prepared and reviewed at September 3rd SPG meeting. Post meeting review and amendment by CMO and CNO so will be resubmitted for approval.	03/09/2015
Develop and implement a plan to introduce the use of the Datix action module for the recording and management of SIs and then all incidents / complaints	Chris Rawlings Head of Clinical Governance & Risk Management	31/10/2015	Discussed and supported at the Datix User Group. Divisions requested to use the Datix Action module for all serious incident actions whaich are being reviewed at the SI Review Group monthly. A template report for the Divisions to use has been developed by the Datix Manager and the Information Department to make monitoring of progress with actions and reporting easier. The same request has been made for complaints.	30/10/2015
Hold workshops for staff who have attended training (1 day) and the Executive / DMTs (1/2 day) to explain and embed process and responsibilities for the SI investihgation / action / improvement process.	Chris Rawlings Head of Clinical Governance & Risk Management	30/11/2015	November 26th booked for Executives and held as planned Other dates being arranged. COmbined with action for Phase 2 training	26/11/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	SI Review Group transition complete. New ToRs require CMO / CNO to chair the meeting with Divisional Director attendance. Improved accountability, timeliness and quality of reports is expected. Initial Case reviews were introduced for all potential / actual serious incidents in October. Well received by the CCGs and sent to the CQC at their request between 5th October and 5th November. The W&C pilot of a new SI investigation approach has been delayed by operational factors. Each Division now holds a weekly meeting to review progress with SI investigations and new potential SIs December 2015 - New action added to complete job planning for senior clinicians to allow time to lead investigations and provide independent investigators. Target dates for revision of policies and Phase 2 training amended. Several actions in the PCIP are relevant to this risk.

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk [2995 If Patient Safety Incidents are not managed in a timely way there will be missed learning and preventable harm]

Date opened 03/08/2015

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 Nursing Officer / Safe Patient Group
Description/Impact	High numbers of incidents that are either not acknowledged / opened or investigated in a proportionate and timely manner do not demonstrate an effective safety culture or process. The impact is a high likelihood of failure to effectively review incidents & near misses, failure to learn and failure to prevent avoidable harm.
Key Controls	Incident reporting policy Diatix Risk Management software to provide a reporting and management system Weekly review and reporting to Divisions of the open incidents and their status Divisional management teams targetting action at the areas / managers with high numbers of incidents open / in-process Datix User Training - provided to all new users - includes basic investigation training, explanation of responsibilities and use of Datix incident management module
Sources of Assurance	Internal Audit-Internal audit of the serious incident management system Internal reports to the Board-Monitoring by the Patient Safety Team of incidents with the provision of Quarterly - now monthly - reports to the Safe Patient Group
Performance Monitoring	Status of open incidents by Division, Location Exact and manager of the area where the incident occurred. Number of incidents not opened within 7 days number of incidents (excluding SIs) open beyond 20 working days Daily monitoring of incidents by the Divisional Quality Governance Teams with further monitoring of incidents that have been reported but not acknowledged (holding area) Setting targets for numbers of incidents open at any one time: The Women & Children's Division have agreed an initial target of a 100 open incidents at any one time (this does not include SI). This target will be reviewed in 3 months. Other Divisions will be considering their own targets
Gaps in Control	Performance management of the Directorates / managers in this area by Divisional management Teams Ownership of incidents and their review / appropriate closure by Directorate and department / ward managers Easy availability of reports from Datix - manually produced on a weekly basis by the PST
Gaps in Assurance	

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done

Determine further controls to maintain / sustain the improvement in response and management while ensuring that each incident report is appropriately reviewed	Chris Rawlings Head of Clinical Governance & Risk Management	30/06/2016	Discussions held with Divisional representatives to review the position, actions already taken to improve response, share good practice and identify actions that will sustain the improvement. Each Division now holds a weekly meeting to review progress with SI investigations and progress with incident reports. Targets for numbers of incidents open at any one time have been set. The Medical Division will be arrnaging meetings with their outlying departments to determine assistance required. Report provided to the SPG on 4th December detailing progress made in most Divisions and further work required. Attached to the risk assessment. 24th December 2015 - The further controls have been determined but are taking time to have an effect in all the Divisions. The new weekly Operational Governance meeting will review incidents at three meetings per month, using the weekly incident performance reports, and so adds another level of monitoring / control. The completion date has been extended to February allow this control to be evaluated. March 3rd 2016 - W&C and TACO performance acceptable. Clinical Support, Surgery & Medicine is not yet. Advised to target staff and areas with high numbers of incidents open to understand the causes and offer additional support. Overall Trust performance = 60% after a few weeks in February where the initial target of 50% was met. March 2016 - Discuss at OGM on 1st April - targetted support for departments/wards with high numbers of open incidents (from Divisions and/or corporate team) and review incidents reported to determine whether a) they are incidents, b) the high reporting areas need to report them c) whether the individual investigations need to be reported d) whether the ward/department structure and systems allow for incident review and timely closure. Expected closure date moved on to June 30th to allow time for these measures to take effect.	
Develop patient safety incident reports for Divisional use and to feed performance dashboards from Datix	Chris Rawlings Head of Clinical Governance & Risk Management	31/01/2016	Datix Manager commenced working with Information Department. Report to provide actions for incidents made available from 1st December 2015 March 2016 - data now available on dashboards and on-line via the intranet. 24th December 2015 - good progress being made in developing reports and inclusion in dashboards. March 2016 - REports made available on-line in February 2016. Dashboard display in progress and expected to be in place by the end of March. Agreement with Datix to employ Datix Dashboards to provide individual user reports/display for all the modules used on the Datix log-in screen. this should be avaialable in March with development work required to tailor the reports to individuals.	29/01/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	3rd November - Risk rating reduced to 'moderate' in response to the improvements made in incidents 'in process' - but action to determine further controls remains open until complete. Development of reports extracted from Datix on a live basis have commenced and will replace weekly report and provide data for dashboards when complete. New actions raised to cover this. 24th December 2015 - Action for further controls to be determined has been amended with the addition of the Governance Operational Meeting due to commence in January. March 2016 - W&C incidents remain under control. initial 50% target met for a few weeks in February but performance is variable. Improvements in other Divisions but further work required to review and close incidents within 20 working days where possible. The Medical Division is experiencing increasing numbers of open incidents which has been discussed with the DMD and DIvisional Quality Governance lead with an aim to support staff and areas with high numbers of open incidents. Both actions therefore remain open until performance improves. Weekly reports continue with twice monthly reports to and discussion at the Operational Governance Meeting. Agreement with Datix to use the Datix Dashboard Module to provide tailored graphical reports to individual user's log-in screens. Available in March it will be developed before roll-out in April / May. March 2016 - Discuss at OGM on 1st April - targetted support for departments/wards with high numbers of open incidents (from Divisions and/or corporate team) and review incidents reported to determine whether a) they are incidents, b) the high reporting areas need to report them c) whether the individual investigations need to be reported d) whether the ward/department structure and systems allow for incident review and timely closure

