Worcestershire NHS
Acute Hospitals NHS Trust

There will be a meeting of the **Worcestershire Acute Hospitals NHS Trust Board** on **Wednesday 8 June 2016**
at 09:30 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	**Patient Story**	Interim CNO	
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest** *To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.* To note the following declarations of interest: • 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)		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **4 May 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 7 June 2016.* ***Please note change of email address***		
8	**Chairman's Update Report** *For information*	Chairman	**Verbal**
9	**Chief Executive's Report** *For assurance*	Interim Chief Executive	**Enc C**
STRATEGY **Board Assurance Framework 2665, 2904, 3140**			

10.1	**Priorities for 2016/17** *For approval*	Director of Planning and Strategy	**Enc D1**
10.2	**Sustainability and Transformation Plan – update** *For assurance*	Director of Planning and Strategy	**Enc D2**
	QUALITY AND PATIENT SAFETY **Board Assurance Framework 2790, 2902, 3038, 2895**		
11.1	**Quality Governance Committee report** *For assurance*	Committee Chair	**Enc E1**
11.2	**Quality Account** *For approval*	Interim CNO	**Enc E2** *Plus separate enc*
11.2	**Patient Care Improvement Plan** *For approval*	Director of Planning and Development	**Enc E3**
	WORKFORCE **Board Assurance Framework 2678, 2894, 2893**		
12.1	**Workforce Assurance Group report** *For assurance*	Committee Chair	**Enc F1**
12.2	**Nursing and Midwifery Workforce** *For noting*	Interim CNO	**Enc F2**
	FINANCE AND PERFORMANCE **Board Assurance Framework 2888, 2668**		
13.1	**Finance and Performance Committee** *For assurance*	Committee Chair	**Enc G1**
13.2	**Annual Accounts and Annual Audit Letter** *For assurance*	Deputy Director of Finance	**Enc G2**
13.3	**Integrated Performance Report** *For assurance*	Director of Planning and Development	**Enc G3**
13.4	**Financial Performance Report** *For assurance*	Deputy Director of Finance	**Enc G4**
13.5	**Sustainability Strategy – update** *For assurance*	Interim Chief Executive	**Enc G5**
	GOVERNANCE AND COMMITTEE REPORTS **Board Assurance Framework 2888, 2668**		
14.1	**Audit and Assurance Committee** *For assurance*	Committee Vice-Chair	**Enc H1**
15	**Any Other Business**		
	Date of Next Meeting The next public Trust Board meeting will be held on **Wednesday, 6 July 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 4 MAY AT 09:30 HOURS

Present:

Interim Chairman of the Trust:	John Burbeck	Vice Chair and Non-Executive Director
Board members: (voting)	Rob Cooper	Interim Director of Finance
	Stephen Howarth	Non-Executive Director
	Rab McEwan	Interim Chief Operating Officer *until minute no 9/16*
	Bryan McGinity	Non-Executive Director *from minute no 12/16/2*
	Andy Phillips	Interim 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
	Lisa Thomson	Director of Communications
	Bill Tunnicliffe	Associate Non-Executive Director
In attendance:	Paul Crawford	Patient Representative
	Kimara Sharpe	Company Secretary (minutes)
Public Gallery:	Press	0
	Public	11
Apologies:	Stewart Messer	Chief Operating Officer
	Lynne Todd	Board Advisor
	Marie-Noelle Orzel	Improvement Director

21/16 **WELCOME**

The Interim Chairman welcomed members of the press and public to the meeting.

22/16 **PATIENT STORY**

Mr Burbeck invited the Interim CNO, Ms Jan Stevens, to introduce the patient story. Ms Stevens introduced Mrs S, a nurse working within the Trust. Mrs S explained that her mother had been admitted on a Monday with anaemia. She had received two blood transfusions and a gastroscopy and was discharged on the Saturday.

The care that her mother had received was outstanding. However, she felt that her mother need not have been admitted to undergo the necessary treatment and investigation. She had urged the staff to allow her to take her mother home, but found it quite difficult to obtain the correct approval.

She wondered what the Trust could do to ensure that people were not admitted for procedures that could be undertaken as an outpatient or within the community.

Ms Steven thanked Mrs S for sharing her story. She was pleased that the care her mother received was good. However, Ms Stevens stated that the story emphasised the necessity to break the traditional cycle of caring for people and review where the best place is for treating someone. She agreed that the treatment and investigation undergone should have been as an outpatient.

The Interim COO, Mr Rab McEwan asked Mrs S whether she would be willing to speak to a wider group of staff about her experience. Mrs S confirmed she would. He also asked whether Mrs S's mother knew who was in charge of her care. Mrs S's mother confirmed that she did not know. Mr McEwan was disappointed that she was unaware as the senior clinical decision maker was crucial to how a patient is treated.

Mr Sleigh thanked Mrs S for her story. He stated that the Board were cognisant of the need to change practice and culture throughout the Trust.

Mr Howarth asked what the reasons were for the care of Mrs S's mother in hospital. Mr McEwan stated that clinicians would have thought that they were acting in the patient's best interests. Mrs S commented that clinicians need to begin to 'think outside the box' to ensure patients were treated at the right time in the right place.

Mr Burbeck thanked Mrs S and her mother for attending the Board. He hoped that Mrs S's mother continued to make a full recovery.

Resolved: that
The Board

- Noted the content of the story

23/16 **ANY OTHER BUSINESS**

No other items of business were raised.

24/16 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interest.

25/16 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 6 APRIL 2016**

Resolved: that

- The Minutes of the public meeting held on 6 April 2016 be confirmed as a correct record and be signed

25/16/1 **MATTERS ARISING/ACTION SCHEDULE**

The Company Secretary confirmed that all the actions had been completed or not yet due.

26/16 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

A question had been received from Dr Howard Eeles. Mr Malcolm Cooper was present in the audience to note the Trust's response.

We are concerned re potential closure of the GP unit at Kidderminster Hospital and this will be discussed at the CCG meeting on Tuesday. Should this unit be closed we would wish to know what alternative arrangements are being planned for intermediate care in the Wyre Forest district? It is obvious that should this be closed then this will put enormous pressure on the acute unit which already has a high incidence of delayed discharges due to inappropriately placed inpatients. We would like to remind the acute trust that South Worcestershire is well served with Community Hospitals in all the main towns eg Malvern, Evesham, Pershore and Worcester providing intermediate care.

The Interim CEO, Mr Chris Tidman, thanked Mr Cooper for the question. He explained that the Trust had been notified by Wyre Forest CCG that they were considering a revised model for the provision of intermediate care which did not involve the use of the GP Unit. He stated the people being cared for within the GP unit should be being cared for in other settings such as Mrs S's mother who should not have been admitted to hospital.

He went onto state that he is working with Wyre Forest CCG on the revised model of care and assured members of the public that the GP Unit would not be closed unless there was alternative provision made.

Mr Cooper explained that some people needed a place to go to when they could not be cared for at home and he gave some personal examples of such circumstances. Mr McEwan sympathised with Mr Cooper but explained that the current GP Unit is not the right environment for end of life care. He was keen to work with the CCG and Health and Care Trust so suitable other accommodation was available.

Mr Burbeck thanked Mr Cooper for his question. He assured Mr Cooper that the Trust would continue to work with other health and social care colleagues to ensure that there was the right provision in place for patients.

27/16 **Interim Chairman's Report**

Mr Burbeck stated that he was keen to continue to improve services for the population of Worcestershire and in particular the frail elderly. He was delighted with the progress being made with recruitment and was pleased that performance was good in many areas, despite a difficult winter period. He was optimistic that the service offered by the Trust would continue to improve.

Resolved: that
The Board

- Noted the report

28/16 **Interim Chief Executive's Report**

Mr Tidman, presented the report circulated with the agenda (enclosure C) and highlighted the main points. He began by thanking all staff for their work during the two day strike of junior doctors. The Trust coped well with excellent flow through the hospitals. He confirmed that he has asked Ms Stevens and Mr McEwan to capture the lessons learnt during this time.

Mr Tidman then went onto highlight his visit to South Warwickshire NHS Foundation Trust's hospital at night service. He has asked Ms Stevens to lead a similar project for Worcestershire. He then explained that he has been working with the University in relation to training opportunities for new and current staff.

Mr Tidman stated that the West Midlands Clinical Senate visited the Trust on 3 May as part of the assurance process for the Future of Acute Hospital Services in Worcestershire programme. He confirmed that there was a consensus that no change was not an option given the fragility of some of the services. He requested that progress was made quickly to minimise any further temporary measures caused by the fragility of some services. The Clinical Senate would report by the end of May.

Mr Tidman then turned to the programme *Listening into Action.* Ten areas of work had been identified to take forward. He explained that the programme enabled staff to make changes to services for the benefit of patients. He gave some examples of the

areas of work and stated that the formal launch will be on 12 May.

Finally, Mr Tidman confirmed that Mr Wake, the Chief Medical Officer, had resigned. He thanked him for his work at the trust. The position of CMO would now be advertised. He thanked Dr Andy Phillips, Interim CMO, for his work whilst on secondment from University Hospitals Coventry and Warwickshire and wished him well on his return to his employer. The Divisional Medical Director for Women and Children, Andrew Short, will act as Acting CMO from 1 June until a permanent replacement is appointed.

Resolved: that
The Board,

- Received the assurance within the report

29/16 **Integrated Performance Report**

The Director of Planning and Development, Ms Sarah Smith, presented the report which had been circulated as enclosure G2. She stated that there had been significant under performance during March 2016. She acknowledged that this was disappointing. The root causes were the cancellation of electives due to the junior doctors' strike; a new policy in respect of waiting list initiative sessions as well as operational pressures.

Mr McGinity joined the meeting.

Mr McEwan confirmed that the performance on some aspects in emergency care had improved and the Trust was now performing close to the national average for the four hour emergency access target. One main challenge was the difficulty in discharging patients needing social care due to the reduction in social care budgets.

He stated that emergency admissions were up 6% on the same period in 2015/16 and attendances up 9%. Bed occupancy was at 102%. The effect on the services was that patients were unable to leave A&E when needing admission.

Mr McEwan added that failure to deliver performance in relation to diagnostics was anticipated due to the volume of activity in relation to the cancer 2 week wait and the subsequent number of endoscopy procedures this generated. This in turn had led to the deterioration in the cancer 2 week wait and 62 day treatment targets. However the Trust delivered safe and appropriate care for the vast majority of patients.

He was now ensuring there was focus on increasing flow through the hospitals. He was keen to ensure more patients were discharged in the mornings and that ward rounds were multidisciplinary. He was pleased that early indications showed that patients were being triaged more quickly in A&E in April and the ambulatory care scheme was increasing numbers seen. The OPAL (Older Persons Assessment and Liaison service) trial in March has excellent results; out of 60 patients seen, 40 were discharged with a zero day length of stay. Changes underway with the working of the patient flow centre would support better flow.

Mr Sleigh asked for the narrative to be clearer in outlining the assumptions being made in relation to the trajectories. He asked what the actual impact of the strike action was on patients.

Mr McEwan stated that the nine days of industrial action have had a major impact on the elective programme, particularly the cancer 2 week wait and the referral to treatment (RTT) time. When there had been a full withdrawal of labour, the senior clinical decision makers made a significant impact on the work of the emergency

departments. Mr McEwan confirmed that the trajectories had been agreed with the local health economy.

Mr Sleigh commented that the 28 day readmission rate should distinguish between those readmitted that should not have been and those readmitted due to other factors. He stated that with the high number of comorbidities and the drive to discharge home earlier, the readmission rate would be higher than expected. Mr Tidman agreed and stated that the presumption that a lower readmission rate was an indicator of a safer service should be challenged.

Mr McEwan reminded members that the readmission rate is below the average for the last year and length of stay also decreased in March.

Mr McEwan then turned to the A&E performance. He confirmed that there would be a team of senior assessment nurses in post by the end of the month to ensure better performance with initial assessment. This service would also improve ambulance handover times.

Mr McGinity asked for clarification on the 2 week cancer wait and about the theatre utilisation project. Mr McEwan stated that cancer 2 week wait performance should show an improvement in May. Mr Tidman explained that theatre utilisation was one of the Listening into Action work streams.

Mr McGinity then asked about performance relating to time to theatre for people who have had a fractured neck of femur. The Interim CMO, Dr Andy Phillips, confirmed that there is good engagement and active working to improve the metric. He would anticipate month on month improvement.

Mr Burbeck asked for confirmation that quality impact analyses are being undertaken when appropriate. Mr McEwan confirmed that they were.

Resolved that:-
The Board

- Received the Integrated performance Report and noted the actions being taken to improve performance

Mr McEwan left the meeting.

30/16 **STRATEGY**

30/16/1 **Strategy and Transformation Committee**

The Chair of the Committee, Mr Sleigh, presented the report (enclosure D1) and highlighted the main points. He stated that the Committee had discussed the need to ensure prioritisation to be able to deliver the transformation programmes. Mr Burbeck agreed that it was difficult to identify resources for the future whilst tackling the present challenges.

Mr Tidman agreed that prioritisation was key. He confirmed that there were few extra resources available. He stated that it was imperative to work with colleagues across organisational boundaries to develop sustainable services. Organisation structures should not be the driver; the important issues were to ensure safe services for patients. He was critical of the press coverage which seemed to indicate that patients would have to travel vast distances to secure services. He confirmed that local access was of paramount importance and only when there was a life changing event would centres of excellence be needed.

Resolved: that
The Board:-

- Receive assurance in respect of the importance of the Sustainability and Transformation Plan process in terms of future financial and clinical sustainability and the priority programmes of work for the Trust
- Receive assurance in respect of the development of the Local Digital Roadmap and the requirements around access to the investment for technology enabled transformation fund.
- Receive assurance that the BAF risks associated with the Committee were reviewed and agreed that the associated actions will be strengthened.

31/16 **QUALITY AND PATIENT SAFETY**

31/16/1 **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. He assured the Board that the QGC had received a detailed plan about how the time to theatre for people who had a fractured neck of femur was being improved. The Committee were assured on the plans being put into place. He echoed concern about the cancer performance and gave assurance that harm reviews were in place. He was pleased that there was an increase in the number of primary mortality reviews being undertaken and it was reported that the Trust was working with primary care colleagues to review deaths taking place outside of the hospitals. He also reported progress on the completion of responses to complaints. Finally QGC received a report on the excellent progress that the R&D agenda was making.

In relation to the last point, Mr McGinity asked whether the University was involved in the research agenda. Dr Tunnicliffe confirmed that the University was involved. He was hopeful that in future clinicians would be able to generate their own research, rather than respond to requests from other organisations.

Mr Sleigh asked whether the QGC tracked learning from issues. Dr Tunnicliffe confirmed that a focus with the Division deep dives was learning. Ms Stevens outlined the work being undertaken with the investigation process and she was keen that the process for learning lessons within the Women and Children division should be rolled out trust-wide.

Dr Phillips stated that the R&D function would now be named Research, Development, Improvement and Innovation. Work would continue and increase with the University.

Ms Stevens emphasised the importance of multidisciplinary research and described the work she was undertaking with the University with joint appointments such as a Head of Midwifery.

Resolved: that
The Board

- Supported the renaming of the Research and Development work stream to Research, Development, Improvement and Innovation
- Received assurance that the Committee is concerned about the fracture neck of femur metric and are reviewing the actions monthly
- Received assurance about the actions being taken to mitigate harm with the poor cancer wait performance
- Noted the targets that have been agreed for the completion of primary and secondary mortality reviews
- Noted the work being instigated by the Trust for completion of primary reviews

relating to deaths outside hospital
- Noted that the complaints target will be reviewed
- Received assurance in relation to the progress of clinical research within the trust
- Noted the deep dive report into Women and Children division
- Received the assurance in respect of the consideration of the four BAF risks allocated to the Committee
- Received assurance in relation to the management and progress of the Governance and Safety Improvement Plan
- Noted the report

31/16/2 **Patient Care Improvement Plan**

The Director of Planning and Development, Ms S Smith, presented the report which had been previously circulated as enclosure E2. She explained that the report had been informed by the meeting of the Improvement Board held in April. The reports as presented had been driven by staff working in the areas. She was confident that the approach taken would be beneficial to making the significant changes required.

Mr McGinity asked whether the leadership programmes were for existing staff as well as for staff moving into new positions. Mrs Harnin confirmed that they were.

In response to a question from Mr Sleigh, Ms Smith confirmed that ECIP have already reviewed the patients arriving at A&E. She stated that the frailty work stream within the urgent care PCIP was addressing the appropriate admission or not of patients. Mr Tidman reminded Mr Sleigh that the Strategic Resilience Group (SRG) was undertaking work on understanding the increase in ambulance conveyances.

Mr Burbeck asked for the timeline for the trajectories. Ms Smith confirmed that the trajectories are in place for mortality and organisational development. Those for urgent care will be presented at a meeting on 18 May.

Resolved: that
The Board
- Reviewed progress with the Patient Care Improvement Plan (PCIP) as reported to the April 2016 meeting of the Trust Improvement Board

32/16 WORKFORCE

32/16/1 **Workforce Assurance Group**

Mr Burbeck, Chair of the WAG presented the report (enclosure F1). He reported that good progress is being made with recruitment. Most medical vacancies have a plan for recruitment and there are understood reasons why the others are not being recruited to. He also reported good progress with the recruitment of qualified and unqualified nurses. He was pleased to see more focus on appraisals and that mandatory training rates have increased. He highlighted that the requirements relating to Equality and Diversity training had changed which had affected the mandatory training position.

In response to Mr McGinity, Mrs Harnin stated that some medical posts were not being recruited to because the speciality was waiting for a tranche of newly qualified staff. She was also reviewing whether some posts needed to be disestablished or reviewed due to the difficulty in recruiting.

She also confirmed to Mr McGinity that she was working with the medical consultative committee in respect of mentoring for newly appointed consultants. In respect of a further question on job planning, Dr Phillips stated that he was ensuring that all

divisions were aware of their position and would be performance managed on the percentage of job plans outstanding. Mrs Harnin confirmed that job plan reviews to take account of working in different ways was planned for the future.

Mrs Harnin, in response to a question from Mr Tidman stated that she was ensuring that the E&D training was more relevant to the work within the Trust. Mrs Thompson confirmed that she was reinvigorating the E&D group as this area of work was a priority for the staff engagement group.

Resolved: that
The Board

- Approved the revised terms of reference
- Received assurance on the controls in place to manage nurse agency spend
- Received assurance on the processes in place for medical recruitment
- Received assurance in relation to the introduction of the junior doctors contract
- Noted the medical appraisal rate of 83% and note the concern about the progress of job plans
- 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

32/16/2 **Nursing and Midwifery Workforce**

The Interim CNO, Ms J Stevens, presented the report (enclosure F2). She apologised for the inconsistency within the report in relation to the figures and confirmed that those in table 1 were correct.

She stated that whilst the vacancy figure was low compared to other areas, she was not complacent and was pleased with the number of innovative recruitment methods were in place. She reported that she has had a number of staff complain to her about the negative publicity about the Alexandra Hospital and staff have confirmed that this is discouraging people from applying for posts.

The turnover rate of 14% was higher than she would like. She was reviewing the reasons and negative publicity was one major area of discontent. Other areas included work-life balance and personal development.

Resolved that
The Board received for assurance:-

- Management of recruitment and retention
- Management of vacancies
- Links to the University
- Safer staffing levels
- Birthrate plus desk top exercise

Ms Stevens left the meeting

32/16/3 **People Engagement Programme update**

The Director of Communications, Mrs Lisa Thompson, presented the report (enclosure F3). She was pleased that more than 500 members of staff had taken the opportunity to complete the first real time staff survey, ChatBack. She was now utilising other methods of gaining responses such as paper questionnaires and face to face questioning.