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 3018 As a result of the care models on the Wyre Forest GP unit, medicines are not managed safely

Date opened 15/09/2015

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

Strategic objective(s) Develop and sustain safe services

Initial Risk Level Catastrophic Possible 15 Moderate

Director/Committee	Chief Operating Officer /
Description/Impact	This risk follows on from Corporate Risk 2822, as described in March 2015: 1. Some prescribing on the GP unit is outside of trust policy. Examples include ranges of medications prescribed for syringe drivers which allow staff nurses to titrate doses for the patient but this relies on the nursing staff to select appropriate medication and for the palliative care team to monitor them. The nursing support on the ward is excellent and the palliative care team from Worcester provides excellent support but this needs ot be vreviewed in conjunction with the GPs. The GPs follow the community model of care which may be appropriate in this setting. 2. Warfarin prescribing is also at variance to trust policy. Nurses order INR checks on ICE, fax the results to the GP surgery and receive a fax return with dose schedule until next INR check. The fax is kept with trust warfarin prescription and is transcribed onto warfarin chart by the nurses, some of whom get a second check on transcribing. It is not prescribed on the chart by the prescriber. This again fits a community model of warfarin doses. There has been 1 example of an INRs not being checked for 1 week whilst patient is taking antibiotics which is at variance to trust policy although INR was in range after 1 week. 3. Documentation on the GP unit is variable. Some of the GP practices do not use the trust notes. The presumption is that the visits are documented at the surgery. Not all patients present on admission with any documentation. Some have a GP letter as would be received on admission to A&E. For others the nurse receives a verbal handover. The nursing staff are therefore relied upon to co-ordinate care. This poses challenges for pharmaceutical care for example the need to challenge the prescribing of ciprofloxacin as approriate anitibiotic and then in conjunction with the fact that the patient was epileptic 4. Communication between GPs and pharmacist is difficult due to the GPs clinical responsibilities in the practice and the need for a ward pharmacist to ask and receive responses to medication queries. It would be inappropriate for a pharmacist prescriber to act without the full history and consent of a GP. Current practice is to try to speak to the doctor who has seen the patient. If they are not available the duty doctor is requested. If the duty doctor is unavailable then a request for the duty doctor to telephone the ward is made. If the pharmacist is not on the ward the query is handed to the nurse responsible for the patient and documented in the notes. 5. Medicines reconciliation has not occurred prior to the ward pharmacist visit. If GP letters are available or the patient gives consent to access SCR medication reconciliation can occur. This has resulted in increased awareness of medication not prescribed or prescribed at variance to the prescription outside of the acute trust. There is currently no satisfactory way of confirming the variances with the prescribers in a timely manner which complies with trust policy. Verbal orders require a signature within 24 hours. 6. There is no current method of reporting prescribing errors to the GP prescribers within the trust which does not support investigation or learning from incidents.
Key Controls	Daily Clinical Pharmacist service available during normal working hours,Monday-Friday. All staff undergo annual medications training. All new staff undertake training followed by 5 supervised drug rounds by mentors before undertaking medicines administration
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level Catastrophic Possible 15 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Review contract with Worcestershire Health & Care Trust	Robin Snead Divisional Director of Operations	12/09/2016	Chris Tidman has contacted and held a discussion with Simon Haresnape requesting the HCT to confirm their their commissioning intentions for WFGPU by 31st March 2016. Commissioning intentions have been reviewed and GP unit is scheduled for closure 1st September 2016.	
Consider ward re-configuration to enable renegotiation of model of service delivery	Robin Snead Divisional Director of Operations	30/11/2015		12/01/2016
Discuss with Wyre Forest CCG as part of broader discussions with commissioners	Robin Snead Divisional Director of Operations	31/12/2015		12/01/2016
Ensure interim safety measures are effective	Robin Snead Divisional Director of Operations	21/03/2016		28/04/2016

Target Risk Level Catastrophic Unlikely 10 Low

Corporate Risk Report

Progress	Wyre Forest Clinical Commissioning Group currently deciding on the future community ward based services required. Due to the delays, Robin Snead to discuss interim solutions with Pharmacy and Wyre Forest CCG to provide further risk mitigation. Update-Scheduled closure for GP unit is 1st September 2016

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**3019 As a result of the care models on Ward 1, medicines are not managed safely resulting in sub-optimal care**
Date opened	15/09/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services

Initial Risk Level	Catastrophic	Possible	15	Moderate

Director/Committee	/
Description/Impact	Risk taken from past Corporate risk 2822, described in March 2015 as: 1. RMOs of varying quality employed by the trust. This has been a problem identified by the nursing staff and from a number of adverse events. The issues to date noted by the ward pharmacist cover knowledge of trust paperwork, dosing errors (chlorphenamine 40mg), lack of anticoagulant knowledge (thought warfarin was IV) , uncertainty over prescribing fluids and antibiotics (didn't know what cephalexin was). 2. Uncertainty over consultant responsibility for transfers to ward 1 from Worcester. All patients have a named consultant but it is unclear if they are then seen by that consultant therefore any outstanding care issues are not solved. 3. RMO's are locums therefore are not subject to the same guidance given by our deanery eg junior training posts are unable to prescribe chemotherapy. 4. Safe and timely discharges to the unit. For transfers from Worcester to a non acute bed on ward 1 there are additional difficulties ensuring all medications are supplied on discharge are in a suitable form for discharge as medications on the ward cannot be checked in pharmacy as off site. 5. To date there has been no medicines reconciliation on ward 1. This has been resolved by the addition of a ward pharmacist in the patients seen. e.g anastrozole omitted on a patient undergoing breast surgery. e.g A patient was prescribed ibuprofen post operatively but was already taking naproxen.
Key Controls	
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level	Catastrophic	Possible	15	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Agreed by Cape Medical that RMOs on KGH site will become more embedded in the clinical infrastructure on KGH site. E.g. RMOs will attend lists in Theatres with anaesthetists and surgeons and will join consultant physicians and surgeons on that site in OP	Julian Berlet Consultant Anaesthetist - Alex	30/06/2016		
All RMOs to undergo Trust Induction and will be granted access to relevant Trust IT systems	Julian Berlet Consultant Anaesthetist - Alex	30/06/2016		
All Consultants reminded that consultant responsibility continues if patients are transferred from Ward 1 to WRH	Julian Berlet Consultant Anaesthetist - Alex	07/11/2016		05/11/2015
Meeting with Cape Medical (company who provides RMOS)	Julian Berlet Consultant Anaesthetist - Alex	16/11/2015	Meeting held discussion regarding RMOs undergoing Trust induction and IT access	16/11/2015

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**3041 If the Trust does not increase efforts to save money, it may not realise the CIP target, worsening the financial position**
Date opened	16/10/2015
Strategic goal	Ensure the Trust is sustainable and financially viable and makes the best use of resource
Strategic objective(s)	Use resources wisely

Initial Risk Level	Catastrophic	Likely	20	High

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	The £15.6m CIP 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 5, the forecast value of schemes stands at £9.3m.
Key Controls	Confirm and challenge meetings have been arranged to close the QIPP gap and improve delivery Finance and Performance Committee Executive accountability
Sources of Assurance	Internal Audit-CIP – Programme Management Audit

Performance Monitoring	Monthly Confirm and Challenge meeting includes CIP performance CIP report to Finance & Performance Committee
Gaps in Control	Operational pressures
Gaps in Assurance	

Current Risk Level	Catastrophic	Likely	20	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Focus on developing flow in the organisation including medically fit for discharge	Rab McEwan Chief Operating Officer	31/03/2016		
Develop clear accountabilities along with training to develop financial capacity and capability	Rob Cooper Director of Finance	15/04/2016	Training being developed with a roll out plan.	

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**3044 If the Trust does not manage CCG QIPPs the financial plan will not be realised**
Date opened	21/10/2015
Strategic goal	Ensure the Trust is sustainable and financially viable and makes the best use of resource
Strategic objective(s)	Use resources wisely

Initial Risk Level	Major	Possible	12	Moderate

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	Financial plan has been set assuming £2.75m impact of CCG QIPPs as agreed by the Trust review panel. The Trust is working through the required actions to realign capacity in line with the income reduction. Further QIPP reductions are likely to be added as they are agreed by the Trust review panel.
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 QIPP report to Finance & Performance Committee Expenditure controls
Sources of Assurance	Management Assurance-Monthly review via Finance and Performance Committee and Trust Board Management Assurance-Monthly monitoring of cost improvement programme delivery by divisions reported to F&P Internal Audit-Financial Management Arrangements & Reporting Audit Independent Assurance-Value for Money 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	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	