She reiterated the impact the *Listening into Action* was having and reported that the

programme should expand in June.

Mr Burbeck thanked her for her work.

Resolved that
The Board:-

- To note the content of the report
- Receive assurance on the actions being taken to engage with staff, in particular the ChatBack, The Big Conversation, Listening into Action
- Agree to receive further assurance via the Workforce Assurance Group which will be monitoring the actions agreed.

Ms Stevens re-joined the meeting

33/16 FINANCE AND PERFORMANCE

33/16/1 Finance and Performance Committee Report

Mr Sleigh, Committee Chair, presented the report from the Finance and Performance Committee held on 29 April 2016 (Enclosure G1) and highlighted the main points. He recommended to the meeting that the budget for 2016/17 could be signed off. He reported that the capital programme was approved by the Committee and he was pleased that the reported deficit was £59.9m at month 12 with an achievement of £10m reduction in the run rate.

He was pleased that the Procurement function had achieved savings in relation to the Carter review.

Mr Burbeck expressed his thanks to the Executive Team and the Divisions for gripping the financial challenges.

Resolved that:-
The Board

- Agreed the Actions set out in the financial plan, budget and contractual position for 2016/17, (Enc G4). The Board noted the positive implications of the result of contract negotiations with commissioners and the key assumptions that underline the budget. The impact of meeting the CQUINS was particularly noted.
- Agreed the proposed budget sign-off process ensuring ownership of budgets by budget holders, noting the approach now adopted of integrating all savings targets into the budget to be delivered holistically.
- Agreed the Capital priorities set by the Executive Team as advised by the Capital Prioritisation Group.

33/16/3 Financial Performance Report

The Interim Director of Finance, Mr R Cooper, presented the financial performance report (Enclosure H2) and highlighted the main points. He was delighted that the Procurement team have been nominated for an HSJ award.

He reported that at month 12 the deficit was £59.9m. This was still being audited. There had been an achievement of £9.7m of the £10 target and he had instructed PWC to audit this.

Mr McGinity asked whether controls were in place to ensure that the Trust's financial position did not deteriorate as in the previous year. Mr Cooper explained that there were now controls in the use of agency staff. This had risen last year and was a main

cause of the financial deterioration. He then outlined the controls in detail to Mr McGinity. Mr Tidman added that the position in relation to recruitment had improved and the Workforce Assurance Group was monitoring this.

Mr Sleigh commented that elective income needed to be a priority for 2016/17.

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.

33/16/4 **Financial Plan 2016/17**

Mr Cooper presented the financial plan (Enclosure H3) and highlighted the main points. He explained that the Finance and Performance Committee had reviewed the prosed plan in detail. In summary, the deficit was planned to be £51.4m. If £13.1m was available from the national Sustainability and Transformation fund, this deficit would reduce to £38.3m. This deficit included a cost improvement programme of £14.3m, of which about 50% had been identified.

The capital plan had also been agreed by the Finance and Performance Committee. Finally he confirmed that he was in discussion with NHS I in relation to the cash requirements.

In response to Mr McGinity, Mr Cooper agreed that the CIP was a huge commitment but he was confident of success.

Mr Tidman stated that the contract agreed with commissioners was fair. Crucial to its delivery was the reduction in demand. He asked Mr Cooper what the position was in relation to fines and penalties. Mr Cooper confirmed that as the Trust was likely to receive monies from the STP fund, the rules around fines differed to other trusts. He was exploring this with NHS I and the CCGs.

Mr Burbeck commented that the Trust was in a better position than previously. He urged the Executive Team to maintain a tight grip.

Mr Burbeck thanked the finance team for the work undertaken in relation to the budget setting.

Resolved that:-
The Board:-

- Received assurance that those assumptions have either been appropriately reflected in the financial plan or have robust mitigation plans.
- Noted that formal divisional sign off of activity plans and income and expenditure budgets will be by 13 May 2016.
- Noted that presentations covering budget holder responsibilities will be held by end of May.
- Noted the progress of contracts with commissioners and requested signed contracts as soon as possible.
- Noted that the plans for the £14.3m CIP target will be finalised and implemented by the end of May.
- Noted that workforce plans for the recruitment to medical and nursing staff will be in place by end of June 2016.

DATE OF NEXT MEETING

The next Trust Board meeting will be held on Wednesday 8 June at 09:30 in the Charles Hastings Education Centre, Worcestershire Royal Hospital

Mr Burbeck thanked the Dr Andy Phillips for his time at the Trust and wished him well in the future.

The meeting closed at 12:00 hours

Signed _____ **Date** _____

John Burbeck, Interim Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT 8 JUNE 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.	
4-5-16	Interim CEO report	28/16	Capture the lessons learnt in relation to the junior doctor strike	JS/RM			Being taken forward by the EMT	
4-5-16	Interim CEO report	28/16	Lead a project in relation to hospital at night	JS			Being taken forward as part of the improving patient flow work stream. Project plan in place.	

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc C**

Report to Trust Board

Title	**Interim Chief Executive's Report**
Sponsoring Director	**Chris Tidman, Interim Chief Executive**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is asked to • Note the items covered in the report • Receive the assurance contained within the report
Previously considered by	Not applicable

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	√
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is 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	None.
Legal Implications or Regulatory requirements	None
Glossary	Sustainability and transformation plan (STP)

Key Messages

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

Date of meeting: 8 June 2016 **Enc C**

WORCESTERSHIRE ACUTE HOSPITAL NHS TRUST

REPORT TO PUBLIC TRUST BOARD – 8 JUNE 2016

1 Situation

This report aims to brief Board members on various issues.

2 Background

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

3 Listening into Action

We officially launched "Listening into Action" on 12 May in Bromsgrove with our Sponsor Team and the volunteers for the first 10 workstreams. This has already stimulated ideas and proposals form front line staff. The early feedback from our first pulse check has been really positive and I intend to keep the Board updated on progress. One suggestion was on how we could improve the entrances to our hospitals and we have initially responded by opening of a fruit and veg stall at the main entrance to WRH. This is proving to be very popular with the staff, patients and visitors and is also helping to reinforce a healthy lifestyle message in line with our zero tolerance approach to smoking on site. We intend to roll this out to the Alexandra Hospital shortly.

4 Senate Report

The West Midlands Clinical Senate has now completed its final review on the countywide reconfiguration plans and has endorsed the model. We will now enter the NHS England assurance phase and still hope to move to a CCG-led public consultation in September 2016. In the meantime we continue to review the fragility of our affected services.

5 Proposed consultation on the re-provision of the GP Unit

The Trust has received a petition from Wyre Forest in relation to the CCG proposals to re-provide the service currently provided by the GP Unit, Kidderminster Hospital. The Trust has noted the views and is working closely with the CCG and the Worcestershire Health and Care NHS Trust to ensure an improved service for the Wyre Forest population.

6 International Nurses' Day

I am delighted that we celebrated International Nurses Day last month. The day started with breakfast with Jan Stevens and some of our brilliant nurses about what made them proud about their teams. I then spent some time with nursing staff on GAU, outpatients and MAU – there was great passion from all staff about the care they deliver to their patients and the improvement they wish to make.

7 Switchboard staff

Last month, the media reported that our switchboard teams were in the top 10 fastest in the NHS. This is excellent recognition for our switchboard staff and a reminder that the NHS relies on teamwork from both clinical and non clinical staff to deliver the best patient experience.

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

Date of meeting: 8 June 2016 **Enc C**

8 Mock Inspection

A number of front line staff and external peers participated in a series of mock CQC inspection visits over 17 and 18 May to wards and departments at the Alexandra Hospital, Worcestershire Royal Hospital and Kidderminster Hospital. The feedback was largely positive with good learning points as to where we need to focus to ensure a consistently "Good" rating.

9 Emergency Department Expansion

Our modular build extension was delivered and lifted into position on Saturday 28 May as part of our plans to expand the WRH Emergency Department. Thanks go to our Estates Team for ensuring the process went smoothly and for managing the re-direction of the traffic into the hospital site. We remain on track to open the facility in late July/early August.

10 Trust Management Committee (11-5-16)

10.1 STP – planned care

TMC agreed to progress more collaborative working with Herefordshire clinicians for ENT, Clinical haematology and colorectal surgery. We are also focusing on improvements that can be made by better integrating acute and primary care clinicians. Work is being taken forward quickly to meet the STP submission date of 30 June.

10.2 Electronic Prescribing & Medicines Management

A business case was presented to commission a product from 'off the shelf'. TMC agreed to the termination of the current contract due to the lack of supplier response in relation to critical risks and the tendering for an 'off the shelf' product was agreed, subject to more detailed financial modelling around the clear benefits.

10.3 Renal strategy

An update was given to the work being undertaken to develop a renal service in the County. A partner has been identified to help the Trust develop its own service within five years. Assurance was given on the involvement and support of local commissioners. It was agreed that the next steps would be to outline the strategic intentions at the Trust Board and then update the strategic business case. A timeline is now being developed.

10.4 Key documents

A group has been meeting to approve key documents on behalf of TMC. The Group has approved 19 policies since November 2015 ranging from a Policy on Volunteers to clinical policies such as the use of oxygen through nasal cannulas.

10.5 Local Digital Roadmap

This is about the Trust becoming paperless by 2020. The Trust is working with other healthcare colleagues in relation to patient records. This work links to the STP process and the paper was discusses at the Strategy and Transformation Committee at its last meeting.

10.6 Cancer and RTT – recovery plan

Assurance was given on the governance arrangements for the delivery of the cancer and RTT targets. Each division then presented their plans for recovery.

Concern was expressed about how best to meet the increasing demand for cancer diagnosis and treatment driven by the national advertising campaigns which has increased awareness. It was agreed that a multi-professional workforce plan was crucial to ensuring the sustainability of the targets moving forward.

11 New Chair – Worcestershire health Scrutiny

The New chair for Worcestershire Health Scrutiny is Cllr Alan Amos. He replaces Cllr Andy Roberts who has moved to join the Cabinet.

12 National Update

12.1 Queen's Speech

The following items were included in the Queen's speech:

- NHS (overseas visitors charging bill): This is a commitment to introduce legislation to ensure that only UK residents who live in the UK lawfully and make a financial contribution to the country will get free NHS care.
- Seven day services: A further on-going commitment was made in respect of seven day NHS services
- Sugar tax: There was confirmation that legislation will be coming forward to implement the levy

12.2 Junior Doctors Industrial Action

It is pleasing to note that a mutually agreed settlement has been reached through negotiation. It is now hoped that this is accepted by BMA members so that disruption to services can come to an end.

13 Recommendation

The Board is asked to

- Receive the assurance contained within the report

Chris Tidman
Interim Chief Executive

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 08 June 2016 **Enc D1**

Report to Trust Board in Public

Title	Trust Control Plan and Performance Framework Trust Priorities
Sponsoring Director	Sarah Smith, Director of Planning and Development
Author	As above
Action Required	The Board is asked to receive the Trust Plan for 2016/17 which is presented as a control plan with an associated performance framework
Previously considered by	Executive Management Team

Priorities (√)

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

Related Board Assurance Framework Entries	This item relates to all the current BAF risks
Legal Implications or Regulatory requirements	

Key Messages

The Trust plan for 2016/17 has been developed as a simple control plan with an associated performance framework to clarify and simplify the messages for staff across the Trust.

The plan presentation also supports a stronger focus on performance management by the Trust Executive Team in line with the Trust turnaround situation.

The 2016/17 plan provides a bridge between the existing five year Integrated Business Plan for the Trust (and associated strategic goals) and the Herefordshire and Worcestershire Five Year Sustainability and Transformation Plan, which will in turn require that the Trust to reset its five year plan in this context.

Date of meeting: 08 June 2016 **Enc D1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JUNE 2016

1. Situation

This paper provides a summary of the Trust Plan for 2016/17 by way of a control plan and associated performance framework

2. Background

The Trust is in a turnaround situation with a requirement to deliver the necessary improvements to the quality and safety of care (and subsequently leave the special measures regime) and to recover the financial deficit position.

The Trust Board approved the decision to simplify and clarify the priorities for staff for 2016/17 to focus on four key aspects:

- Invest in our staff;
- Deliver better performance and flow;
- Improve patient safety; and
- Stabilise our finances

The Trust has also taken the opportunity to learn from the West Mercia and Warwickshire Constabulary in terms of the cascade of priorities and plans and the links to the performance regime. Consequently Trust priorities for 2016/17 are presented as a control plan with associated performance framework.

The 2016/17 plan provides a bridge between the existing five year Integrated Business Plan for the Trust (and associated strategic goals) and the Herefordshire and Worcestershire Five Year Sustainability and Transformation Plan, which will require the Trust to reset it's five year plan in this context.

In 2016/17, in development terms, the Trust will focus on the creation of a countywide vision and strategy for Medicine that is aligned with the STP proposed models of care.

In turn, the development of the STP is intended to support the Trust in addressing the quality and safety concerns that have resulted in the CQC overall rating of inadequate and the placing of the Trust in special measures.

3. Assessment

3.1 Key risks

There are some major programmes of work in the Trust Control Plan alongside some fundamental improvements in the way the Trust operates. It is essential that Trust staff are engaged in these programmes and that the priorities are clearly communicated, translated and understood.

The Trust is facing some significant performance issues and there needs to be a strong focussed approach to performance management from the Executive

Team.

The Trust needs to remain engaged with the development of the Sustainability and Transformation Plan and needs to work with clinical staff to reset the Trust longer term vision and strategy in this context.

3.2 Controls in place

The Control plan and performance framework are intended to provide a strong focus on in-year priorities and a simple and clear communication tool for staff.

The Executive Team have agreed a stronger focus on operational and financial performance through the monthly and quarterly Divisional performance review meetings.

The development of a vision and strategy for Medicine is seen as key to unlocking some of Trust's financial and operational performance challenges.

3.3 Gaps in controls and mitigation

Through the delivery of the PCIP it has become evident that the Trust lacks a significant degree capacity and capability to deliver service improvement alongside operational performance challenges and additional resources have been identified to support the improvement work.

Staff have expressed a lack of clarity around Trust priorities and the approach for 2016/17 has been developed in response to this issue.

4 Recommendation

The Board is asked to receive the Trust Plan for 2016/17 which is presented as a control plan with an associated performance framework

Sarah Smith
Director of Planning and Development

Worcestershire NHS
Acute Hospitals NHS Trust

TRUST CONTROL PLAN 2016/17

Vision	**Aiming for GOOD; aspiring to OUTSTANDING**			
Context	Care Quality Commission Inspection rating 'Inadequate' – WAHT in *special measures* regime Herefordshire and Worcestershire Five Year Sustainability and Transformation Plan			
Trust Priorities	**Investing in staff** 	**Delivering better performance and flow** 	**Improving Patient Safety** 	**Stabilising our finances** 
Patient Care Improvement Plan (PCIP)	➢ Organisational Development Plan ➢ Staff Engagement Programme	➢ Urgent Care and Patient Flow Programme	➢ Reducing Mortality Programme ➢ Governance and Safety Action Plan	➢ Medical Workforce Plan
		Developing our seven day services		
Other Improvement Plans / Major Projects	Listening into Action	➢ Acute Services Reconfiguration Programme ➢ Commissioning for Quality and Innovation (CQUIN) Programme ➢ Outpatient and Waiting Time Improvement Programme ➢ Elective Productivity Improvement Programme		
In - year essentials	***Best practice in:*** ➢ Recruitment and retention ➢ Performance appraisal and personal development plans ➢ Mandatory training compliance	***Performance improvement:*** ➢ 4 hour emergency access standard (EAS) ➢ 18 week referral to treatment (RTT) standard ➢ 62 day cancer waiting time standard ➢ 6 week diagnostic waiting time standard	***Safety & Improvement Culture*** ➢ Build improvement capability ➢ Develop new patient & public engagement strategy ➢ Design & launch Trust Safety Campaign ➢ Improve Incidents & Complaints management ➢ Strengthen governance & assurance processes	***Restoring controls:*** ➢ Budgetary management ➢ Reducing agency staffing/expenditure ➢ Delivering the contract activity plan
Strategic development	A countywide vision and strategy for Medicine Safe, sustainable countywide service strategies for W&C, SCS and Surgery			

Worcestershire NHS
Acute Hospitals NHS Trust

TRUST PERFORMANCE FRAMEWORK 2016-17

Aiming for GOOD; aspiring to OUTSTANDING

Priorities	Deliverables	Measures
Investing in staff 	➢ Improved evidence of staff satisfaction as measured by the national staff opinion survey ➢ Reduction in staff turnover ➢ Reduction in sickness absence ➢ Mandatory training compliance ➢ Performance appraisal completion	– ChatBack survey results – Staff turnover % – Sickness absence % – Training compliance % – Appraisal rates % – Staff FFT scores
Delivering better performance and flow 	➢ Start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions; ➢ Seen by a cancer specialist within a maximum of two weeks from urgent GP referral where cancer is suspected. ➢ A maximum four-hour wait in A&E from arrival to admission, transfer or discharge; ➢ Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral; ➢ A maximum two month (62-day) wait from urgent referral for suspected cancer to first treatment ➢ All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant ASAP but at the latest within 14 hours from the time of arrival at hospital	– RTT performance and backlog – Cancer 2ww performance – Cancer 62 day performance – Diagnostic waiting time by modality – Time to specialty review in ED – Trust EAS performance – Time to first Consultant review – emergency admissions – Patient FFT
Improving Patient Safety 	➢ Build an internal programme of Quality Improvement approaches offering 4 levels of expertise ➢ A stronger dynamic collaboration with community we serve ➢ Transparent, efficient incident & complaints processes ➢ Evidence of co-production ➢ Targeted improvement: ○ "Safe 6 : Sepsis, Preventing deterioration, AKI Falls, Pressure Ulcers #NOF, ○ Prudent Antimicrobial prescribing ○ Device -related infections ○ Mortality Reviews & learning	– No. staff trained in improvement techniques – Improvements in patient surveys/feedback – Complaints compliance to 25 day standard and 100% acknowledgement in 3 days – Improved HMSR & SHIMI due to: ○ Sepsis – compliance to bundle ○ Reduction in cardiac arrests ○ NEWs documentation completed ○ Reduction in device related bacteraemia ○ All patients with # NOF fit for surgery with have their operation within 36hrs – % reduction in falls with harm & overall rate – Eliminate back-log of open incidents – 90% SI's completed within timeframe – Mortality reviews completed within agreed timeframes
Stabilising our finances 	➢ Medical recruitment ➢ Agency expenditure ➢ Contract activity delivery ➢ CIP delivery / budgetary control	– Medical vacancy rates – % Medical and Nursing agency expenditure – Actual vs plan Budgetary expenditure – Actual vs plan Outpatient activity – Actual vs plan Day case elective activity – Actual vs plan Inpatient elective activity

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 08 June 2016 **Enc D2**

Report to Trust Board in Public

Title	Herefordshire and Worcestershire Sustainability and Transformation Plan (STP)
Sponsoring Director	Sarah Smith, Director of Planning and Development
Author	Sarah Smith, Director of Planning and Development
Action Required	The Board is asked to review the progress with the local Sustainability and Transformation Plan, and the requirements in respect of the June 30th 2016 Gateway submission
Previously considered by	

Priorities (√)

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

Related Board Assurance Framework Entries	This item relates to all the current BAF risks
Legal Implications or Regulatory requirements	
	NHSE – NHS England NHSI – NHS Improvement

Key Messages

The Herefordshire and Worcestershire Sustainability and Transformation Plan is due for submission for the next 'gateway' review on June 30th 2016.