Current Risk Level	Major	Possible	12	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Work closely with CCGs to support the development of effective but realistic QIPP schemes for 2016/17	Haq Khan Deputy Director of Finance	30/04/2016	Structure in place for rapid identification and quantification of shared QIPP opportunities. Due date updated.	
Develop workstreams to deliver QIPP	Haq Khan Deputy Director of Finance	30/07/2016		
Realign capacity in line with the income reduction	Rab McEwan Chief Operating Officer	31/12/2016	Due date updated to reflect current approach	

Target Risk Level	Major	Unlikely	8	Low

Progress	

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk [3078 Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner]

Date opened 23/11/2015

Strategic goal

Strategic objective(s)

Initial Risk Level Major Likely 16 High

Director/Committee	Chief Operating Officer /
Description/Impact	Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner. The commissioners are aware that the community beds are insufficient for the numbers of patients that require rehab beds. Risks 1 Patients remaining in Trust beds when they require a rehab bed are not recieving rehab treatment 2 New patients are unable to be admitted to HASU/Stroke bed thus affecting performance measures being monitored by CCG, SSNAP, and CQC 3 Lenght of stay is therefore too long which means that new patients out lie on MAU and other wards blocking those beds to other admissions 4 Lenght of stay targets are not met (monitored by CCGs) 5 Thrombolysed patients cannot be moved fron ED directly to HASU. This is a hugh risk in terms of the correct pathway not being followed and level 2 care. The patient may have to stay in ED longer thus blocking a space and creating additional workload post thromboylsis during to the requirement for increased monitoring. 6 The Stroke Unit currently has 31 beds open and is commissioned for 29 7 The Trust has to make descisons to step patients down off the pathway and transfer them to AVON 4 so that it can accomodate new patients 8 The Trust risks reputational damage as it is not delivering local or national gold standards in stroke care 9 The financial risk - best practice tariff and stroke tariffs
Key Controls	Escalate downstrean capacity to PFC Escalate downstrean capacity to CCG Escalate to DDOps Medicine and COO Stroke patients not on ASU are assessed by a Stroke Consultant and MDT Outlier list held on ASU being reviewed daily Stepdown process identifying patients who can step off based on balance of patient needs
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Highlight to CCG'S the issues with availibility of stepdown beds	Robin Snead Divisional Director of Operations	31/08/2016	This is action is still in progress Up-date 24/6/16 - Integrated MDT established with Health and Care Trust to improve discharge process from community beds. Locum consultant appointed to provide medical cover in community. COO to Chair a monthly health economy wide/strategy meetings to address stroke capacity constraints. Expected completion date August 2016	
Instigate a process of identifying patients who can step off the pathway based on a balance of patient needs	Caroline Lister Directorate Manager	26/02/2016	Process only utlised where there are extreme bed pressures. CCG's informed of action	24/02/2016
Introduce an outlier list to be held on ASU for daily consultant review	Philemon Sanmuganathan Stroke Consultant	26/02/2016	Outlier list in use, duplicated on whiteboard	24/02/2016
Introduce cultural change to ensure all Stroke pts not on ASU assessed by Stroke consultant and MDT	Philemon Sanmuganathan Stroke Consultant	26/02/2016	Patients are identified on a daily basis for step down 24/2/16	24/02/2016

Target Risk Level Moderate Unlikely 6 Very Low

Corporate Risk Report

Progress	

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk [3079 Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care]

Date opened 23/11/2015

Strategic goal Ensure the Trust is sustainable and financially viable and makes the best use of resource

Strategic objective(s) Use resources wisely

Initial Risk Level Major Likely 16 High

Director/Committee	Chief Medical Officer / Workforce Assurance Group
Description/Impact	Continued recruitment difficulties result in high levels of agency expenditure. At month 7 of 2015/16, medical staff are £4.4m overspent. This is split between 22 over established posts, at an agency cost of £2.5m with the remaining £1.9m being from increased premium costs of temporary staff net of any under establishments.
Key Controls	Working within framework Agency price cap in place Process embedded within divisions to identify need and authorisation by senior divisional management Escalation process for approval of rates or agencies outside framework system
Sources of Assurance	Management Assurance-WAG Medical Workforce Report

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Ensure divisions provide clear strategy to increase substantive workforce and reduce costs	Andrew Short Consultant Paediatrician	19/08/2016		
Review all non-substantive contracts with a view to identifying employment status	Julie Stupart Head of HR	31/12/2015	Report has been provided to Divisions for their follow up.	01/12/2015
MWAG to be reintroduced with specific TOR and workforce issues to be discussed and actions agreed	Andy Phillips Interim Chief Medical Officer	15/02/2016	No longer planned to be a separate group. This work will be incorporated into the work of WAG.	15/02/2016
Develop strategy to increase substantial consultant body	Andy Phillips Interim Chief Medical Officer	13/06/2016	Update March 2016: Workforce Development Plan in progress, to be completed May 2016. April 2016 update: Regular WAG medical staff report to Trust Board commenced in April 2016 which includes actions taken by divisions. June 2016 update: WAG medical staff report continues. Action closed.	13/06/2016

Target Risk Level Moderate Possible 9 Low

Progress	

Next Review Date 30/06/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**3097 If managers do not adhere to financial controls, there will be excess expenditure and financial recovery plan not met**
Date opened	27/11/2015
Strategic goal	Ensure the Trust is sustainable and financially viable and makes the best use of resource
Strategic objective(s)	Use resources wisely