The national process is iterative and, following the April 'gateway' submission, there are clear expectations for the June submission based on the degree of maturity of the planning footprint relationships.

The Herefordshire and Worcestershire STP programme received feedback on the April submission that was not significantly out of line with the majority of other STP areas however the scale of the local financial challenge is significant.

The latest guidance (relating to the June 30th submission) provides a challenge to the Herefordshire and Worcestershire STP in terms of closing the health, quality and finance gap and identifying what are the key transformational changes to achieve sustainability by 2020/21 and beyond. This is compounded by the gap across the system in terms of available capacity to do this improvement' work, and by Two Trust's in the patch in special measures with internal improvement priorities.

Title of report	Sustainability and Transformation Plan
Name of director	Sarah Smith

Date of meeting: 08 June 2016 **Enc D2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JUNE 2016

1. Situation

This paper provides an update to the Trust Board on progress with the Herefordshire and Worcestershire Sustainability and Transformation Plan and the expectations in respect of the June 30th 2016 'Gateway' submission.

2. Background

Shared planning guidance was issued by NHSE in December 2015, which described the expectations in terms of the submission of 2016/17 operational plans by individual provider and commissioner organisations, and the requirement to move towards the development of a 'place – based' five year Sustainability and Transformation Plans (STPs). Locally the STP covers Herefordshire and Worcestershire.

In essence and in line with the NHSE Five Year Forward View (FYFV), STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances, and the STP is framed within the national transformation fund that was agreed in the comprehensive spending review in November 2015, to support delivery of the FYFV

Nationally there are 44 STP planning foot prints, each with a nominated leader and an agreed set of governance arrangements. Each STP footprint was required to make an early gateway submission in April 2016, setting out the leadership, governance and collaborative working arrangements for the local STP and the emerging priorities and proposals. These were derived from a gap analysis focussing on the triple aim: health and wellbeing gap; care and quality gap and finance and efficiency gap, plus the local self - assessment in respect of the ten priorities described in the NHSE 2016/17 Business Plan (See Appendix One).

At a national level, following the initial STP submissions in April, it was clear that although a great deal has been achieved in a short period of time, every footprint is at a different starting point in terms of their collective understanding of their current position and their proposals for the future with a marked difference between those areas where work was already in train across a geographical area and those areas with less history of partnership working at a strategic level.

In broad terms, feedback on the Herefordshire and Worcestershire STP submission shared a lot in common with others in terms of having a greater focus on the identification of problems and less on the solutions, and the inclusion at this stage of too broad a range of priorities. 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.

The next checkpoint is June 30th 2016, when each footprint will submit the next iteration of their plans, building on the April submissions by:

- Ensuring a shared understanding of the current state in relation to the three gaps (health, quality, finance) and where the system needs to be by 2020/21, taking into account indicative allocations in respect of the Sustainability and Transformation Fund in 2020/21 and the requirement to achieve financial balance
- Presenting an overall coherent strategy for the footprint that reflects the 5YFV ambition to keep people well, with strong primary care, community based services and support at home, and the optimal use of the acute sector across the system
- Identifying the 3-5 critical decisions required to realise the vision
- Setting out the anticipated benefits in terms of health, quality and financial impact, making clear the timescale for anticipated benefits working back from 2020/21 to 2016/17
- Where possible, set out how this will enable delivery the ten key priorities set out in March (note that this only to be included for those footprints with pre-existing system plans, not those just starting their journey)
- Identify which actions lie within individual organisations and which require system wide change/action and/or are dependent upon the actions of other partners/neighbouring footprints
- Assess the degree of consensus/support for any proposed changes, and plans for meaningful engagement with workforce, the public and key partners

The plans submitted on June 30th will form the basis for a conversation with the national leadership throughout July. Submissions will therefore be work in progress, and as such do not require formal approval from boards at this early stage. The plans however must reflect a shared view from the system leadership team and a robust plan to engage more formally with boards and partners following the July conversations.

3. Assessment

3.1 Key risks

Sustainability and Transformation Plans are being developed at pace to support delivery of the Five Year Forward View set out by NHSE in December 2014. Progress varies according to the stage of maturity of the system in terms a history of 'place' and existing planning on a place – based footprint.

Although there is a history of planning and service provision on a Herefordshire and Worcestershire basis, the STP represents a fresh opportunity and relationships are being re-established, whilst acknowledging that there are existing in - county programmes of work that need to continue to develop and deliver.

The latest guidance (relating to the June 30th submission) provides a challenge to the Herefordshire and Worcestershire STP in terms of closing the

health, quality and finance gap and identifying what are the key transformational changes to achieve sustainability by 2020/21 and beyond.

3.2 Controls in place

The Herefordshire and Worcestershire Programme Board has established two planning away days to establish a shared understanding of the challenge and to start to develop some potential proposals to close the triple aim gaps.

A small group of organisation representatives from Herefordshire and Worcestershire is meeting to review the role for strong primary care, community based services and support at home, to ensure the optimal use of the acute sector across the system

The Herefordshire and Worcestershire STP is in receipt of regular oversight and support from both NHSE and NHSI.

3.3 Gaps in controls and mitigation

There is an acknowledged gap across the system in terms of available capacity to do this improvement' work, compounded by Two Trust's in the patch in special measures with internal improvement priorities.

The Herefordshire and Worcestershire STP has had access to a limited amount of the 2016/17 transformation fund to support this work and partner organisations are providing support 'in kind'.

4 Recommendation

The Board is asked to review the progress with the local Sustainability and Transformation Plan, and the requirements in respect of the June 30th 2016 Gateway submission

Sarah Smith
Director of Planning and Development

Date of meeting: 08 June 2016 **Enc D2**

Appendix One: Ten priorities for 2016/17 – NHS England Business Plan

Title of report	Sustainability and Transformation Plan
Name of director	Sarah Smith

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 8 June 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 about the implementation of the CQUIN on antimicrobial prescribing • Note the deep dive report into Medicine division • 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 19 May 2016

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Date of Trust Board: 8 June 2016 **Enc E1**

REPORT TO TRUST BOARD – 8 JUNE 2016

1. Situation

This report provides the Board with key quality issues and risks discussed at the QGC's meeting held on 19 May 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 Assurance

Ms Stevens outlined an approach to assurance and the strengthening of the clinical governance systems and processes. The work with Oxford Hospitals FT was key to this.

3.2 Quality Account and Corrective Action Statements

Concern was raised by the number of urinary tract infections in people with a long term catheter. Assurance was given that work was underway with the community and within the hospital on device infections. Trajectories were presented in relation to the improvement in time to theatre for patients with a fractured neck of femur.

3.3 Cancer and RTT – harm

The work being undertaken on harm reviews was outlined. Concern was expressed about the number of patients waiting.

3.4 Operational Governance group and avoidable mortality

HSMR continues to decline. Work is being undertaken with GP leads on deaths outside hospital as the SHMI continues to be high.

3.5 CQUIN

The Director of Pharmacy outlined the CQUIN for antimicrobial prescribing. The aim was to reduce antimicrobial prescribing and there are four key targets to meet. Progress will be monitored via the routine CQUIN report to the Committee.

3.6 Health and Safety update

Concern was expressed about the slow progress of training within the Theatres. Additionally, concern was expressed about the lack of assurance in the engagement of divisions in the health and safety agenda.

3.7 Quality Exception Report

The Medicine division presented their deep dive report. The number of open incidents was reducing. The Division has appointed a mortality lead to ensure a more focussed approach and have agreed to concentrate on secondary

mortality reviews. Assurance was provided in respect of the timely administration of antibiotics for sepsis; timely VTE assessment and management of stranded patients. The Full Hospital Protocol has been deployed twice and this support faster discharge of patients with no adverse effects on patients.

3.8 Quality Account

The Quality Account was approved by the Committee and is for approval by the Trust board at this meeting.

4 Recommendation

The Board is requested to:

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

Dr Bill Tunnicliffe
Chair – Quality Governance Committee

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc E2**

Report to Trust Board (in public)

Title	**Quality Account 2015/16**
Sponsoring Director	**Jan Stevens, Chief Nursing Officer**
Author	**Chris Rawlings, Head of Clinical Governance & Risk Management**
Action Required	The Board is asked to approve the Quality Account for 2015/16
Previously considered by	*Quality Governance Committee*

Priorities (√)

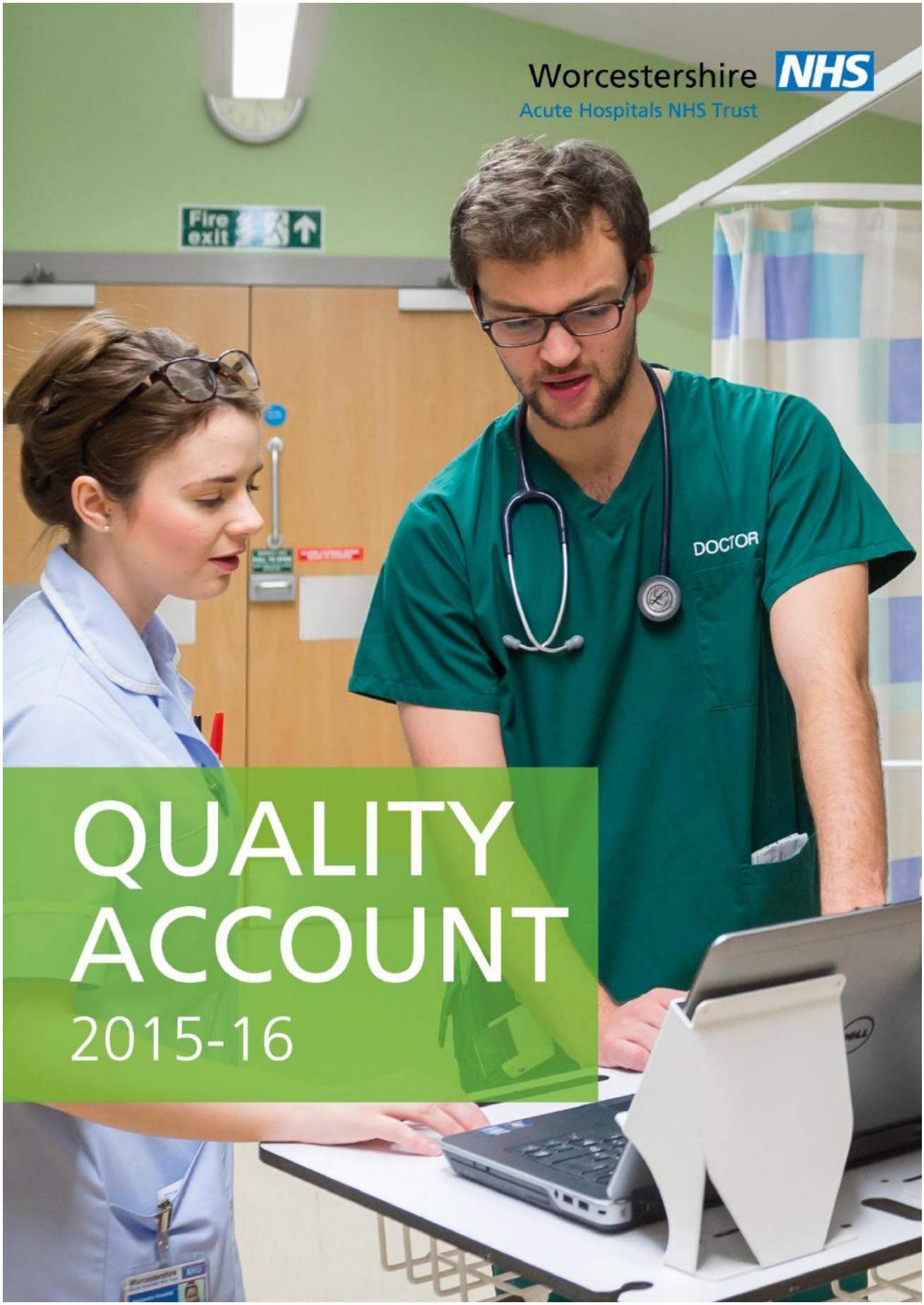
Investing in staff	
Delivering better performance and flow	
Improving safety	✓
Stabilising our finances	

Related Board Assurance Framework Entries	n/a
Legal Implications or Regulatory requirements	NHS Trusts are required by regulation to publish an annual Quality Account by 30th June each year. The regulations include some mandatory content and assurance statements from the Board.
Glossary	Quality Account – an annual report required by regulation that provides and honest and accurate account of a Trust's quality performance.

Key Messages

- The Quality Account for 2015/16 has been prepared to meet the regulations and provide an honest and factual account of the quality of the services provided by Worcestershire Acute Hospitals NHS Trust.
- Stakeholders have been invited to provide commentaries on the Quality Account as required by regulations. The Worcestershire Health Overview and Scrutiny Committee have been unable to provide a commentary this year.
- The External Audit of the Quality Account has been conducted. One mandatory indicator – Venous Thromboembolism Assessment has not been validated. As in 2014/15 this will lead to a qualified opinion.
- The Chairman and Chief Executive are required to sign the declaration in the Quality Account.
- The Quality Account will be published on the NHS Choices website before 30th June 2016

Title of report	Quality Account 2015/16
Name of director	Jan Stevens


Worcestershire NHS
Acute Hospitals NHS Trust
Fire exit
DOCTOR
QUALITY ACCOUNT
2015-16

Overview of the 2015/16 Quality Account

We have compiled this document to provide readers with information about Worcestershire Acute Hospitals NHS Trust.

About the Trust
Worcestershire Acute Hospitals NHS Trust provides hospital-based services from three main sites - the Alexandra Hospital in Redditch, Kidderminster Hospital and Treatment Centre, and Worcestershire Royal Hospital in Worcester.

- We provide a wide range of services to a population of more than 550,000 people in Worcestershire as well as caring for patients from surrounding counties and further afield.
- The Trust employs more than 5,500 people and have an annual turnover of over £360 million.

What is the quality account and why is it important to you?

Worcestershire Acute Hospitals NHS Trust is committed to improving the quality of our services we provide to our patients, their families and carers.

Our 2015/16 quality account is an annual report of:

- How we have performed over the last year against the priorities which we set out in last years' quality account.
- Statements about quality of the NHS services provided.
- How we have engaged staff, patients, commissioners, governors, Healthwatch and local Overview and Scrutiny Committees (OSCs) in deciding our priorities for the year.
- Statements about quality provided by our commissioners, governors, OSCs, Healthwatch and Trust directors.
- Our priorities setting out clearly how we are going to improve in the coming year (2016/17).

As you read this report we hope that it will explain what we believe that great care looks like and what you can expect if you need use your local NHS services.

If you would like to know more about the quality of services that are delivered at the Trust or any of our hospitals further information is available on our website www.worcsacute.nhs.uk/

Contents

Statement from the Chief Executive

Worcestershire Acute Hospitals NHS Trust remains committed to delivering compassionate care for our patients.

The Quality Account forms part of our annual report to the public about the quality of our services. It describes our key achievements during 2015/16 and our priorities for quality improvement during the forthcoming year. In developing our Quality Account we have identified and shared information across the Trust with our doctors, nurses, therapists and management teams, as well as our service users and those who commission services from us.

Challenges and focus

2015/16 was a very challenging year for the Trust, which started with unannounced visits to our Emergency Departments (ED) by the Care Quality Commission (CQC), following concerns about safety and performance due to overcrowding.

Early in the year, the Trust also experienced a considerable change in personnel at Board level, and it is noteworthy that significant operational stability was restored rapidly.

As for many NHS organisations, our quality improvement plans are set against a background of continued pressure on services and an absolute commitment to deliver safe services for the people we serve.

Providing care within national waiting time standards has continued to be difficult for us, with particular challenges in emergency inpatient services, diagnostic services, some areas of planned surgery and waits for first cancer treatment.

Continued pressure on our inpatient services for people needing urgent care, as well as the rise in ambulances arriving at our A&E departments, has meant that we have not met the national standard for seeing, treating, admitting or discharging our emergency departments within four hours. This is an issue which many hospitals are facing. Despite a very busy winter, year-on-year we are seeing improvements, but we are by no means complacent and are committed to ensuring that all of our patients are seen and treated as quickly as possible.

Patient flow is a key issue for our hospitals as we regularly see the levels of bed occupancy reach 100%. As part of our on-going improvement journey we are continuing to work with the NHS Emergency Care Intensive Support Team to develop our services so that we can provide the urgent care people need quickly whilst minimising the use of hospital beds.

We have commenced work to expand our Emergency Department at Worcestershire Royal Hospital and have recently introduced an ambulatory care system which means that those needing to see a consultant specialist can be seen quickly without having to be admitted to a hospital bed. This is especially beneficial to frail elderly patients and those with complex needs as it delivers high quality care and prevents unnecessary admissions to a hospital bed. We have a high number of patients remaining in hospital after their acute episode has finished and we will continue to work with our healthcare partners to address this.

In much of 2015/16, the national standard for treating patients who are referred by their GP with suspected cancer within 62 days was not met. Changes in patient pathways and on-going issues with high levels of demand are being addressed, including additional consultant staffing and theatre realignment.

Patients referred for planned care have also waited longer than the '18 week referral to treat' national standards during the year, however month-on-month improvements have been made with at the end of the year the standard being affected …

We continue to control the rate of C.difficile infections, with fewer cases (29) in 2015/16 than the year before (36), or than our 2015/16 target (33).

Particular pressures have been faced in specialist surgery and we are continuing to work closely with those specialties experiencing high levels of demand for their services including dermatology and thoracic medicine.

Over the year we have focused on patients who have had symptoms of breast cancer and referred under the 2 week wait system for assessment and although the overall year performance is below the national standard, we achieved the standard in the last two months of the year. During the year we were able to appoint to two new registrars and this has further helped in us being able to provide more clinics for our patients.

Throughout the year we have continued to assess our compliance on nursing numbers and how we perform with regard to the numbers of shifts filled.

Engaging stakeholders to transform services

In 2015, 'Risk Summits' were held with patients, clinicians and our commissioners to develop and improve our services specifically around urgent care and maternity services. Following concerns raised by clinicians over patient safety we made the difficult decision, in consultation with our commissioners, to make temporary emergency changes to maternity, neonatal and gynaecology services in Worcestershire.

These were decisions we did not take lightly but our focus has always to be on patient safety. NHS England, the NHS Trust Development Authority and the county's three Clinical Commissioning Groups have all agreed that, despite extensive recruitment campaigns, staffing levels have not improved sufficiently to allow these temporary emergency changes to be reversed.

I recognise that many people will be disappointed that we are still not in a position to reverse these temporary emergency changes but safety of patients has to be our primary concern. There are simply not enough staff to safely run services across the two sites on a 24/7 basis. The current shortage of specialist staff, which is a national problem, means it would be unsafe to reverse these emergency arrangements.

This year we were extremely pleased to be part of the system-wide proposed Clinical Model for the Future of Acute Hospital Services in Worcestershire. Agreed by clinicians from across the county, along with the three Clinical Commissioning Groups (CCGs), we now look forward to the proposals going through the West Midlands Clinical Senate's assurance process. In the proposed model, emergency gynaecology, neonatal and consultant-led births in the county are all to be centralised at Worcestershire Royal Hospital. The CCGs are

committed to consulting on the possibility of introducing a midwife-led birth centre in the north of the county for low-risk births. The proposed clinical model will be put to public consultation before any permanent changes are made, and under the current timetable this will take place later in 2016.

Our regulators

The Care Quality Commission (CQC) conducted a full inspection of the Trust's three sites in July 2015, producing their report in December 2015. In this we were recognised as a very caring organisation and of the 115 domains they reviewed, 54 were rated as good, 46 require improvement, 13 were inadequate and 2 domains were outstanding. All services were rated as good or outstanding for care and the CQC also commended the Trust's leadership team for the level of understanding and commitment shown over recent months.