Initial Risk Level	Catastrophic	Likely	20	High

Director/Committee	/ Finance and Performance Committee
Description/Impact	The trust has financial controls in place to effectively manage the trusts financial resources. For example, delegated authorised spending limits, business case process, budgeted establishment. These controls are not always adhered to for example, with agreements made outside formal trust procedures. The impact of this is that we will overspend and have detrimental impact on the Trusts financial performance and cash position.
Key Controls	Multiple financial controls in place as described in the Standing Financial Instructions and Scheme of Delegations Electronic budget holder training Support from Finance via budget holder meetings Disciplinary consequences if financial instructions breached Masking on iProc
Sources of Assurance	Internal Audit-Financial management internal audits of systems and processes

Performance Monitoring	Budget variance reviewed within division via budget holder meetings, meetings with Finance team. Detailed financial performance data provided to F&P committee.
Gaps in Control	It can be difficult to detect failure to adhere to controls until after it has occurred Staff are expected to manage within their scheme of delegation Electronic systems limit by amount but not by category of spend or vary by requesting department Discipline and escalation procedures not fully enacted
Gaps in Assurance	

Current Risk Level	Catastrophic	Likely	20	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Identify breaches of financial code, and provide to Finance and Performance Committee with suggested actions	Rob Cooper Director of Finance	15/01/2016		
Implement enhanced financial controls as endorsed at November 2015 Finance & Performance Committee	Rob Cooper Director of Finance	16/12/2015	Chief Executive has met with Directors of Operations to explain the new financial controls which include agency caps and minimising contracted staff. This has also been sent formally to the Divisional Management Teams advising them of the changes.	30/12/2015

Target Risk Level	Moderate	Blank	12	Moderate

Progress	

Next Review Date 30/06/2016

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 July 2016 **Enc: H2**

Report to Trust Board in public

Title	**Organ Donation Annual Report**
Sponsoring Director	**Dr Andrew Short**
Author	**Dr Gavin Nicol** **Clinical Lead Organ Donation**
Action Required	The Board is asked to: • Specifically support the training of link nurses in the accident and emergency departments and intensive care units to promote organ donation. • Generally support the work of the organ donation committee both within WAHT and outside in the community.
Previously considered by	*Not applicable*

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	
Stabilising our finances	

Related Board Assurance Framework Entries	N/A
Legal Implications or Regulatory requirements	
Glossary	

Date of meeting: 6 July 2016 **Enc: H2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 6 July 2016

1. Situation

This report refers to the organ donation activity within WAHT during the period 1st April 2015 to 31st March 2016. NHS BT produces an annual executive summary of organ donation activity within WAHT. A report from NHS BT is available and details clinical activity. This report also describes the activity of the organ donation committee at WAHT and highlights the committee's plan to utilise link nurses to promote organ donation and improve organ donation rates from the accident and emergency departments.

2. Background

- The latest organ donation data shows that we had 6 proceeding organ donors resulting in the transplantation of 13 organs between 1st April 2015 and 31st March 2016.
- There were 2 donors after brain death (DBDs) and 4 donors after circulatory death (DCDs).
- We had a 100% brain stem death testing rate and a 100% referral rate of potential DBDs to the specialist nurse for organ donation.
- The daily safety brief that is now incorporated on the two intensive care units in WAHT discusses the potential for organ donation and has replaced the daily phone call from a specialist nurse that was highlighted in last year's report.
- The organ donation committee continue to promote organ donation in the wider community. The organ donation memorial was officially unveiled last year. An organ donation champions day was run in collaboration with Worcestershire County Council. An organ donation study day for nursing students was held at the University of Worcester.
- Michael and Elisabeth Amies have stepped down from their roles as chairman and lay member on the organ donation committee. I would like to place on record my thanks to them for all their hard work and dedication in promoting organ donation both locally and nationally. They were a truly inspirational couple.
- Chris Clarke a senior lecturer in advanced clinical practice at the University of Worcester has been appointed as the new chairwoman of the organ donation committee. She previously worked as a critical care nurse at WAHT and brings a wealth of experience and opportunity to this role. A new lay member has yet to be appointed.
- Emma Lawson our specialist nurse has been seconded to a managerial role in Birmingham by NHS BT. We will invest in our

link nurses in the accident and emergency departments and intensive care units to fill the void caused by her secondment.
- We will implement the recommendations of NHS BT to improve organ donation in the emergency department.

3 Actions

3.1 We have appointed link nurses in the accident and emergency departments and intensive care units across WAHT. Their role is to promote organ donation and reduce the numbers of missed potential organ donors. They will require support and training in their roles. Funding for their training will be from the organ donation fund.

3.2 NHS BT has launched the "Big Win Collaborative" that aims to improve organ donation rates from accident and emergency departments. We will implement their recommendations in WAHT.

4 Recommendation

The Board is asked to:
- Specifically support the training of link nurses in the accident and emergency departments and intensive care units to promote organ donation.
- Generally support the work of the organ donation committee both within WAHT and outside in the community.

Name of Director: Dr Andrew Short
Title: Acting Chief Medical Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: July 2016 **Enc H3**

Report to Trust Board

Title	**Safeguarding Adults & Children Annual Report April 2015 – March 2016**
Sponsoring Director	**Jan Stevens** **Interim Chief Nursing Officer**
Author	**Deborah Narburgh – Interim Lead Nurse Safeguarding Adults** **Anne Crohill – Lead Nurse Safeguarding Children**
Action Required	Trust Board are requested to note the work of the Safeguarding team and the annual report
Previously considered by	*Quality Governance Committee*

Priorities (√)

Investing in staff	
Delivering better performance and flow	
Improving safety	√
Stabilising our finances	

Related Board Assurance Framework Entries	
Legal Implications or Regulatory requirements	Working Together to Safeguard Children (2015) PREVENT duty guidance (2015) Counter Terrorism and Security Act (2015) The Care Act (2014) Intercollegiate Document (2014) - safeguarding children & young people : roles and competencies for healthcare staff Deprivation of Liberty Safeguards (2009) Health & Social Care Act (2008) Mental Capacity Act (2005) Mental Health Act (1983) CQC Fundamental Standards Statement on CQC's roles and responsibilities for safeguarding children and adults (June 2015) Children Acts (1989) and (2004) Female Genital Mutilation Act (2003), FGM enhanced data set (2015)
Glossary	CQC – Care Quality Commission CCG –Clinical Commissioning Group DOLS –Deprivation of Liberty Safeguards MASH –Multi Agency Safeguarding Hub WAHT – Worcester Acute Hospitals NHS Trust WSAB –Worcestershire Safeguarding Adult Board WSCB –Worcestershire Safeguarding Children Board

Key Messages

This report outlines the work undertaken, and in progress to safeguard adults and children /young people within WAHT and the requirements currently identified as risks to the organisation in order for key pieces of work to reach completion.

Date of meeting: July 2016 **Enc H3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

ANNUAL SAFEGUARDING REPORT 2015 / 16

1. Situation

This report provides the annual update to the Trust Board on service developments in relation to safeguarding adults, children /young people.

This report provides assurance to the Board that WAHT is fulfilling its statutory responsibilities in relation to safeguarding adults and children/young people who access services from the Trust.

2. Background

Effective safeguarding and promotion of the welfare of adults and children/ young people relies upon joint working and constructive relationships that are conducive to good multi - agency partnership working. This can only be effective when all staff are knowledgeable, confident and equipped with the skills to deal with process and procedures when concerns arise relating to patient safety.

The Care Quality Commission [CQC] undertook A Review of health services for Children Looked After and Safeguarding in Worcestershire 14th - 18th September 2015. The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

The findings from the review were published on 14th December 2015, the conclusion being that services across Worcestershire were Inadequate to safeguard children and young people.

Although the report highlighted some good practice within The Trust, there were also areas where improvement was required. The recommendations from the review have been formulated into an action plan, which is discussed in more detail on page 4, point 3.5.

The purpose of this Annual Report is to provide assurance to the Board by highlighting any areas for development and to inform of any intervention and change that has been made to strengthen the safeguarding process within WAHT.

3. Assessment

3.1 Appointment of new staff

A new Head of Safeguarding was appointed in January 2016 and commenced in post May 2016. An administration Support Officer, part time commenced into post January 2016. The Named Midwife Safeguarding commenced into post November 2015.

Following the resignation of the Associate Nurse Safeguarding Children in October 2015 a new Associate Nurse Safeguarding commenced in post January 2016. This post will continue to assist the safeguarding team

primarily with the delivery of training.

3.2 **Governance**

Following a realignment of the Trust governance structure, the adult and children safeguarding teams became integrated in January 2016, in order to streamline and strengthen the safeguarding agenda within WAHT. This led to the formation of the Integrated Safeguarding Committee to oversee the safeguarding agenda. The outstanding work plans from both teams were amalgamated into a new delivery plan alongside newly identified work streams. This plan is overseen by the integrated Safeguarding Committee and helps drive the safeguarding agenda.

The integrated Safeguarding Committee is a subcommittee of the Quality Governance Committee (QGC) gaining assurance on behalf of the Trust Board that its legal and statutory duties are met in respect of the safeguarding of adults, young people and children.

The integrated Safeguarding Committee acts as a conduit for the following agendas and has representatives from the health economy, including, the designated Nurse for Safeguarding, Worcestershire:

- Safeguarding adults – including compliance with the Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DOLS), and the Mental Health Act (MHA).
- Response to the Trusts duties as part of the PREVENT strategy, working with partner agencies across the health economy.
- Safeguarding children – including child sexual exploitation and female genital mutilation
- Gaining assurance from the Divisions that responses to external or internal inspection reports are met and that risks are managed and mitigated accordingly
- The Trust upholds its reputation and meets its responsibilities in relation to the Worcestershire Safeguarding Adult and Children's Boards and associated sub-groups.

3.3 **Risk Register**

The newly created safeguarding risk register incorporates the risks formally managed by the Safeguarding Adults Committee and Children's Safeguarding Subgroup.
Risks have been consolidated and are now all linked to, and overseen by the Integrated Safeguarding Committee.

A newly added risk is that of the lack of a standalone guideline/policy relating to People working in a Position of Trust. Meetings have been held with Human Resources representative who will lead on the finalisation of the document.