Our overall rating of inadequate was very disappointing and was due largely to concerns over the risks about our maternity and paediatrics services, services that we and our commissioners had already recognised as needing change. Therefore, the CQC report is helpful in endorsing the actions we had already taken. For example, the enhanced leadership and governance support provided to maternity and paediatric services since July, coupled with the decision to temporarily suspend birthing services at the Alexandra Hospital, has significantly reduced the risk profile of the services.

At the time of inspection, the CQC recommended that we required an enhanced level of support to continue our improvement journey. Following its report the CQC recommended that we should be put into 'Special Measures' which in the NHS means that we are provided with additional support to assist in a programme of further improvement. With an Improvement Director already in place and support being received from ECIP we also were able to access further support from a neighbouring trust to support our maternity and paediatric improvements and a nationally recognised trust to assist on governance.

Our people

Our people are our greatest asset. Engagement of staff from ward to Board is fundamental to improving the quality and safety of care across all Trust sites. It is testament to staff that despite the challenges the Trust has faced; the CQC found the staff approach to caring for patients to be good and in some cases outstanding, and the Trust must build on this going forward, especially in light of the disappointing results for the Trust from the recently published 2015/16 National Staff Survey.

Our open and 'Big Conversation' approach which we started in October last year will be further supported in 2016/17 as we launch Listening into Action (LiA). This is a tried and tested programme called which has already led to increased engagement and morale of staff in other NHS trusts, and supports an important aim of our strategy – to listen to what frustrates staff at work, what they would like to see improve and change, and how leaders can support, enable and 'unblock the way' for staff to make that change happen. Our LiA journey over the initial 12 months will include a high profile round of LiA Staff Conversations to create an clear view of 'what matters to staff', a series of 'big impact' actions in response, and support for the first 10 and then next 20 teams 'on the ground' to adopt LiA as a vehicle for change.

The key Trust priorities for 2016/17 are:

1. **Delivering better performance and flow**, by supporting the Medicine Division to:
   Create a sustainable countywide strategy
   Deliver ambulatory care to avoid admission
   Reduce the number of stranded patients

2. **Improving safety** by:
   Learning from incidents and harm reviews in a 'no blame' culture
   Reconfiguring fragile services
   Reducing overcrowding and occupancy levels
   Making data transparent to expose variability

3. **Investing in our staff** to:
   Find solutions through teamwork
   Develop new roles, improve recruitment and retention and to reduce reliance on agency staff
   Become our ambassadors and to promote our organisation

4. **Stabilise our finances** by:
   Delivering priorities 1-3
   Managing to budget and delivering better value for money

The Trust enters 2016/17 with a major challenge around its financial position. Major progress was made in the later part of 2015/16 but this still leaves us with the challenge of continuing to improve quality and reduce our overall deficit. Primarily our position is a result of on-going issues with patient flow and bed occupancy and the need to open and staff additional non-elective bed capacity, leading in turn to a reliance on premium rate temporary staffing. This also impacts negatively on the delivery of the elective programme and on income levels. We are committed to delivering against this challenge.

Our teams are focused on our forthcoming CQC inspection and delivering against our programme of patient care improvement. This will enable us to ensure that we head towards being out of special measures by the end of the year and are able to demonstrate to our Regulators the significant improvements we have made to key areas highlighted including learning from mistakes and reporting of incidents.

We are focused on building on our success in attracting great people to come and work at the Trust as well as developing new roles with the support of Worcester University. Through LiA we will be looking to improve staff engagement and focus on quality improvements for our patients. This will be further supported by the progress of the Future of Acute Hospital Services as this enables clarity of the services on each site to be delivered.

In short it will be another very busy year for the Trust, set against a very complex and changing NHS. We are totally focused on delivering the highest quality, safe and sustainable care for the whole of Worcestershire and to achieve this will be working even closer with our healthcare colleagues from across the county throughout the year. I would like to put on record my sincere thanks to all of the staff working at the Trust who have gone the extra mile

during a very difficult year and have taken up the challenge of improving services for the benefit of the patients we serve.

I am pleased therefore, to present our Quality Account for 2015/16 to you which I believe to be a fair and accurate report of our standards of care across the Trust.

Chris Tidman

Acting Chief Executive

Looking back: progress on quality priorities for 2015/16

This section of the report describes our quality improvement priorities for 2015/16 and the progress we made during the year. Some of the work will roll over into next year.

Quality Priorities 2015/16	Quality domains			Additional CQC quality domains	
	Patient safety	Clinical effectiveness	Patient experience	Responsive	Well-led
1. Restore operational performance with a specific focus on Emergency Departments	✓			✓	
2. 'Sign up to Safety' campaign	✓				✓
3. Improve outcomes and experience for patients with a fractured hip	✓	✓	✓		
4. Improve mortality surveillance	✓				✓
5. Reducing variation in mortality between weekday and weekend working	✓	✓			
6. Reducing harm from medicines incidents	✓				✓

1. Restore operational performance with a specific focus on Emergency Departments	**Not met**

Overview of achievement:

- The CQC condition required the Trust to ensure that every patient attending the Emergency Department at Worcestershire Royal Hospital to have an initial clinical assessment within 15 minutes of arrival. This has not been met consistently through 2015/16
- The 4 hour access standard has not been met for the year of 2015/16
- Building work to increase capacity at the Worcestershire Royal Hospital Emergency Department has commenced
- In the Trust's 2015/16 operational plan, the System Resilience Group (SRG) agreed £1m funding for sub-acute capacity, which translates into one additional ward for six months. In reality, as a result of the high levels of bed occupancy and bed days associated with poor patient flow, the Trust has utilised additional capacity throughout the year with at its peak, three additional wards open and multiple medical patients outlying on surgical wards, which has in turn impacted on the delivery of the planned elective programme.
- Worcestershire as a health and social care economy is part of the Emergency Care Improvement Programme (ECIP) and from Q4 2015/16 onwards has been receiving support with the implementation of the SAFER patient flow bundle, review of the system-led patient flow centre and the development of more ambulatory emergency care including frailty assessment. High levels of bed occupancy in itself leads to

delays and inefficiencies as patients are often not able to access the right bed first time.

Taking it forward:

- In light of the ECIP concordat, the Trust will work intensively with partners to address the issues with patient flow and to develop a trajectory for a reduction in the number of stranded patients at the Trust. This work is embedded in the Patient Care Improvement Plan and this must be delivered early in 2016/17. The Trust will reframe budgets in the second half of the year to reflect any realignment of capacity.
- Through the 2016/17 contract negotiations, the Trust will seek to ensure funded capacity to manage emergency surge pressures and will develop surge workforce plans aligned with this.
- In addition to these immediate capacity problems, the Trust has worked with partners in health and social care to develop an agreed longer term bed model for the county based on a shared set of demand assumptions. This model has identified under a range of planning scenarios, an underlying shortfall in the number of acute beds at the Worcestershire Royal Hospital site.

2. Sign Up to Safety Campaign	**Partially met**

Overview of achievement:

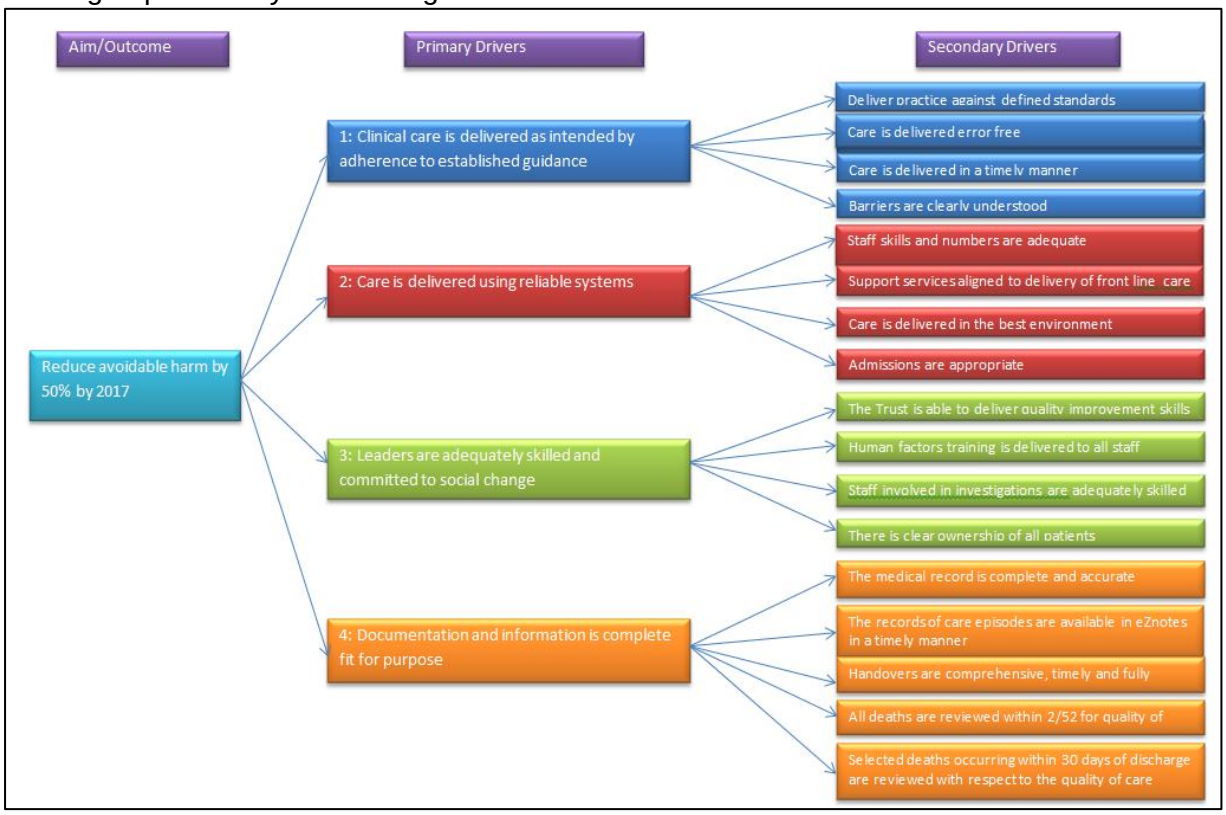
Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. Launched by the Secretary of State in 2014, the ambition is to halve avoidable harm in the NHS over the next three years, and save 6,000 lives as a result. The Trust has signed up to campaign.

We have established our 'sign up to safety' plan using the driver diagram below. We have identified that in terms of the primary drivers, Nos. 1 (clinical care is delivered a intended by adherence to established guidance), 2 (care is delivered using reliable systems) and 3 (leaders are adequately skilled and committed to social change) are comprehensively covered within the PCIP however we need to create an additional action plan to address deficiencies identified in respect of 4. Documentation is complete and fit for purpose, and this action is in train.

Taking it forward:

Integrate drivers within the Trust's improvement programmes developed during 2015/16 – create an additional plan for health records.

The Sign up to Safety Driver Diagram:



3. Improve outcomes and experience for patients with a fractured hip	**Not met**

Overview of achievement:

A range of actions taken to improve the access of patients with a fractured hip to theatre within 36 hours of presentation have had some positive impact but the 95% target has not been met for the financial year.

Actions taken:

- Prioritisation of patients with fractured hips to be done first on the afternoon Trauma Theatre Sessions
- Hip Fracture Escalation Policy implementation supported with daily reporting of achievement of the target
- Trauma Nurse Practitioners & Clinical Teams are reviewing and escalating daily trauma issues
- Theatre maintenance sessions have been rescheduled to not interfere with theatre availability

Taking it forward:

- A business case has been developed for additional weekend Trauma Theatre Sessions for both The Alexandra and Worcester Sites.
- The Surgical Division will continue to take action to improve performance in 2016/17.

4. Improve mortality surveillance	Partially met

Overview of achievement:

There has been progress with this priority but we intend to continue the work as one of the improvement programmes in 2016/17.

- Surveillance process has improved and awareness and engagement have improved. We identify deaths, provide primary review forms and primary reviews are provided with gradings for the care/concerns identified. Secondary reviews of concerns are undertaken and will generate more learning.
- Targeted case note reviews of diagnostic groups (patients/procedures) are identified from review of mortality data and undertaken by clinical teams.

Taking it forward:

- Carried forward into the improvement programme

5. Reducing variation in mortality between week days and weekend working	Partially met

Overview of achievement:

- In line with the commitment to achieving seven day services, the Trust has convened a Medical Workforce Assurance Group and is developing a progressive medical workforce plan and reviewing all of its Consultant job plans. The Trust has experienced chronic recruitment difficulties in some key clinical specialities in particular in Medicine. There is an emergency vision for the countywide acute medical service that is key to unlocking some of this
- Investment in development of roles such as Physician's Associate and Associate Nurse Practitioners agreed and recruitment under way
- Hospital at Night being launched in summer 2016
- There are already some enhanced and innovative services in place to maintain patient flow seven days a week, including diagnostic support services extending into the evenings and at weekends, the weekend pharmacy service and the nationally recognised pharmacist in A&E initiative

Taking it forward:

- Carried forward into the Organisational Development improvement programme
- 7 day services will be scoped during 2016/17 in line with national development and will be implemented incrementally concentrating on non-elective admissions and the Emergency Departments

6. Reducing harm from medicines incidents	Partially met

Overview of achievement:

- EPMA – we have produced a draft clinical specification for electronic prescribing at WAYHT, through the EPMA team working with a development partner, which reflects the improvement in functionality across the market
- Target higher risk medications – the drug chart has been designed to focus on higher risk medicines (as identified by a review of all medicines incidents) – insulin, anticoagulants, antibiotics, analgesics
- Restructure the governance of medicines optimisation through a Medicines Optimisation Committee (MOC), reporting to Quality Governance Committee. MOC is supported by sub groups focusing on safe medicines practice, policy, PGDs and procedures and medicines assurance. This programme of work is driven through the Divisions by governance leads. This structure will also deliver CQC, CCG and professional reporting requirements

Taking it forward:

- EPMA – A revised outline business case including the specification will be presented to TMC in May 2016
- Higher risk medications – continue to review incidents and patient safety alerts to identify high risk medicines – ensuring that communication, training, and policy revision reflects learning
- Governance – continue to drive a safe medicines culture and improve reporting to reduce harm. Deliver the annual action plan for medicines optimisation through the MOC

Looking forward: quality account priorities for 2016/17

This section of the report describes a selection of quality priorities for the coming year. They are part of a wider work plan designed to deliver high quality care to our patients.

One of the key drivers has been to respond to the results of the CQC inspection in July 2015. Our Trust Improvement Plan (TIP) contains all the “must do” and “should do” elements, and progress is closely monitored by our quality governance and management committees. Other drivers include national NHS priorities, as well as feedback from our local Healthwatch, service users and stakeholders in the wider health economy.

Domain	CQC domain	Quality priorities for the Trust
Patient safety	Safe	Improve patient safety through optimising patient flow and developing effective systems for early senior review
Clinical effectiveness	Effective	Ensure that we are learning from incidents and other harm reviews (including mortality reviews) and identifying and addressing the causes of avoidable harm to patients in our care; including pre-emptively through the adoption of early warning tools and best practice care bundles.
Patient experience	Caring	Develop a greater quality and safety culture across the organisation through engagement, training and staff development from ward to Board

Patient safety

Priority 1: Improve patient safety through optimising patient flow and developing effective systems for early senior review	
Why this is a priority	Emergency demand and the increased acuity of patients, the lack of available capacity and flow within the Trust and within the health and social care system, have been significant challenges in 2015/16 and have been major limiting factors for the Trust achieving optimal operating performance and quality of care. A good flow of patients through the hospital ensures that patients are in the right place at the right time and get the care they require when they need it. Poor patient flow creates difficulties throughout the hospital, most noticeably in the Emergency Department, but interferes with the provision of good care and patient experience. Patient who stay in hospital longer than the acute phase of their condition requires, continue to deteriorate.
How we will deliver the improvement	Four workstreams have been identified from review of systems and performance to support the delivery of this improvement aim:

	• Safer care bundle: Reduce length of stay through implementing best practice ward rounds and reduction in stranded patients • Frailty pathway: establish admission avoidance and rapid assessment of elderly care patients • Acute care model: a. Improve Emergency Department response time to improve quality and flow b. Establish acute medical service to support flow • Patient Flow Centre Evaluation: improve responsiveness to support flow and patient needs
Measures:	A range of measures will be used includeing: • % discharges before 12 midday • Less than 45% of over 75 year old patients who are stranded (Length of stay over 7 days) • Time to initial assessment in the Emergency Department (ED) 95% seen within 15 minutes. • % of patients spending more than 12 hours in the ED
Targets:	• 33% of discharges before 12am • Less than 45% of over 75 year old patients who are stranded (Length of stay over 7 days) • Time to initial assessment in the Emergency Department (ED) 95% seen within 15 minutes. • Less than 3.7% of patients spending more than 12 hours in the ED
Reporting route:	An Urgent Care Programme Board has been established to monitor progress in meeting these goals and take action where necessary to meet them. This reports to the Executive Improvement Board, which in turn reports to the Trust Board.
Responsible Officer:	Chief Operating Officer

Clinical Effectiveness

Priority 2: Ensure that we are learning from incidents and other harm reviews (including mortality reviews) and identifying and addressing the causes of avoidable harm to patients in our care; including pre-emptively through the adoption of early warning tools and best practice care bundles.	
Why this is a priority	The Trust's mortality ratio is higher than expected. We need to understand the factors that may contribute to this and direct our efforts to improvements that will increase the quality of care and reduce the mortality ratio to within its expected range.
How we will deliver the improvement	Four workstreams have been identified from review of systems and performance to support the delivery of this improvement

	aim: • Mortality reviews – Establish effective review of all patient deaths • Sepsis bundle – implement Sepsis Six for early detection and screening of patients with suspected sepsis and antibiotic therapy commenced within 1 hour of presentation • Fractured neck of femur – access to theatre within 36 hours of a patient presenting with a fractured hip • National Early Warning Score (NEWS) – introducing the best practice approach to management of the deteriorating patient. This replaces our current system.
Measures:	• SHMI (Summary Hospital Mortality Indicator) • HSMR (Hospital Standard Mortality Ration) • % of patients with completed early warning score • Sepsis bundle compliance • HSMR Sepsis • % of primary review forms received within 10 working days from dispatch • % of secondary review forms completed and presented within 60 days of request • Cardiac arrests per 1000 admissions • Proportion of clinical areas to which NEWS (National Early Warning System) has been rolled out against plan • % of patients admitted with a fractured hip undergoing surgery within 36 hours of admission
Targets:	• National targets for HSMR and SHMI • Graduated and increasing targets for completion of primary and secondary mortality reviews throughout the year • 90% of patients undergo surgery for fractured neck of femur within 36 hours
Reporting route:	An Avoidable Mortality Review and Improvement Board has been established to oversee the workstreams. This reports to the Executive Improvement Board which in turn reports to the Trust Board.
Responsible Officer:	Chief Medical Officer

Patient experience

Priority 3: Develop a greater quality and safety culture across the organisation through engagement, training and staff development from ward to Board	
Why this is a priority	There is a strong relationship between how a workforce feels and safe, effective care with a good patient experience. The Good Governance Institute's report in 2015 identified a number of issues that the Board are striving to address.