The current high risks are:

- Safeguarding Training
- Lack of Responsible Clinician
- Administration of Mental Health Act

Key achievements 2015/16

- Named Midwife commenced in post November 2015
- Work completed to match staff role with required level of children's safeguarding training in line with intercollegiate document. Trust wide data is now available by Level 1,2 & 3. End of March data Level 1 = 62.14% Level 2 = 27.32% Level 3 = 28.38% across all staff. Divisional figures of attainment are also available and will enable those staff groups with low compliance to be targeted.
- Review of training packages to check if they meet the requirements of the intercollegiate documents has been completed –further action required for 2016/17 to meet compliance
- Any outstanding work was incorporated into the newly integrated delivery plan at time of development.
- The following audits were undertaken:
  ID 37 – Safeguarding Referral documentation children
  ID 535- safeguarding children's documentation
  ID 555 children safeguarding A& E
  ID 396 compliance of asking safeguarding questions questionnaire
  ID 116 safeguarding of children ED

- All briefings received from the Safeguarding Boards are circulated via the integrated Safeguarding Committee.
- Submission of the Section 11 Audit February 2015.
- Completion of Electronic Flagging for vulnerable children onto the Trust patient data system Oasis.
- The Trust is a virtual member of the Multi Agency Safeguarding Hub [MASH] for adults & children. This process is for the multi-agency sharing of information where safeguarding concern arises, and is now embedded into practice. The timescale to provide responses are time limited and place significant pressure to gather information from across the relevant division and respond. A total of 24 MASH requests were received during 2015/16.

  However, requests from Children's Social Care for information relating to children's attendance at Emergency Departments is more frequent and does not always come through the MASH email contact route but via telephone conversations.

- Introduction of a quarterly internal newsletter - Safeguarding Snippets - produced by the safeguarding team. It contains information in relation to the 'must do/must knows' in respect of safeguarding, embracing the 'think family' ethos.
- Trust wide senior level divisional representation on the integrated safeguarding Committee to ensure information is cascaded across the organisation
- Safeguarding is a standing agenda item on all Divisional meetings
- CQC review and inspection undertaken, resulting in compilation of an action plan to address recommendations. Several of these actions were completed during 2015/16.

3.4 **CQC action plan**

CQC Review of health services for Children Looked After and Safeguarding in Worcestershire 2015, explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. The focus was on the experiences of looked after children and children and their families who receive safeguarding services. In total the experiences of 123 children were reviewed.

There were several recommendations for WAHT, Relating to keeping babies / children safe within Maternity Services & Emergency Department. There were also Governance issues re the safeguarding reporting pathway, safeguarding supervision & training for staff and the lack of capacity within the safeguarding team.
The report is available at

www.cqc.org.uk/sites/default/files/20151214_CLAS_Worcestershire_Final_Report.pdf

The action plan is monitored via the Trust Integrated Safeguarding Committee and the CCG's.

Many of the recommendations have been completed, those outstanding will be addressed 2016/17. The two actions where progress has been delayed are the introduction of the K2 phase 2 community electronic maternity records system and installation of CCTV into the children's waiting area of the Emergency Department at Worcestershire Royal Hospital.

A finance bid was submitted in February for funding of the K2 maternity community record system. Installation of CCTV in the Emergency Department has been factored into the expansion project due for completion in September 2016.

3.5 **Lampard Report - Action Plan**

February 2015, Kate Lampard published her second report following investigations into the abuse of individuals by Jimmy Saville on NHS premises. The report made 14 recommendations in total of which 9 were pertinent to acute hospital trusts. These were incorporated into an action plan, which has been monitored by the Integrated Safeguarding Committee.
Actions for 5 of the recommendations are complete , the remaining 4 are progressing towards completion 2016/17

3.6 **Female Genital Mutilation (FGM)**

The Trust now has 3 leads for FGM, Named Midwife Safeguarding, Consultant Obstetrician and Consultant Paediatrician. The Trust wide pathway for FGM is currently out for final consultation. This pathway includes information relating to the national data set. A training programme will follow adoption of the policy as part of the roll out.

There have been no identified / reported cases of FGM within the timeframe of this report.

3.7 **Child Sexual Exploitation (CSE)**

The Named Midwife Safeguarding is the Trust lead for CSE and attends the WSCB operational sub group. It has been agreed that children who are known to be at risk of CSE will be flagged as vulnerable children via the Trust electronic flagging system.

3.8 **Domestic Abuse**

Tackling domestic abuse is a strategic priority for the Safer Communities Board and the wider partnership. The recording of domestic abuse has significantly increased over the past 12 months, with significant increases in older people (45-85yrs) and young people. Compared with domestic abuse crimes recorded between 2014 and 2015, there has been a 72% increase.

A criminal offence of coercive and controlling behaviour became law on the 29th December 2015 under Section 76 –the Serious Crime Act.

The Trust is working with partner agencies to develop a single Domestic Abuse pathway for the health economy which will incorporate the recent NICE guidance around domestic abuse.
The Trust actively participates in the Multi Agency Risk Assessment Conference (MARAC), and has Midwifery lead and links for Domestic Abuse in Emergency Departments.

Independent Domestic Violence Advisor (IDVA) - an extremely successful pilot project was undertaken at Worcester Royal Hospital Emergency Department, with over 120 referrals being made to the IDVA. Funding for the initial pilot ceased January 2016. A business case has been submitted to the CCG for funding to continue this role

3.9 **Training**

Safeguarding adult and children training is mandatory for all Trust staff and is monitored as part of the safeguarding assurance process. Mandatory training attendance data shows a continued upward trend over the last year. The training attainment target of 95% set by commissioners and CQC was reduced to 90% at the beginning of 2016.