How we will deliver the improvement	Six workstreams have been established to support the delivery of this programme: • Leadership development to develop effective leaders • Culture improvement and safety – to develop a culture where employees are committed to safe, compassionate care and maximising productivity • Workforce plans – to support recruitment and retention of staff • Policies and standard – developing a clear set of policies for bullying and harassment and raising concerns • New roles and skills development – to meet current and future requirements
Measures:	• Staff turnover • Number of comments related to poor leadership at exit interviews • Staff opinion survey - key questions related to staff, including: bullying and harassment, support from their manager; feeling valued; confidence to report unsafe practice and incidents; working additional hours • HR case work – number of bullying and harassment cases • Occupational Health Referrals – Number of work - related stress referrals • Vacancies • Number of new roles created for Physicians Associates; Band 4 nurses; Ward Administrators or Ward Housekeepers • Number of compliant rotas – medical and dental
Targets:	• Staff turnover – 10% • Number of comments related to poor leadership at exit interviews - zero • Staff opinion survey - key questions related to staff, including: bullying and harassment, support from their manager; feeling valued; confidence to report unsafe practice and incidents; working additional hours – comparison with national average • HR case work– number of bullying and harassment cases- 0 • Occupational Health Referrals – Number of work - related stress referrals – 10 • Vacancies • Number of new roles created for Physicians Associates (12); Band 4 nurses (42); Ward Administrator or Ward Housekeepers (59) • Number of compliant rotas – Medical and Dental - 100%
Reporting route:	An Organisational Development Board has been established to oversee these workstreams. This reports to the Executive Improvement Board, which in turn reports to the Trust Board
Responsible Officer:	Director of HR

Review of other quality performance 2015/16

Patient safety

The safety of patients in our care and the prevention of avoidable harm is our highest priority. The rating from the 2015 CQC inspection for Safety was 'inadequate'.

The headlines from the inspection report included the issues below and some of the key work we have undertaken to improve since that time is also described. A Governance and Safety Improvement Plan was developed to target actions at the issues raised and a wider review of our governance arrangements was undertaken. This is now supported by our partner, Oxford University Hospitals NHS Foundation Trust:

- The environment was generally well maintained as was equipment. Action was taken at the time for the Alexandra Hospital Early Pregnancy Assessment Unit.
- The trust lacked a systematic approach to the reporting, management and analysis of incidents, which were not always reported or investigated in a timely manner, and feedback was not always provided on reported incidents leading to a lack of subsequent learning taking place.
    - We have an electronic incident reporting system, Datix, and we are regularly in the top 25% of highest reporters nationally. We had a backlog of unviewed incidents at the time of the inspection for which a plan was already in place with weekly monitoring reports. There is daily review of incidents by the Divisional Governance Teams and virtually all incidents are now reviewed within 7 days of being reported.
    - The large number of outstanding incidents in Maternity were addressed at the time of the inspection
    - Feedback on learning from incidents has been improved and is something we continue to work on. The 'Lesson of the Month' has been supported with feedback from the weekly serious incident review meetings. Datix has also been configured to email members of staff who report incidents the results of the review when it has been closed. System learning also takes place through changes made to policy or guidance which is implemented through training and changes in equipment, such as replacement of nasogastric tubes following an incident.
    - We will continue to train staff in investigation techniques to improve the quality of the investigation, its findings and recommendations. We know that if we understand the cause, we can design actions to address them and make care safer and more reliable. We already follow through relevant actions from serious incidents through to their completion and will take further measures to improve this and cover all incidents.
- The understanding of the categorisation of incidents was variable
    - There are several ways in which we categorise incidents – where they take place, the type of incident and a range of subcategories. Incidents are reviewed following reporting and corrections made but we are providing direct feedback to reporters who have mis-categorised incidents. We also categorise incidents by the level of harm that we cause. This is sometimes

confused by the outcome for the patient and is something we – and other Trusts – are working to correct.

- There was a lack of understanding of Duty of Candour in some areas.
    - We use the guidelines from the National Reporting and Learning System to categorise incidents by harm. We changed to this in 2014 because the Duty of Candour is triggered by significant harm incidents. Our work with the Duty of Candour is described in a section below.
- Some identified risks were not being reviewed or managed appropriately
    - This was the case for some risks. We had a two-year programme to improve risk management across the Trust supported by an expert risk officer. A clear process for identifying risks, checking with staff that the risk register reflects their concerns, their approval and development of actions to improve control is in place. Training is provided for managers to achieve this and risks are monitored for the timeliness of their review and completion of actions within the required timescales. This is reviewed within the Divisional Management meetings, performance reviews and at Trust committees with necessary action taken. This work will now be extended.

Other issues raised in the CQC inspection report concerning safety are covered in other sections of the Quality Account, including:

- Staffing and reliance on temporary staff in some areas
- Emergency Department consultant cover and overcrowding
- Attendance at mandatory training

Harm-free care

We established a new Harm Free Care Group in February 2016, chaired by the Deputy Chief Nursing Officer, to manage the improvements in care across these areas. This one meeting will replace separate meetings regarding these incidents to bring together the common themes, re-energise and motivate staff and to improve attendance.

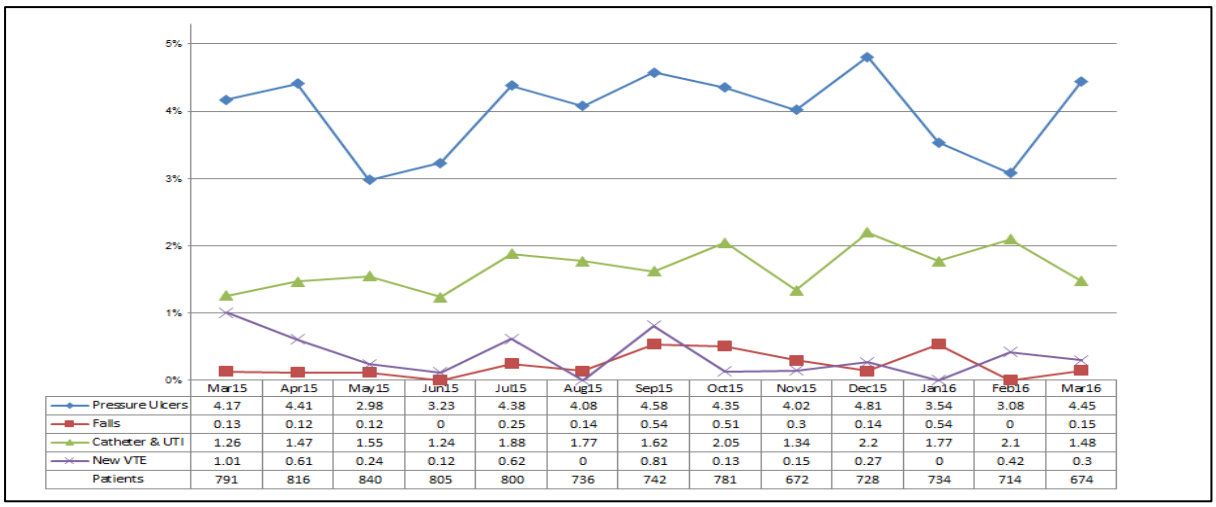
The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism during their working day, for example at shift handover or during ward rounds.

The Safety Thermometer is a point of care survey that is carried out on 100% of patients on one day each month.

The Harm Free target is 95 %. The Trust consistently has an overall score of between 92-95.1%. September 2015 saw the lowest score recorded since April 2014. The position has remained relatively consistent with Harm free scores around 94%.

Month	Apr 15	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan 16	Feb	Mar
No. surveys	816	840	805	800	748	742	781	707	728	672	728	674
No. harm free	764	800	771	746	708	689	727	665	676	633	676	632
% harm free	93.55	93.63	95.12	95.78	93.25	94.65	92.86	93.09	92.49	94.28	94.82	93.77

Safety Thermometer results 2015/16 – percentage harm



	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16
Pressure Ulcers	4.17	4.41	2.98	3.23	4.38	4.08	4.58	4.35	4.02	4.81	3.54	3.08	4.45
Falls	0.13	0.12	0.12	0	0.25	0.14	0.54	0.51	0.3	0.14	0.54	0	0.15
Catheter & UTI	1.26	1.47	1.55	1.24	1.88	1.77	1.62	2.05	1.34	2.2	1.77	2.1	1.48
New VTE	1.01	0.61	0.24	0.12	0.62	0	0.81	0.13	0.15	0.27	0	0.42	0.3
Patients	791	816	840	805	800	736	742	781	672	728	734	714	674

Patient falls

Falls remained consistently within the 95% target. The Safety Thermometer data is consistent with the overall patterns of patient falls across the Trust each month. The national average for falls per 1000 bed days (Royal College of Physicians Audit 2015) is 6.63. The average for the Trust is 5.03 for 2015/16.

Targeted interventions in the areas that saw increased numbers of patient falls has been undertaken and a number of issues have been identified in relation to the prevention of a number of these falls. These included:

- The number of patients with dementia or other mental health issues which pose challenges in an acute ward environment
- The Trust bank staff unable to meet the number of additional staff for 'specialing' or to provide specialist mental health trained staff
- Patients with mental health issues who could be discharged as no longer requiring acute care but suitable alternative placements cannot be found
- Patients whose care needs could be better met outside an acute environment requiring ongoing interventions which cannot be provided in secondary care e.g. IV antibiotics three times day

- Patients who are prone to seizures due to their medical condition

A number of actions were put in place to support these areas.

- The Professional Development Team visiting or phoning daily to offer support and advice to staff
- Weekly audits of falls success measures instigated (normally monthly)
- Documentation audited to ensure risk assessments and falls care plans are being completed appropriately
- Ensuring medication reviews are completed in a timely manner
- Further training on the use of alarms and other falls prevention equipment

The professional development team continues to work across the county on falls prevention strategies, and sharing documentation and good practice.

Pressure ulcers

The national target is for zero avoidable grade 3 and 4 pressure ulcers.
We had 117 patients develop avoidable grade 2, 3 or 4 pressure ulcers during 2015/15.
13 of these were Grade 3 or 4.

[Comparison with other Trusts]

Every pressure ulcer developed in hospital is reported as an incident and investigated. Accountability meetings are held for grade 3 or 4 pressure ulcers which are also reported as serious incidents.

Themes from pressure ulcer incidents have been identified and local and system wide actions being taken including:

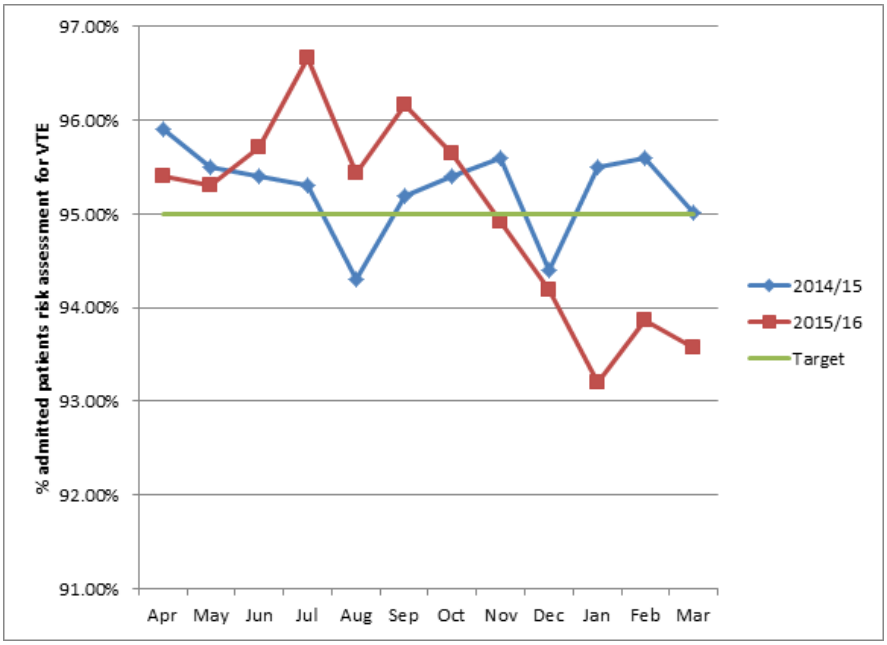
- Targeting additional training in areas where pressure ulcer incidence has increased
- Providing heel pads for patients waiting on trolleys in the Emergency Department
- Changing the format of accountability meeting to include ward staff on duty at the time the grade 3 or 4 pressure ulcer developed. This has had a positive impact

Venous Thromboembolism (VTE)

VTE (the formation of blood clots within the veins) is a condition that contributes to an estimated 25,000 deaths amongst patients in hospital each year, some of which could be avoided. VTE risk assessment and prophylaxis (preventative measures) have been national priorities since 2010. NICE guidance states that 95% of all adult inpatients should be VTE risk assessed (weighing their chance of developing a clot against their risk of bleeding) and given preventative therapy.

We have consistently achieved the 95% VTE assessment rate and did so again for the whole of 2015/16. However, performance fell below 95% in the last half of the year.

VTE assessment – comparison of 2014/15 with 2015/16



A range of actions have been taken to improve the assessment rate including:

- Introduction of a new VTE assessment form developed with the input of junior doctors to make it easier to use
- Communication to staff to encourage VTE assessment
- Requiring Ward Clerks to monitor the assessment of patients

Note: The data for this section is provided in the Performance Target section of this report.

Incident reporting and investigation

A high level of incident reporting reflects a good reporting culture and is an aim in the NHS Outcomes Framework. Our reporting rate slightly increased during the financial year from 36.0 incidents per 1000 bed days in 2014/15 to 38.74 in 2015/16. The total number of incidents and near misses also increased to 11255.

Severity of incidents

Severity	2013/14	2014/15	2015/16
No harm /insignificant	6540	7483	8163
Minor harm	3353	2417	2819
Moderate harm	521	298	222
Severe harm	47	21	19
Death	14	8	32*
Totals:	**10475**	**10227**	**11255**

(*the number of incidents rated as 'death' are subject to amendment following investigation and will reduce)

Patient safety incidents April 2013 to March 2016	2013/14	2014/15	2015/16
Number of patient safety incidents	10475	10227	11252
Number of patient safety incidents that resulted in severe harm or death	61	29	51
Percentage of patient safety incidents that resulted in severe harm or death	0.6%	0.3%	0.5%

The first annual 'Learning from Mistakes League' was published in March 2015 by NHS Improvement. This Trust was rated 219 out of 230 Trusts and placed in the 'poor' reporting culture category. While we are a high reporter of patient safety incidents, as the National Reporting and Learning System data shows, the inclusion of questions from the annual Staff Survey listed below brought the score down as we rated in the lowest 20% of Trusts for each of these questions:

- Key Finding 30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Key Finding 31: Staff confidence and security in reporting unsafe clinical practice
- Key Finding 7: Percentage of staff able to contribute towards improvements at work.
- Key Finding 26: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Our response to the Staff Survey results is described in the Mandatory Indicators section of this report and our improvement priorities for 2016/17 focus on the areas covered by these questions.

A selection of the learning we have obtained and shared from review and investigation of incidents includes:

- Escalation of the deteriorating patient to senior medical care or outreach teams
- Check patient details when requesting radiological imaging
- Check that emergency trolleys are fully equipped and in date – and check another areas when you visit
- Risk management principles and escalation
- Causes of incidents include: human factors; system failure; clinical complexity – individuals are rarely the cause
- Following a patient fall – look for contributory factors including medication, blood pressure, and perform neurological observations if the fall wasn't witnessed or the patient hit their head
- Discharge letters – check that the GPs address is accurate when patients attend clinics or appointments
- Communicate clearly in health records – use the Situation Background Assessment Recommendation (SBAR) approach
- Penicillin allergy incidents – check the patient's allergy status and the drug prescribed to avoid administering penicillin to an allergic patient
- Nasogastric tubes - confirming correct placement by testing the pH value of stomach aspirate and then x-ray if unsure.

- Senior Medical Review of high-care patients must happen on a daily basis, including weekends and bank holidays
- Diagnostic test – if you request a test: follow up and act on it
- Always get a suitably qualified colleague to check before you inject drugs
- 1ml syringes – don't make the mistake of using the wrong syringe (for insulin)
- Make sure your patients have had a VTE assessment
- Use the Delirium Pathway correctly
- Blood Transfusion – make sure you follow the correct procedure to safeguard patients
- Don't continue to use equipment if you think it isn't functioning correctly
- Don't give warfarin without an INR – always check
- Identifying rare, life threatening conditions
- A rare diagnosis was missed for a patient with acute chest pain. Consider whether there may be a rare cause that requires further investigation – ask a senior colleague

Serious incidents requiring investigation (SIRI)

Every serious incident is investigated. We introduced an Initial Case Review in November 2015 to provide a summary of the event within 3 working days of the incident occurring. These are reviewed at a weekly meeting and assist in determining the severity of the incident, the level of investigation required, the key lines of enquiry and any immediate action that need to be take and shared across the Trust to minimise risk of further incidents occurring. The investigations generate reports which are approved at an Executive Director chaired meeting and actions are followed through to completion.

A total of 111 patient safety incidents were reported as serious incidents to the CCG within the following categories.

Category	**No.**
Tissue viability	29
Patient fall	26
Obstetric speciality specific	14
Diagnosis	11
Treatment	8
Bed management	6
Infection control	6
Radiology triggers	5
Medication/Drugs	2
Documentation (clinical)/Patient records	1
Neonatal specialty specific	1
Pathology	1
Staff	1
Totals:	**111**

This is 21 fewer serious incidents than 2014/15 when 132 were reported to the CCG, which included:

- 53 tissue viability
- 24 falls
- 14 obstetric specific incidents

Learning from 'Never Events'

A 'Never Event' is described as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. There are 14 types of incidents categorised as such by NHS England.

Incidents are considered to be 'Never Events' if:

- There is evidence that the 'Never Event' has occurred in the past and is a known source of risk
- There is existing national guidance or safety recommendations which, if followed, would have prevented this type of incident from happening
- Occurrence of the 'Never Event' can be easily identified, defined and measured on an ongoing basis

In 2015/16 we reported two such incidents that met these criteria. An investigation team gathered evidence and determined root causes and contributory factors for each event. Neither event caused significant harm to the patient involved. Action plans have been devised and reviewed with our commissioners and closely monitored by our Safe Patient Group.

1. Overdose of insulin due to abbreviations or incorrect device
   The learning and actions arising from this incident were:
   - Supervision will be provided to new starters until competence has been demonstrated
   - The Nurse training programme will include a focus on 'high risk' medicines
   - The staffing of the ward will be adequate to facilitate:
     - Nurse in Charge without clinical commitment
     - Provision of capacity to deliver preceptorship programme
   - The insulin prescription chart will:
     - Provide direction regarding two nurse checking
     - Enable the recording of 'dose delivered' for variable dose prescriptions
   - 1ml syringes have been removed from ward areas to prevent future confusion for insulin delivery.
   - Improving the recognition of 'Never Events' amongst governance staff and senior staff.
   - Staff requiring supervised practice will not be left to care for patients alone.
   - Handover of all patients between in-charge nurses will be improved as this severely restricts their ability to manage the shift or focus supervision where needed.

2. Wrong implant/prosthesis
   The recommendations and actions arising from this incident were identified as:
   - The five steps to safer surgery WHO checklist was completed satisfactorily in this case but is not designed to identify variables in prosthetic implants. Before implanting any prosthesis the formal 'STOP' moment in proceedings to allow all variables relating to the implant to be checked will be enforced.
   - All theatre staff across all sites of the Trust must be made aware of any new product information and any new surgical technique that they may be exposed to.

We have published and distributed information to help staff recognise when suspected 'Never Events' occur and remind them to report the incident to senior staff without delay. The Divisional Governance Teams screen incidents reported in Datix to ensure that we do not fail to recognise and respond to 'Never Events'.

Duty of Candour

We are committed to delivering safe, high quality care. However, mistakes occasionally happen. Although there are numerous safety checks to ensure that these do not affect patients, sometimes these systems break down and patients may be harmed whilst in our care.