As at 31st March 2016, the year -end target of 90% set by the CCG was achieved with Safeguarding Adults training – 92.18% (previous year 83%), but not attained with Safeguarding Children training– 87.36% (previous year 75%).

These figures indicate the number of staff who have attended some level of safeguarding training, not specifically the level of training required for the role undertaken. See figures by level reported under 3.4 - Key achievements

The work to enable a similar set of data for safeguarding adult training, by specific level, is progressing. Work has been completed to match staff job roles to level of required training. Data is awaited from the training department to provide information in relation to the current compliance with the appropriate level of training for job role.

Further work is required to develop an action plan and training trajectory for both children's and adult safeguarding training by specific level.

The integrated safeguarding team have progressed work to review the content and delivery of safeguarding training. This work will be finalised with the new Head of Safeguarding. Training packages will require further review to ensure they meet the correct levels defined in the intercollegiate document.

Multi agency elements for Level 3 safeguarding children training have been secured via Worcestershire Safeguarding Children Board and Worcestershire CCG.

3.10 **PREVENT / WRAP**

PREVENT awareness training continues to be delivered on induction and all mandatory training programmes with an extended workshop to raise awareness of prevent (WRAP) delivered on clinical and senior mandatory training sessions.

Of the 3871 staff requiring WRAP training – 40% (1557) staff have completed. This is on trajectory for the 3 year delivery plan by the end of 2018.
The Trust provides a quarterly report to the CCG to monitor compliance with the Governments counter terrorism PREVENT strategy. The Trust is represented at both local and regional PREVENT forums.

3.11 **Mental Health Act**
NHS Information centre KP90 return.

The Trust currently completes an annual KP90 return detailing all detentions within the Trust under the Mental Health Act. Over the last year there have been 12 reportable detentions within the Trust.

3.12 **Deprivation of Liberty Safeguards (DoLS)**

The Associate Professional for adult safeguarding has continued to provide additional training sessions upon request to embed theory into practice within clinical areas. Additional training sessions have also been provided to allied health professionals such as Speech & Language Therapy and Matrons. The application of the theory to practice has also been included on the Trust Preceptorship Programme for newly qualified staff. Sessions have also been delivered to bereavement office staff to ensure compliance with referral to the coroner.

A new process has been embedded with the local authority DoLS administration team for Worcestershire to triangulate referrals reported on the Trust incident reporting system with those referrals received by the local authority. This is providing added assurance as to both the number and status of referrals. Once a standard authorisation is granted by the local authority then the safeguarding team prompt the necessary reporting to the CQC. The local authority is continuing work to address the backlog of referrals.

3.13 **Policy Development**

The Safeguarding Children & Young People Policy Pathway was completed in November 2015.

The Trust wide pathway for FGM is out for final consultation prior to going to the Key Documents Committee in 2016 for approval.

Policy pathway / guideline relating to Allegations against a Person in a Position of Trust is currently being drafted by Human Resources Department.

Development of a generic health economy domestic abuse pathway is progressing.

Work continues with the key documents lead to convert all the policies related to safeguarding adults into a pathway.

Policies due for renewal have been extended to enable work to be completed to move policies into pathways.

3.14 **Serious case reviews and homicide investigations**

WSCB published the Independent Overview Report of the Serious Case Review Concerning the Death of Child GW [date of death 7/12/12] on 28th April 2015. The delay in publication of the report was due to on-going criminal proceedings. The action plan from this serious case review was formulated and acted upon during 2013/14.

There have been no serious case reviews or case reviews undertaken during 2015/16.
There are 2 identified cases awaiting assessment for possible review pending police investigation.

The Trust has participated in two Domestic Homicide Reviews in the previous year, both of which have now been completed. There are 2 general agency recommendations that have been added to the safeguarding action plan:

- Ensuring staff are aware of West Mercia Inter-Agency Child Protection Procedures relating to working with non-compliant families
- Notification to Children's Social Care when a child is withdrawal from traditional services and potential risk of significant harm to the child is a factor.

The Trust has participated in two Adults Case Reviews during this financial year. Both cases have now been accepted by Worcestershire Safeguarding Adults Board. The actions have already been completed. There are 3 known cases which are currently on hold awaiting the outcome of police investigations.

3.15 **Safeguarding Supervision**

Lack of adequate safeguarding supervision was highlighted following the

CQC visits and is a focus for the CCGs quality reviews. The staged roll out of 1:1 safeguarding supervision has begun amongst community midwifery teams and specialist community midwives. The need to increase the pool of supervisors remains an issue.
The next WSCB supervisor training course is July 2016, and nominated staff will be applying for places.

3.16 **Objectives 2016/17**

The safeguarding team will continue to monitor / action the following:

- Safeguarding Delivery Plan
- CQC action plan
- Lampard action plan.
- review of all adult and children training packages to ensure compliance with intercollegiate document
- Devise and identify the route of delivery for the appropriate training packages, incorporating the use of external agency packages
- Develop a Trust policy pathway for managing Child Sexual Exploitation (CSE)
- Identify audit programme
- Work with IT is progressing to implement the National Child Protection Information System [CP-IS]
- Relocation of the integrated safeguarding team into one location

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4 Recommendation

The Board is asked to note the work of the Safeguarding team and the annual report.

Jan Stevens
Interim Chief Nursing Officer