When this happens, we strive to be open and honest in telling the patient or their family. We share our understanding of why it happened and offer to involve the patient or their family in how we plan to reduce the chances of the same mistake happening again.

The Duty of Candour became law in 2014. It reinforces the Being Open principles and means that healthcare providers must ensure that patients, and where appropriate their families, are told openly and honestly when unanticipated errors occur which cause significant harm. Medical and nursing staff also have a professional duty of candour that they must adhere to.

Being open involves:

- Saying sorry, explaining what went wrong and why
- Investigating why the incident happened and reassuring patients, their families and carers that lessons learnt will help to stop it happening again
- Hospital staff providing support to the patient and others involved or affected by the incident

The duty is triggered when a patient suffers significant harm (moderate harm, severe harm or death) that is caused through our error or omission, not as a natural progression of their disease or condition.

We continue to develop our systems to record and ensure that the Duty of Candour is triggered and the process described in our policy is met. New patient safety incidents are reviewed by the Divisional Governance Teams. Any incidents where significant harm is

suspected are reviewed at a weekly meeting where an Initial Case Review is presented. The application of the duty is tested at this meeting. When investigation reports for serious incidents are reviewed, the application of the duty is again tested, including who will be offering a copy of the investigation report to the patient or family to discuss its findings.

We have provided a range of materials and awareness training for clinical teams to help them understand their responsibilities and awareness of when the Duty of Candour is triggered. Our incident reporting system contains prompts for staff when they report an incident and access to this information. We have developed a means of recording whether the duty has been followed, which we will roll out in the coming year, and we will be auditing the quality of the communication with patients and families. Further training will also be provided to ensure all clinical staff are aware and to support the overseeing roles of the corporate and Divisional Governance Teams in identifying significant harm incidents and ensuring that the duty is met effectively.

The Duty of Candour has challenged Trusts. Improving awareness of the Duty of Candour was a 'should do' action from our CQC inspection. The spirit and aims of it are well understood and fully supported but the guidance provided by professional bodies, the Care Quality Commission and the NHS Contract is all subtly different and we are developing our own understanding of how to meet both the spirit and process of the duty. Our processes will evolve and mature as we invest in them and use our connections with other Trusts to share and learn what works well.

Safeguarding

The Trust's Safeguarding Adult and Children's teams were integrated into one team in January 2016. The structure of this integrated safeguarding team has been reviewed and a new Head of Safeguarding appointed to lead on safeguarding within the Trust.

The Trust is a virtual member of the adult Multi Agency Safeguarding Hub (MASH) and has attended for both adult and child cases.

The Worcestershire Safeguarding Adult Board (WSAB) has recently published a training competency framework which the Trust is currently in the process of reviewing - this will involve matching competency to job role to level of training – the trust has met its contractual training figure for adults of 95% - year end training for adults being 96.2%.

The Trust is represented on the sub groups of WSAB and actively participates in work streams and serious case reviews upon request.

Clinical Effectiveness (Outcomes)

The rating from the 2015 CQC inspection for Effectiveness was 'requires improvement'. The headlines included the issues below and some of the work we have undertaken is also described:

- Mortality ratios were higher than those in similar Trusts
    - Our work to improve this is described in the section below
- Most specialties provided care in line with Royal College and NICE (National Institute for Health and Care Excellence) guidelines
    - We have a system that requires checking compliance with NICE guidance
- There were good examples of multi-disciplinary working
- We took part in most national clinical audits but outcomes were not always positive and evidence that areas of no-compliance were being addressed was inconsistent
    - We did in fact take part in all national clinical audits and have again this year as stated in Appendix 1
    - This year we have introduced an on-line Clinical Audit Management System (CAMS) that provides registration and management of audits but also records actions arising from audits and allows them to be followed through to completion and re-audit.
- Nutrition and hydration was not always effectively managed or patients risk assessed
    - New documentation has been devised and introduced alongside staff training to improve the recording of nutrition and hydration
    - A new 'Harm Free Group', chaired by the Deputy Chief Nursing Officer, has been established to ensure that this work and the aspects of care included in the Safety Thermometer are effective.

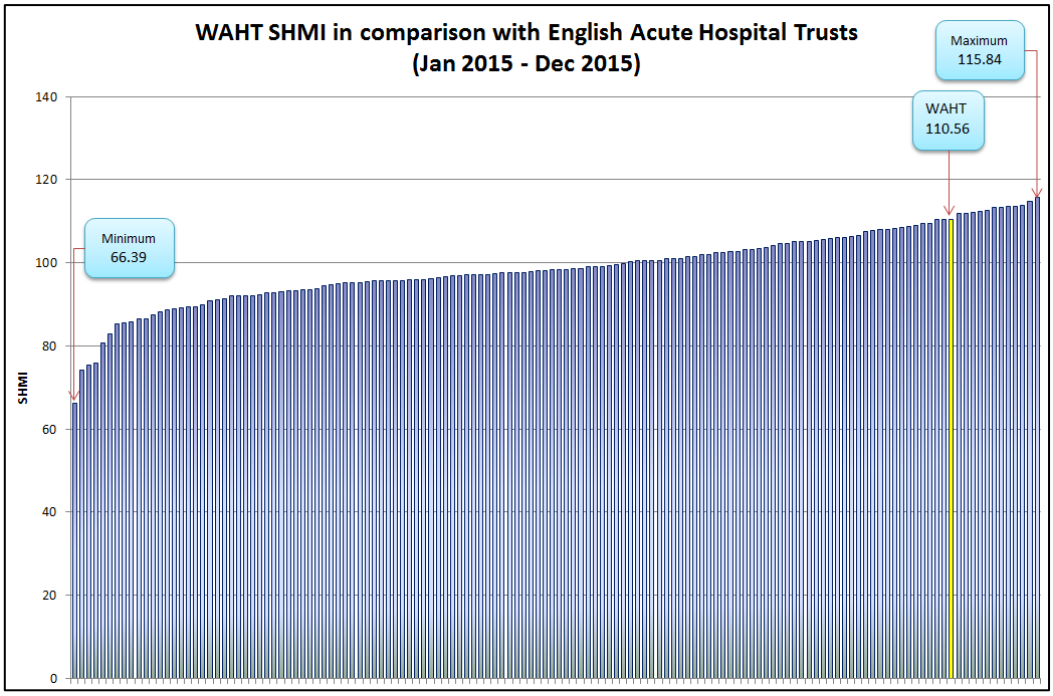
Preventing people dying prematurely

Summary Hospital Mortality Indicator (SHMI)

Hospital mortality indicators provide a ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of the characteristics of the patients treated there.

The SHMI covers all reported deaths of patients who were admitted to non-specialist acute Trusts in England and either die while in hospital or within 30 days of discharge.

The SHMI value for the 12 months of 2015 was 110.56 (local data)

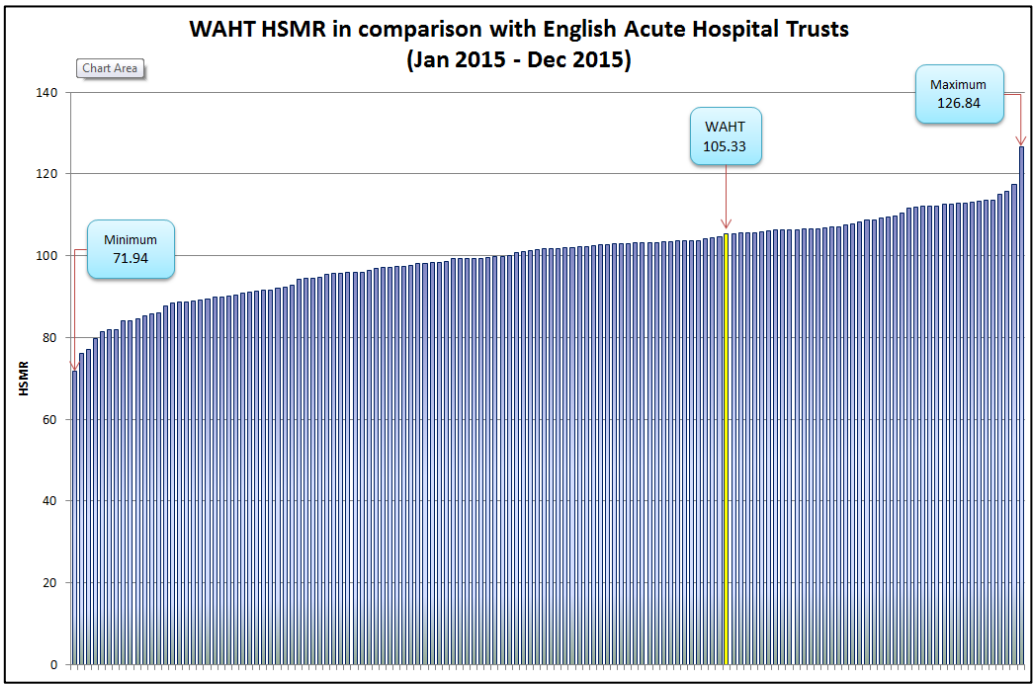


The SHMI value for the 12 month rolling period to December 2015 (latest 12 month period for which data is available) is 109. The Trust is a significant outlier for this metric. The 12 month rolling figures demonstrate a plateauing in value rather than any sustained reduction.

HSMR

The Hospital Standardised Mortality Ratio (HSMR) is similar to the SHMI but includes only those patients who die in hospital.

The HSMR value for the whole of 2015 is 105.33. (local data)



The HSMR value for the rolling 12 months to January 2016 (the most recent period for which data is available) is 105. The comparable peer group figure is 100.

There is month-on-month variation. To identify a sustained trend the rolling 12 month figures are used. There does appear to be an improvement trend from a peak in the May 2014 – April 2015 period.

The Trust has embarked on four work streams to identify and address avoidable lapses in care that would be expected to impact on avoidable mortality as part of the overall Trust Improvement Programme.

- Stream 1: Routine review of the care of those dying whilst an in-patient
- Stream 2: Reduction in avoidable cardiac arrests
- Stream 3: Ensuring patients with sepsis are identified and treated within an hour of presentation
- Steam 4: Ensuring all patients presenting with a fractured neck of femur (hip) receive rapid treatment, specifically surgery within 36 hours of arriving at hospital.

Recovering from ill health and injury

Note: The data for this section is provided in the Performance Target section of this report.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. We have taken action to improve the completion of the survey forms in 2015/16.

The health gain for the four procedures is:

- Hip replacements – better than the national average
- Knee replacements – no results available for this year
- Groin hernia – just below the national average
- Varicose veins – below the national average but the questionnaire completion rate is very low

Emergency readmissions within 28 days of discharge from hospital

These emergency readmission indicators provide information to help the NHS monitor success in avoiding (or reducing to a minimum) readmission following discharge from hospital.

Not all emergency readmissions are likely to be part of the originally planned treatment and some may be potentially avoidable. The NHS may be helped to prevent potentially avoidable readmissions by seeing comparative figures and learning lessons from organisations with low readmission rates.

There are five emergency readmissions indicators: fractured proximal femur; hip replacement surgery; hysterectomy; stroke and 'all readmissions'

For 2015/16 our readmission rates are in terms of percentages for patients aged:

0 to 14	0.0%
15 or over	3.9%

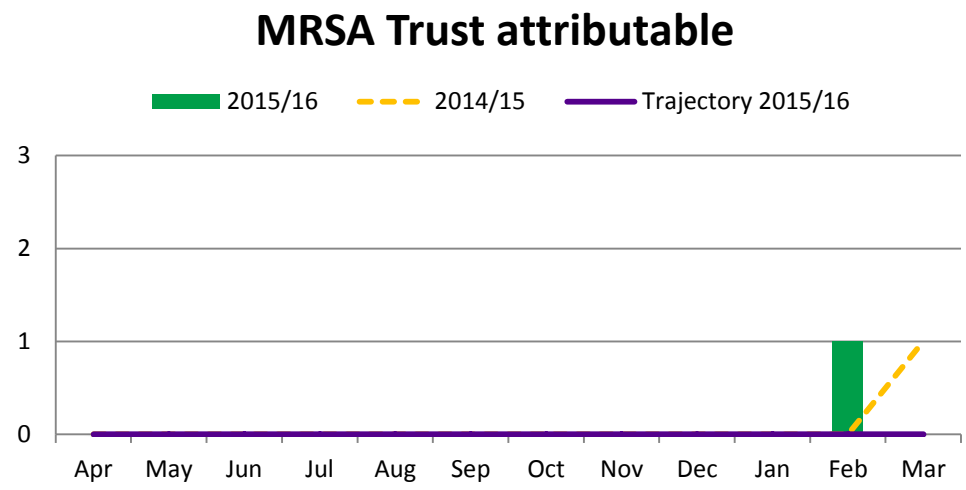
Healthcare acquired infections

MRSA bacteraemia

A national zero tolerance of MRSA bacteraemia continues and therefore a trajectory of zero cases is set for this and all other Trusts.

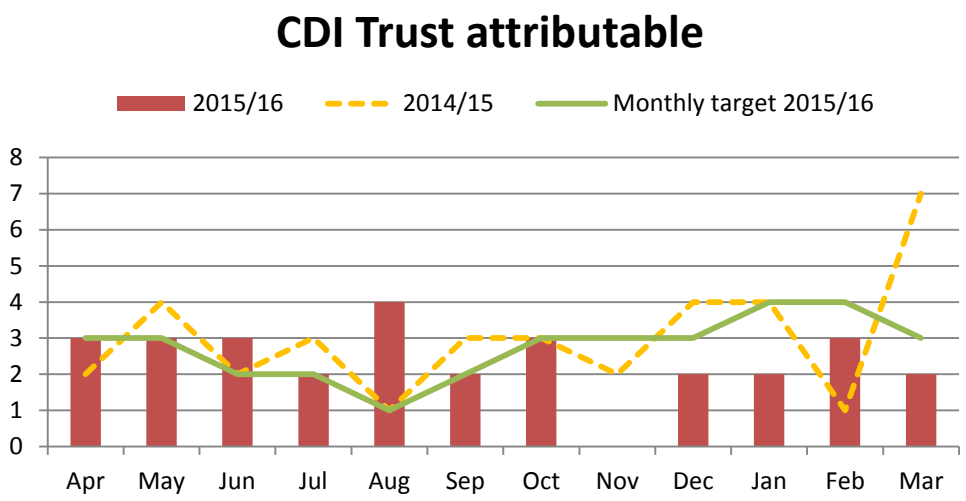
There has been one case of MRSA bacteraemia within the Trust during 2015-16. This was recorded in a patient who had a previous history of MRSA colonisation on the Acute Stroke Unit during February 2016.

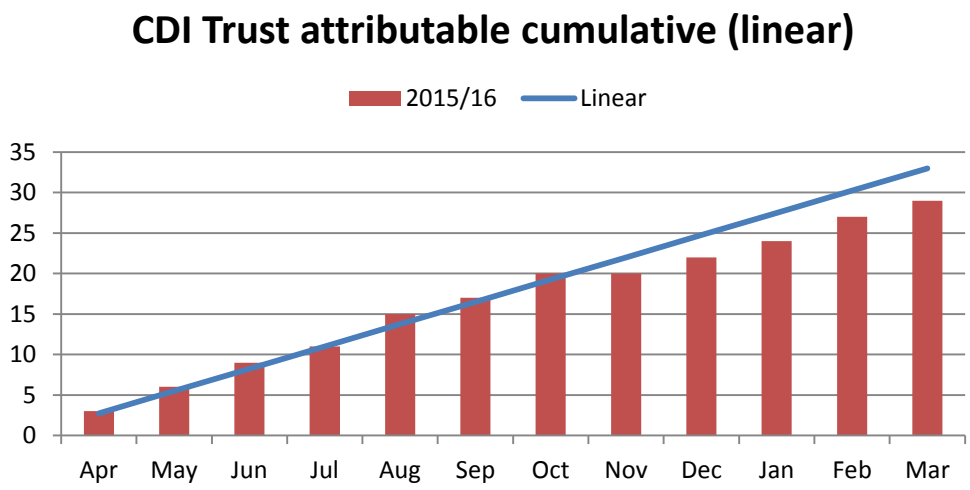
There were four other cases of MRSA bacteraemia during the year. These were in patients where blood culture was taken within 48 hours of admission to hospital. These cases were assigned to organisations other than the Trust.



Clostridium difficile

There were 29 cases of C.difficile (toxin positive) reported during the year 2015-16. This is against an NHS England set target of no more than 33 cases. There were between zero (November) and 4 (August) cases per month. The Trust has therefore successfully remained within the annual target set for the year.





The Trust has an Antimicrobial Stewardship Group reporting to the Medicines Optimisation Committee and a ward focused antimicrobial team. Evidence based antimicrobial prescribing guidelines were also updated and launched during the year. However, the key action for 2016-17 will be to continually strengthen and enhance antimicrobial stewardship and improve provision for a dedicated antimicrobial pharmacist. The Trust takes a health economy wide approach to *C.difficile* and during 2016-17 actions will be identified e.g. in relation to antimicrobial prescribing or other intervention to further reduce the possibility of new cases.

An annual trajectory of no more than 32 cases has been set by NHS England for 2016-7.

Engaging our staff to improve quality

Quality Review Visits

Since 2014 we have used unannounced Quality Review Visits to wards and department to provide an independent check on the standards of care and environment. This year we have refreshed our approach to improve the use of performance information to target the focus of

the review and continue to use colleagues from across the professions and staff groups to undertake multi-disciplinary reviews.

The findings from the visits are used to identify areas that can be improved with follow through and checking by management teams to check that they have been completed and have had the desired impact.

Quality Champions

In early 2015 we formed a group of volunteer staff into ‘CQC Champions’. The aim was to use this group to spread key messages about the inspection to wards and departments but to also listen to their feedback from colleagues. This worked well and was recognised at a celebrations event with the Chief Executive. Now called ‘Quality Champions’ this group continues its work and will again help us to connect with teams across the Trust and prepare for the CQC re-inspection.

Patient experience

Our Trust values

The rating from the 2015 CQC inspection for Caring was 'good'. The headlines included:

- Maternity and gynaecology services and elements of care on Avon 4 ward were regarded as outstanding
- People were supported, treated with dignity and respect, and were involved as partners in their care
- Good communication between staff, patients and their families was observed.
- Patients, their families and carers were involved in decisions about their care and treatment in most areas

Complaints are covered under the Responsive element of the CQC inspection report. This was rated as 'requiring improvement'. The relevant concerns raised were:

- Patients told the CQC that they received a slow or unsatisfactory response to concerns raised
- The response to patient's complaints within 25 working days did not meet our own standards

Our response to improve our management of patient complaints is described in the section below.

As a Trust we are committed to working with our patients and their families/carers to ensure that they are engaged in all aspects of their care, that their experiences are as positive as possible and that their feedback informs continuous service improvements. With the arrival of a new Associate Director in January 2015 the Trust brought together its patient experience, complaints, Patient Advice and Liaison Services (PALS) and volunteering services. This development has supported us in achieving the objectives in our 2013-17 Patient, Public and Carer Experience Strategy and during the past year we have focused on improving our systems and processes for overseeing and delivering patient experience initiatives. This formed the basis of our 2015/16 Work Plan.

Patient experience covers all aspects of the work that we do and is central to our values. To deliver this we need to ensure that we have a robust framework and delivery plan in place. This has required us to develop new ways of working, better data analysis and sharing of feedback to make us more responsive and effective, enabling us to drive forward service improvements.

Our achievements:

- Introduction of a Patient Experience Dashboard to monitor performance and delivery
- Improvements to our complaints processes to improve investigation, timeliness of responses and sharing of learning (reinforced from our CQC Inspection and Internal Audit)
- Introduction of monthly complaints, PALS and patient experience newsletters to share good practice and learning
- Introduction of new ward patient information boards throughout our hospitals

- Delivery of the ‘Small Things Matter’ patient experience CQUIN
- Review our use of surveys and how we benchmark and share data
- Update our Carers Policy and re-launch Carers Champions across the Trust
- Use the TDA Patient Experience Self-Assessment Tool to review and benchmark our Trust
- Introduce an Annual Patient Experience Report
- Review and improve Patient Experience Information
- Comprehensive review of our Volunteer Services to improve consistency and ensure compliance with the Lampard Report recommendations
- Increase our methods of engagement with patients/carers
- Work with Healthcheckers on reviewing our hospitals and improving accessibility and service delivery for patients with learning disabilities

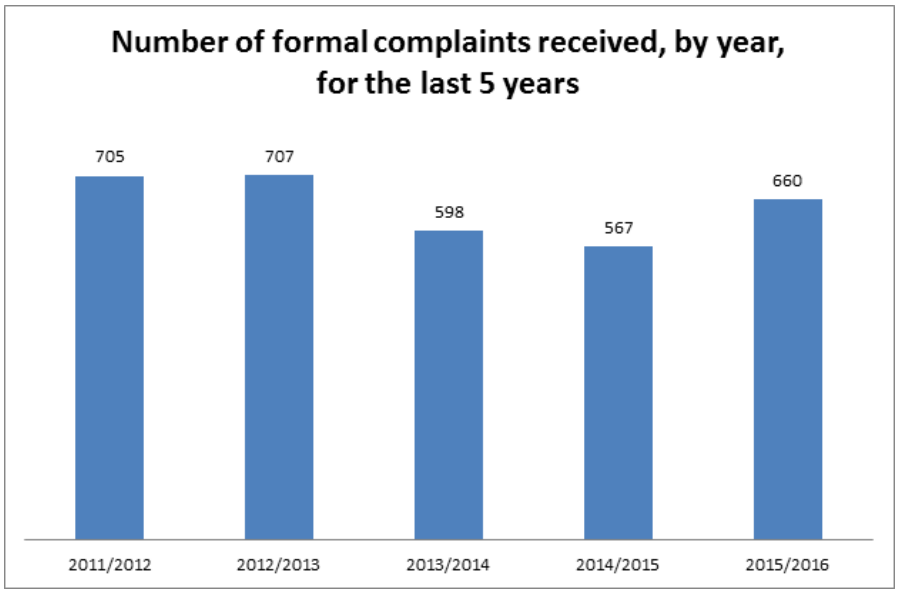
Progress on all areas of patient experience is regularly reported to the Trust’s Patient and Carer Experience Committee, which in turn reports to the Quality Governance Committee and Trust Board. Significant progress has been made in most areas and where there is still work to be done this is being regularly monitored and reviewed.

How we handle complaints

Over the past year we have seen a rise in complaints to 658. Category 2 complaints responses closed within 25 working days were 66% of the total, the same as last year.

Against activity our number of complaints annually is low. We receive 0.22 complaints per 100 bed days.

Four complaints referred to the Parliamentary and Health Services Ombudsman (PHSO) were partially upheld.



The CQC Inspection and an internal audit both identified areas for improvement with regards to our processes and adherence to them. A comprehensive Action Plan has been implemented which is incorporated within our Patient Care Improvement Plan (PCIP).

Key actions include:

- A new Complaints Investigation Template launched in February 2016 to standardise the investigation process and provide an audit trail for quality assurance. It mirrors our Serious Incident process.
- Complaints policy is being re-developed using the Trust Development Authority (TDA) Complaints Framework, the Parliamentary Health Service Ombudsman (PHSO) 'My Expectations For Raising a Complaint' and Patient Association Charter,
- New DATIX Complaint reporting launched in February 2016 to provide instantly accessible information.
- All Category 3 complaints are reported to the Patient and Carer Experience Committee
- A new Complaints and PALS Newsletter introduced for staff in February 2016 to share themes and trends and organisational learning.
- Phase 3 of the Ward Dashboard implementation will incorporate complaints and PALS. This will be reviewed with ward staff during regular schedule of visits by the Patient Experience Lead.
- A programme of complaints letter writing training has been undertaken during the past year by the Patient relations Manager. We are now reviewing this and future complaints training to incorporate the PHSO "My Expectations" report and the Patients Association Charter.
- A revised annual complaints survey has been developed and sent to 290 complainants asking for their feedback on our complaints process.

Complaints are allocated to one of three categories to ensure a proportionate response.

Category 1 complaints are those that can be resolved quickly, and we aim to respond within five working days.

Category 2 complaints are the vast majority, and we aim to reply within 25 working days.

Category 3 complaints are more serious matters which may involve a serious incident investigation and as such response time is negotiated with the complainant.

Categories of complaints received in 2015/2016	Total
Category 1	2
Category 2	630
Category 3	26
Total	658

The key themes and trends identified from Complaints and PALS calls during 2015-16		
Theme/trend/issue	**Evidence**	**Actions proposed/completed**
Communication – with patients and with their relatives or carers	92 mentions of complaints about communication with relatives or carer; 100 mentions of communication with the patient 68 PALS calls about communication with relatives and carers.76 about communication with the patient	• Issues with communication discussed with Divisional Management Team as part of Quality Governance Meetings • Separate specific report will be sent to the relevant management team detailing their complaints themes. • New Patient Information leaflets developed with patient input and 'Approved by Patients' logo • Carer Awareness Training rolled out across Trust from March 16
Attitude of staff – nursing and medical	81 mentions of attitude of medical staff in complaints 80 mentions of attitude of nursing/midwifery staff 27 PALS contacts about attitude of nursing/ midwifery staff, 42 about attitude of medical staff	• Issues with attitude discussed with Divisional Management Teams – additional training and support have been provided, area specific training and where necessary internal HR processes activated. • The Trust continuing to roll out ACE with PACE customer service training to staff and is launching Sage and Thyme communication training in Spring 2016 • Separate detailed report will be sent to the relevant senior management team • Patient Experience slot included on trust Induction from January 2016

Compliments

The Trust receives far more compliments than complaints with 5600 received during the past year, including 107 via the NHS Choices/Patient Opinion websites. Positive feedback is regularly shared with teams to reinforce good practice and positive patient experience including:

Well done A&E

'I went to A&E at Redditch on Sunday afternoon suffering with chest pains. I was immediately taken to be assessed and was seen by a number of staff who were both

friendly and professional. I was impressed at the extent to which the medical personnel investigated my illness until they sure it was not anything more sinister. In addition to the professionalism, the staff constantly checked to see if I would like a drink or something to eat. A follow-up appointment was arranged to ensure that there are no further underlying issues and I was allowed to go home. People are often quick to criticise so I thought it important to give my thanks for the fantastic care I received.'

Eye problem sorted

'Was sent to Kidderminster opthamology department a day after visiting my optician and mentioning to them that I had got a slight problem with floaters in my vision. Can't believe how promptly I was dealt with and had laser treatment straight away! The consultant was brilliant and put me at my ease. I don't think I could have had better treatment if I had been paying for it'

Nine hours in A&E

'I was unfortunate to have to spend 9 hours in A&E with chest pain. I would like to thank all the staff, they were brilliant. Although they were extremely busy they still looked after me very well. Many thanks'

Learning from patients/carers

Patient stories are a very important way of sharing best practice and learning from mistakes. These are shared from 'ward to Board' and are included regularly in our new Patient Experience Newsletter. One lady contacted us to say how the treatment received helped her family:

Patient story – delighted daughter gets her mum back!

"My mum was slowly losing interest in general life over the past 12 months. This was distressing for me, her grandchildren and her sister. During this time I did broach the topic of her lack of interest/depression. My mum said she was just tired.

"Mums appointment came through for her cataract op and from start to finish she could not speak highly enough of the team. I accompanied my mum on the day of the op and for her last check-up. The team came over as very caring not only about the patients and relatives but also about each other.

"The day of the op had been a trying day for the team who apologised for our wait as there had been an emergency. This was fine for us, we had had a good chat and enjoyed people listening/watching, As staff were going home they were thanking each other for the way they had worked, this was lovely to hear and really showed the care they took of each other. My mum was treated with dignity, respect and compassion on all visits.

"The best outcome has been the major improvement in my mum's sight which has brought about a wonderful lift in her spirit and desire to experience life.

“She asked me some four weeks after her op at what point had her eyebrows disappeared! Informing me the lady was coming later that day to shape and colour her eyebrows. I had tears in my eyes at this point as we had our mum/granny back.

Cataract ops may be very routine but please never underestimate the impact your team has on patients their friends and relatives.”

This is such a wonderful story of the care given by the Ophthalmology Department at Kidderminster Hospital, not just for the patients and their families but to each other as well. This is so important. Unless we can be kind and compassionate to one another we cannot possibly care for our patients in this way. It embodies the 6C’s, our Trust values and vision in a powerful way.

The CQC Report highlighted that we were ‘good’ for caring and this story epitomises this.

How we get feedback

Feedback from patients, families and carers is really important to us and we get this from a variety of places.

How we receive feedback	How we use this feedback
Local and national surveys	To develop trend analysis and focus on particular themes/concerns
PALS concerns	This provides a barometer of how the Trust is performing and enables concerns in particular areas to be highlighted in real time, allowing us to raise any issues with individual areas
Complaints	Themes and trends are regularly compiled and shared with wards/departments. The new DATIX Complaints Report provides instant access to Divisions on their complaints and outcomes/learning
Compliments	These are shared across wards/departments to highlight good practice and the impact on patients
NHS Choices/Patient opinion	Each comment is responded to by the Patient Experience Team. Additional information is requested if we need to follow concerns up. Comments are shared with the relevant areas as they come in and a monthly report is shared with the Divisions

Friends and Family Test (FFT)

The Friends and Family Test (FFT), introduced in 2012, is a national initiative designed to help service users, commissioners and practitioners ensure services measure patient experience. Since April 2012, we have been asking our patients whether they would recommend hospital wards to their friends and family if they needed similar care or treatment. This provides a simple way for every patient to give feedback on the quality of the care they receive and helps us improve our services.

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

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

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

The scores are then calculated which gives a total between -100 and +100.

Friends and Family Test completions

	Target	Achievement
Wards	30%	15.7%
A&E Worcestershire Royal Hospital	20%	17.25%
A&E Alexandra Hospital	20%	11.76%
Maternity	30%	26.3%

Friends and Family Test scores

	Target	Achievement
Wards	75	76
A&E Worcestershire Royal Hospital	75	61.52
A&E Alexandra Hospital	75	85.34
Maternity	75	84

Completion of the Friends and Family test by patients has been disappointing low across the Trust, but our scores have been generally high. We are planning a relaunch of FFT early in 2016-17. We have new cards and posters being developed and a new film encouraging completion in our waiting areas. Our new Patient Experience Lead will be visiting wards and areas regularly to discuss completions and scores with staff.

More information on the NHS Friends and Family Test can be found here.

National Patient Surveys

The Trust has participated in a variety of national patient surveys during the year covering: inpatients; outpatients and Accident and Emergency services with further local surveys conducted using the Hospedia patient entertainment system which is available in ward areas across the Redditch and the Worcester sites (with the exception of Aconbury wards). As well as providing entertainment options it also provides hospital information and is used to capture near real time patient feedback. In all surveys the trust has come in as 'average' compared to other Trusts.

National Inpatients Survey 2015-16

National Inpatient Survey – Conducted by Picker – July 2015
• Survey of 81 Trusts - Response rate 46% compared with average of 45% • Rated as 'average' compared to other Trusts

National Outpatients Survey 2015-16

Outpatient Survey – Conducted by Picker - 2015
• Response rate 48% compared with national average of 45% • No significant improvement since 2011 survey (of 71 questions, improved in 2, no change on 69) • Average performer relative to other Trusts (of 71 questions, better in 1, worse in 1 and average in 69)

National A&E Survey 2015-16

A&E Survey – Conducted by Picker – 2015
• Response rate 30.5% compared with national average of 32% • Average performer relative to other Trusts (better in 6, worse in 2 and average in the rest) • Slight deterioration since 2014 survey (of 32 questions, up in none, down in 6 no change on 26)

The results of these audits have been used to inform our patient improvement priorities and workplan for 2016/17

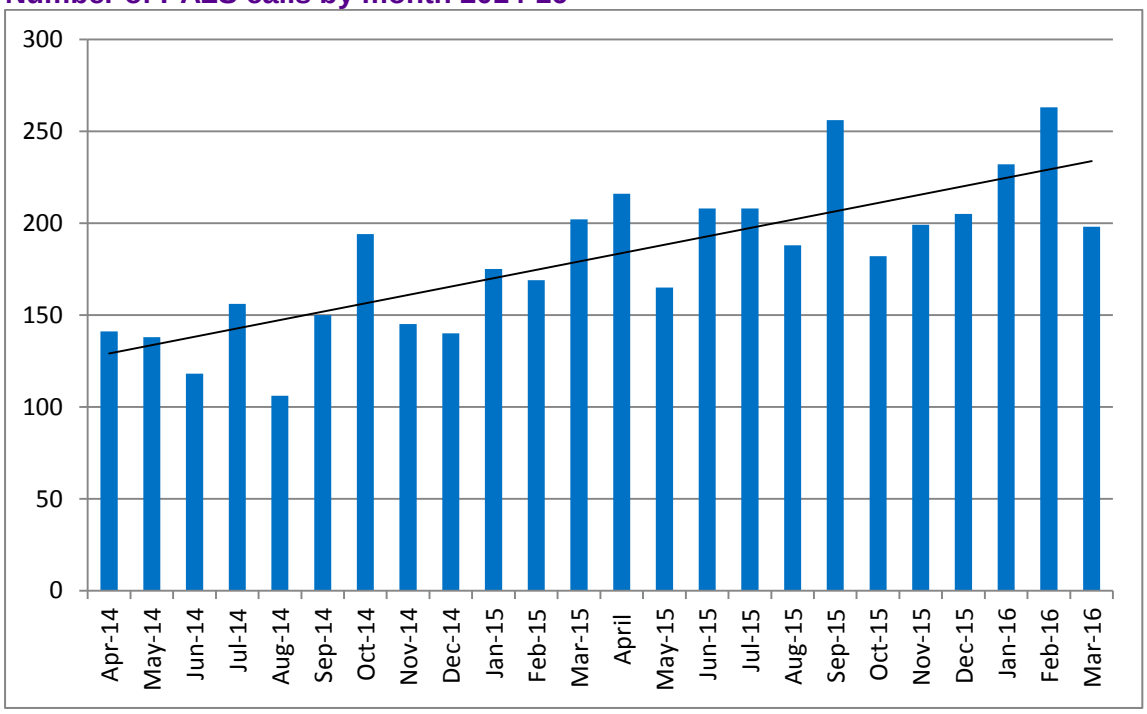
Local surveys

In addition to these national surveys we also undertake a range of local surveys on the Hospedia patient entertainment system covering carers, learning disabilities, patient satisfaction, cleanliness and volunteers. We continually review our questionnaires to ensure that they reflect patient concerns and national priorities.

Patient Advice and Liaison Service (PALS)

The Trust has one PALS Officer covering our three sites, making it effectively a telephone helpline. The number of enquiries continues to rise with 2562 calls being dealt with during the financial past year compared to 1833 in 2014/15.

Number of PALS calls by month 2014-16



The PALS Officer works primarily with matrons to ensure that callers concerns are addressed within 24 hours, thus reducing anxiety and distress. They also follow up calls to ensure that contact has been made and that the caller is satisfied. The main themes of our PALS calls during the past year have been as follows:

Top 5 subject matter of PALS calls in 2015/16	Total
PALS providing information or sign posting	619
Appointments delay	335
Appointment cancelled	153
Other (communication)	106
Other (clinical treatment)	80

Review of other quality performance for 2015/16

Core Indicators for 2015/16 Year to Date

All figures taken from the Board Report - Quality & Outcomes

	Readmissions	YTD	NHS Average*	Data Quality Kite mark
QEFR1.1	Emergency Readmissions (Within 28 Days of Elect. Discharge) - WAHT	0.4%	3.7%	
QEFR1.2	Emergency Readmissions (Within 28 Days Emerg. Discharges) - WAHT	8.0%	14.7%	
QEFR1.3	Emergency Readmissions (Within 28 Days All. Discharges) - WAHT	3.3%	7.5%	

*Based on Jan - Dec 2015 data from HED

Source : Board Report - Quality & Outcomes (Based on Apr 15 - Mar 16)

	Friends and Family	YTD	Target	NHS Avg Feb 2016	Data Quality Kite mark
QEX2.1	Friends & Family - A&E (Score)	71	>=71	85	
QEX2.2	Friends & Family - A&E (Response Rate %)	15.1%	>=20%	13.3	
QEX2.61	Friends & Family - Acute Wards (Score)	76	>=71	95	
QEX2.62	Friends & Family - Acute Wards (Response Rate %)	15.7%	>=30%	24.1	
QEX2.2	Friends & Family - Maternity (Score)	84	>=71	92	
QEX2.3	Friends & Family - Maternity (Response Rate %)	26.3%	>=30%	6.3	

(Based on Apr 15 - Mar 16)

Data source: NHS England

Caveat : In Feb 2016 there has been a change to the reporting definitions to ensure that the Trust is compliant with national guidance.

	VTE Risk Assessment	YTD	Target	NHS Average*	Data Quality Kite mark
QSVT1.0	VTE Risk Assessment	95.00%	95%	95.8%	

(Based on Apr 15 - Mar 16)

Caveat : In Feb 2016 there has been a change to the reporting definitions to ensure that the Trust is compliant with national guidance.

	Infection Control	YTD	Target	Data Quality Kite mark
QPS12.5	Number of MRSA Cases	1	0	
QSIC1.3	Number of C. Difficile cases	29	33	

(Based on Apr 15 - Mar 16)

	Cancelled Operations	YTD	NHS Average	Data Quality Kite mark
PEL4.1	Cancellations (Patients)	698		
PEL4.0	Cancellations as a % of Admissions (inc Daycase)	0.9%	0.9%	

(Based on Apr 15 - Mar 16)

Data Source: QMCO return Jan - Dec 2015

Caveat: Cancelled Operations is based on the 2011 definition. For 16_17 the Trust will be moving to current national definition

	Dementia	YTD	Target	NHS Average	Data Quality Kite mark
PCQ3.1	Dementia: Find, Assess, Investigate and Refer (Pt 1)	96.50%	>=90%	95.8%	
PCQ3.3	Dementia: Find, Assess, Investigate and Refer (Pt 2)	97.10%	>=90%	95.0%	

(Based on Apr 15 - Mar 16)

Data source HSCIC Quality Indicators

	Stroke and TIA	YTD	Target	NHS Average**	Data Quality Kite mark
CST1.0	Stroke Patients to send 90% of LOS on Stroke Ward - based on Apr 15 - Mar 16	82.21%	>=80%	95.8%	
CST2.0	Stroke Patients admitted directly to a Stroke Ward (via A&E) - based on Apr 15 - Mar 16	74.40%	>=70%	95.0%	
CST3.0	TIA - based on Apr 15 - Mar 16	64.23%	>=60%	** Based on SSNAP Q3 2015/16	

Caveat: These metrics are based on local interpretation of the national definition. For 16/17 we will be ensuring national definitions are followed.

Waiting Times and RTT	YTD	Target	NHS Avg Feb 2016	Data sourced from HSCIC
% of Patients Referred and Treated within 18 Weeks - incomplete	89.20%	92.0%	91.9%	
% of A&E Patients Being Seen, Admitted, Discharged or Transferred Within 4 Hours of Presentation to ED (inc.MIU)	87.90%	95.0%	87.8%	
% of Patients having their first treatment within 62 days from urgent GP referral for suspected cancer	81.20%	85.0%	81.02%	
% of Patients having their first treatment within 62 days from NHS Cancer Screening Service Referral	96.80%	90.0%	90.03%	
% of Patients having their second or subsequent treatment within 31 days for surgery	92.20%	94.0%	95.77%	
% of Patients having their second or subsequent treatment within 31 days for anti-cancer drug treatments	99.50%	98.0%	99.60%	
% of Patients having their first treatment within 31 days from diagnosis	97.50%	96.0%	97.7%	
% of Patients seen within 2 weeks for all urgent referrals	85.70%	93.0%	95.41%	
% of Patients seen within 2 weeks for symptomatic breast patients	80.00%	93.0%	94.51%	
6 Week Wait Diagnostics (% Waiting >6 Weeks)	1.28%	<1%	1.3%	

Source : Board Report - Quality & Outcomes (Based on Apr 15 - Mar 16)

Data sourced from HSCIC

Mandatory Indicators

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

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

NHS Outcomes Framework – domain 1

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Summary Hospital Mortality Indicator (SHMI) In text	a) the value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period;	113.04 Banding 1	106.00 Banding 3 (Quarter 3 figure used – different to 12 month rolling average)	100	64.74 110.29
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	1.78%	1.68% (Q1-Q3 2015/16)	1.44% (Q1-Q3 2015/16)	0.0% 1.9% (Q1 – Q3 2015/16)
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		External audit of coding indicates good practice indicating a reasonable degree of confidence in the validity of this metric		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Instigating routine review of the care delivered to all patients who die whilst and in-patient and linking with primary care to review the care of patients dying within 7 days of discharge to a non-palliative care environment.		

NHS Outcomes Framework – domain 3

Title	Indicator PROMs casemix-adjusted scores	2014/15 Adjusted average health gain	2015/16 (provisional data -) Adjusted average health gain	National average (provisional data -) Adjusted average health gain	Upper and lower 95% control limit for the Trust (provisional data) Health Gain
Patient Recorded Outcome Measures **(PROMS)**	(i) groin hernia surgery	0.092	0.077	0.088	Not available
	(ii) varicose vein surgery	NR	0.037	0.104	Not available
	(iii) hip replacement surgery	0.460	0.487	0.454	Not available
	(iv) knee replacement surgery	0.321	NR	0.334	Not available
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		• The Trust is performing marginally above national average for groin hernia surgery, hip replacement surgery and knee replacement surgery • Participation rates where too low to calculate health gains data for varicose vein surgery		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		• Development of an in-house database to monitor participations rates in an effort towards providing statistically significant data • Conduct analysis of health gains data to present to Clinical leads with the aim to optimise data use and improve clinical outcomes • Review possibility of undertaking training with Quality Health to improve participation rates • Undertake discussions with Quality Health to share good practice for implementation in-house		

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Readmission rates	The percentage of patients aged: (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the	0.0% 4.1%	0.0% 3.9%	Not available in required bands	Not available

	reporting period.				
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		This indicator is currently being quality assured internally but the data used is that which is nationally available.		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See text in the Quality Account.		

NHS Outcomes Framework – domain 4

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patient's needs	The Trust's responsiveness to the personal needs of its patients during the reporting period	76.2 (Range: 59.0 to 88.2)	n/a	n/a	n/a
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		This information is not available on the HSCIC website at this time – the 2015/16 data will be released in August 2016		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See text in the Quality Account		

Title	Indicator	2014/15	2015/16	National	Highest and

				average	**lowest NHS Trust and Foundation Trust scores for the reporting period**
Staff recommending the trust as a provider of care	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	67%	56%	70%	Not available
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		The results are provided from the national staff survey and internal surveys show a similar pattern.		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		An Organisational Development strategy has been developed. Patient flow through the Trust is critical to safe and effective care and the effective operation of the hospitals. Improving this is one of our key improvement programmes for 2016/17.		

(There is not a statutory requirement to report this indicator)

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patients who would recommend the Trust to their family or friends	The Trust's score from a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care	Wards: 81.3 A&E Alx: 80.9 A&E WRH: 65.3 Combined A&E: 72 Maternity: 80.2	Wards: 76 A&E Alx: 85.3 A&E WRH 61.5 Combined A&E: 70.2 Maternity: 84.0	Not available	Not available

	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	Data errors have been discovered and corrected in the financial year.
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	See text in the Quality Account

NHS Outcomes Framework – domain 5

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Venous thromboembolism risk assessments	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.2%	95.0%	95.8%	85.7% 100% (Full year 2015)
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		This indicator has been tested and found to have inaccuracies as described in the External Audit opinion.		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		A task group has been established to review each step of the process that generates this indicator and make necessary improvements to ensure that it is effective and improves data quality.		

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C.difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	12.66	9.89	14.9 (Q3 2015/16)	Not available
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		• Laboratory based authorisation for positive cases • All cases validated each month and reported to Public Health England		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:		• Antimicrobial Stewardship Group reporting to Medicines Optimisation Committee • Health economy strategy for C.difficile		

Title	Indicator	2014/15	(April – Sep 2015) The latest data available	National average (April – Sep 2015) The latest data available	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period (Apr–Sep 2015)
Incidents	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	Number of incident reports: <u>Apr 14 - Sep 14</u> 4536 <u>Oct 14 - Mar 15</u> 5534 Rate of patient safety incidents: <u>Apr 14 - Sep 14</u> 36.21 per 1,000 bed days <u>Oct 14 - Mar 15</u> 42 per 1,000 bed days	Number of Incident reports: 5640 Rate of patient safety incidents: 41.57 per 1,000 bed days	Average number of incident reports 4647 The median reporting rate for this cluster is 38.25 per 1,000 bed *d*ays	For the cluster used by the NRLS (136 organisations) Highest number = 12,080 Highest rate = 74.67 Lowest number = 1559 Lowest rate = 18.07
	The number and percentage	<u>Apr 14 - Sep 14</u> Number: • 18 severe	Number = 18 • 10 severe	Number (average) =	Severe harm (number)

	of such patient safety incidents that resulted in severe harm or death	harm • 9 deaths Percentage: • 0.4 severe harm • 0.2 deaths <u>Oct 14 - Mar 15</u> Number: • 14 severe harm • 16 deaths Percentage: • 0.3 severe harm • 0.3 deaths	harm • 8 deaths Percentage: • 0.2 severe harm • 0.1 deaths	• 15.08 severe harm • 4.88 deaths Percentage: • 0.3 severe harm • 0.1 deaths	Highest = 89 Lowest = 0 Deaths (number) Highest = 22 Lowest = 0 Severe harm (percentage) Highest = 2.0 Lowest = 0 Deaths (percentages) Highest = 0.7 Lowest = 0
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	• The data is provided from the National Learning and Reporting System • The incident reports are checked for accuracy by the Trust before they are exported to the NRLS.			
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate (for incident reporting) and number (of incidents that result in severe harm or death) and so the quality of its services, by:	Actions are as described in the Quality Account.			

Mandatory statement of assurance from the Board

Review of services

During 2015/16 the Worcestershire Acute Hospitals NHS Trust provided and/or subcontracted 46 NHS services. The Trust has reviewed all the data available to them on the quality of care in these services.

The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by the Worcestershire Acute Hospitals NHS Trust for 2015/16.

Participation in clinical audits

During 2015/16, 51 national clinical audits and five national confidential enquiries covered relevant NHS services that Worcestershire Acute Hospitals NHS Trust provides.

During that period the Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. Also in 2015/16 we undertook 281 registered local clinical audits

Appendix 1 contains a list of national clinical audits, national confidential enquiries and local clinical audits and describes the actions we have taken or are planning to take to improve our services in response to insights from these audits.

Information on research

1047 patients receiving NHS services provided or sub-contracted by Worcestershire Acute Hospitals NHS Trust in 2015/16 were recruited during that period to participate in research approved by a research ethics committee.

This increasing level of participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Worcestershire Acute Hospitals NHS Trust was involved in conducting 114 clinical research studies across 15 different specialties. The Trust used national systems to manage the studies in proportion to risk. Of the 46 studies given permission to start, 92% were given permission by an authorised person less than 30 days from receipt of a valid complete application.

Goals agreed with commissioners

A proportion of Worcestershire Acute Hospitals NHS Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

We had nine CQUIN targets agreed with our main commissioners, NHS Worcestershire, in 2015/16. Further CQUINs were agreed through the Specialised Commissioning Team,

National Team and Local Area Teams. They covered one or more of the quality domains as shown in the table below, along with our performance against each goal:

Further details of the agreed goals for 2015/16 and for the following 12 month period are available on request from the Director of Resources.

CQUIN Goal	Comment	Met
Acute kidney failure (add brief description)	Completion of the Electronic Discharge Summary to inform GPs of the patient's condition is still inconsistent.	Not met
Sepsis	This will be a revised CQUIN in 2016/17	Not met
Dementia		Met
Urgent and emergency care	Data collected but admission avoidance process is not yet in place.	Partially met
Local CQUIN		
Prevention of falls for patients on the delirium pathway		Met
Patient Experience – 'small things matter'		Met
Improving safety culture – human factors training		Met
Midwifery led care		Met
Patient flow a) discharge lounge		Met
Patient flow b) best practice ward rounds		Met
Specialised Commissioning CQUIN		
Clinical utilisation review		Met
Right Care Right Place: outpatient follow up		Met
HIV: reducing unnecessary CD4 monitoring		Met
NICE DG10 compliance test – oncotype DX	Breast cancer test	Met
Local Area Team Commissioners		
Screening (AAA, bowel, breast)		Met

CQUIN Type	CQUIN Name
National	1A Introduction of health and wellbeing initiatives
National	1B Healthy food for NHS staff, visitors and patients
National	1C Improving uptake of Flu vaccinations for front line clinical staff
National	2A Timely identification and treatment of sepsis in emergency departments
National	2B Timely identification and treatment of sepsis in acute inpatient settings

National	5A Reduction in antibiotic consumption per 1000 admissions
National	5B Empiric review of antibiotic prescriptions
Local	Patient flow – Ambulatory Emergency Care
Local	Patient flow – GP referred attendances to assessment units
Local	Patient flow – SAFER
Specialised	Optimal devices
Specialised	Adult critical care timely discharge
Specialised	eGFR monitoring system
Specialised	Neonatal unit admissions
Specialised	Activation system for patients with long term conditions
Local Area Team	Local information collection on reasons for non-participation in screening amongst the general population
Local Area Team	Promotion of screening programme
Local Area Team	Working with eligible people in a specified priority group to improve access to screening
Local Area Team	Managed clinical networks (MCN)
Local Area Team	Secondary care clinical attachment in oral surgery
Local Area Team	Patient Flow – Emergency Department
Local Area Team	Eating disorder pathway – children and young people

Care Quality Commission (CQC)

Worcestershire Acute Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current status is 'registered with conditions'. The Trust has the following conditions on registration:

Usual conditions: the regulated activates that Worcestershire Acute Hospitals NHS Trust has registered for may only be undertaken on our registered premises.

Following an unannounced inspection of the Emergency Department at Worcestershire Royal Hospital on 24 March 2015, the CQC placed a Section 31 condition on the Trust's registration, which has remained in place throughout 2015/16.

The condition required the Trust to ensure that every patient attending the Emergency Department at Worcestershire Royal Hospital to have an initial clinical assessment within 15 minutes of arrival. Furthermore, the Trust is required to report breaches of this standard to the CQC each week, and on a monthly basis, to provide a report of any incidences of harm caused by delays in initial assessment, together with a root cause analysis for 10% of breaches and details of action taken to prevent recurrence. The Trust has complied with all reporting conditions.

The CQC has taken enforcement action against Worcestershire Acute Hospitals NHS Trust during 2015/16.

The Trust was inspected by the CQC between 14 and 17 July 2015 as part of their scheduled inspection programme. The CQC acknowledged the significant improvements that had been made within the Emergency Department since the March 2015 inspection.

Following the July 2015 scheduled inspection the Trust was rated as 'inadequate' overall and consequently entered special measures.

Special measures apply to NHS Trusts and Foundations Trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support.

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

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

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

The overall ratings for the Trust are provided as Appendix 2.

Worcestershire Acute Hospitals NHS Trust intends to take the following action to address the points made in the CQC's assessment.

Immediately after the inspection, and following the informal feedback at the end of the inspection week, the Trust developed a follow-up action plan based on the key improvement requirements communicated at that stage. 31 out of 33 actions have been completed. One of the remaining actions will be implemented in spring 2016, while the other has been risk assessed and is being managed through the Trust's risk management process.

Following publication of the inspection report an action plan to address the 'must do's' and key 'should do's' was developed. Progress against the action plan has been, and continues to be, reported monthly to the Trust Management Committee, the Trust Board and the Trust Development Authority Quality Oversight Review Group.

Worcestershire Acute Hospitals NHS Trust has made the following progress by 31 March 2016:

Progress with many of the actions has been reported in the sections of this report covering 'safe', 'effective' and experience and is also referred to in the Chief Executive's statement.

- Surgical High Dependency Units (HDU) – We are reviewing the capacity requirements for HDU facilities in surgery and ensuring that they meet the required standards.
- Ensuring that surgical patients receive safe and timely care – up to date information to follow
- Sufficient staffing – up to date information to follow

The Trust has actively engaged in 'buddying' arrangements with other hospital Trusts. For example, with Birmingham Women's and Birmingham Children's NHS FT's around reviewing its current improvement plan and extending this to ensure that the Trust is following best practice across its maternity, neonatal and paediatric services. There has already been an external governance review in maternity and the Trust has also engaged with Oxford University Hospitals NHS Trust to provide support for the development of Trust - wide governance arrangements and processes. The Trust also plans to use the Medical Engagement Survey and to seek support around an organisational development framework that could be rapidly deployed to develop the capacity and capability to improve. The TDA, through the Improvement Director, has been supporting the Trust.

Worcestershire Acute Hospitals NHS Trust has participated in special reviews or investigations by the Care Quality Commission during 2015/16:

Review of health services for looked after children (LAC) and safeguarding

The Care Quality Commission (CQC) undertook a review of health services for looked after children and safeguarding in Worcestershire from 14 to 18 September 2015. The review was conducted under Section 48 of the Health and Social Care Act 2008, which permits the 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 14 December 2015, concluding that services across Worcestershire were 'inadequate' to safeguard children and young people. The full report can be read at this link:
www.cqc.org.uk/sites/default/files/20151214_CLAS_Worcestershire_Final_Report.pdf

- The review 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.

The report highlighted some good practice within the Trust, but there were also areas where improvement was required, including keeping babies and children safe within maternity services and the Emergency Department, the safeguarding reporting pathway, safeguarding supervision and training for staff and the lack of capacity within the safeguarding team, including not having a Named Midwife in post. The recommendations have been formulated into an action plan, which is monitored internally via the Trust Safeguarding Committee, and externally via the Clinical Commissioning Groups.

All actions, except the business plan to extend the Maternity K2 system, have been commenced by 31 March, and in several cases are complete. Some examples are:

- Named Midwife coming into post in November 2015
- Issues within the Emergency Department being resolved except for the installation of CCTV at WRH (part of the current refurbishment work)

- Safeguarding supervision pilot commenced
- Safeguarding training for health staff clarified with Worcestershire Safeguarding Child Board Training Officer
- Safeguarding governance restructure completed
- Integration and planned expansion of the adult and children safeguarding team

Data quality

Clinicians, managers and staff rely upon good quality information to support the effective delivery of patient care.

The Trust is committed to pursuing a high standard of accuracy, completeness and timeliness within all aspects of data collection in accordance with NHS Data Standards.

The Trust understands the importance of using good quality data to support patient care. All staff are accountable for recording data accurately and supported by training, guidance and feedback on an ad-hoc basis and via internal and external audits. Regular monitoring of key data is undertaken and issues are addressed promptly. The Trust liaises closely with the CCGs on any data quality concerns they may have from their commissioner role or raised by GPs.

There is a clinically led Data Quality Steering Group in place, chaired by a Consultant. The Trust strategic Data Quality Lead is the Chief Medical Officer. The DQSG maintain a strategic overview of data quality issues within the Trust, and support the enablement of better data quality from ward to Board.

Worcestershire Acute Hospitals NHS Trust submitted the following number of records during 2015/16 to Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data:

- A&E records 150981
- Inpatient records 171991
- Outpatients 746482

The percentage of records in the published data are below:

Patient's valid NHS number was:

- For admitted patient care 99.6%
- For outpatient care 99.7%
- For accident and emergency care 97.5%

Patient's valid GP was:

- For admitted patient care 100%
- For outpatient care 100%
- For accident and emergency care 100%

Inpatient valid Ethnic Origin was:

- For admitted patient care 96.7%

Whilst these figures are extremely encouraging, the Trust acknowledges that there is significant work remaining to ensure that data are not only present, but also accurate.

Information Governance Toolkit Attainment

The Trust achieved an overall score of 71% and has remained as an overall satisfactory level, with all of the standards achieving a minimum of a level 2. The overall score has decreased by 5% due to the changes in the requirements in Version 13 of the toolkit. However the Trust has a recovery plan in place to increase the score back to at least 76% for 2017. A recent external audit of the Toolkit included an in-depth review of the evidence for 9 standards and of the 5 actions only 2 are outstanding with actions in place to address any further evidence required.

Worcestershire Acute Hospitals NHS Trust has taken the following actions to maintain and improve data quality in the Trust.

Data Steering Quality Group

There is a clinically led Data Quality Steering Group in place which includes fellow clinicians, divisional leads and operational staff. The Group has been operational since September 2015, and has met 4 times so far. It reports into the Trust Committee structure via the Quality Governance Committee. The Group monitors strategic data quality concerns, keeps a log of data quality issues, and will also support the data assurance element of the Information Governance (IG) toolkit.

Data Quality Kitemark

During 2015/16 the Trust introduced a Data Quality Kitemark to support the transparency of any data quality concerns identified by the Trust. This has been rolled out to the Trust level dashboard, and can be seen against all key performance indicators in Board papers.

NHS Number

One of the elements of IG and national standards is completeness of the NHS number. Our NHS number compliance averages 99%.

Board assurance around data quality is received through the Audit and Assurance Committee. Papers giving an overview of monitoring and improvement of data quality were presented to the Audit and assurance Committee in November 2015 and updates reported to the Quality Governance Committee in February 2016.

A range of audits has been carried out by external auditors on behalf of the Trust to provide internal and external assurance regarding the accuracy and timeliness of its data. These include:

- Continuous audit cycle – in order to meet the requirements of the IG toolkit 506 standard, an auditor was employed by the Trust to conduct a continuous process of auditing case notes against the Trusts PAS. This process is documented in the Data Quality Policy and reports are included as a standing agenda item for the Information Governance meeting. The findings are reported back to the Divisions as part of the IG reporting system. .
- Clinical Coding/IG audit – in order to meet the IG Toolkit 505 requirements; an audit of 200 case notes was conducted in November 2015.
- Internal coding audits – a coding internal audit schedule is in place and the coding auditor has conducted several clinical and staff audits.

Clinical Coding Error Rate

In line with the requirements of the IG toolkit standard 505, a coding audit which included auditing 200 sets of case notes, was undertaken by an external coding auditor and the Trusts qualified coding auditor.

The table below shows the overall percentage of correct coding.

Primary diagnosis	77.5%
Secondary diagnosis	91.2%
Primary procedure	88.8%
Secondary procedure	81.7%

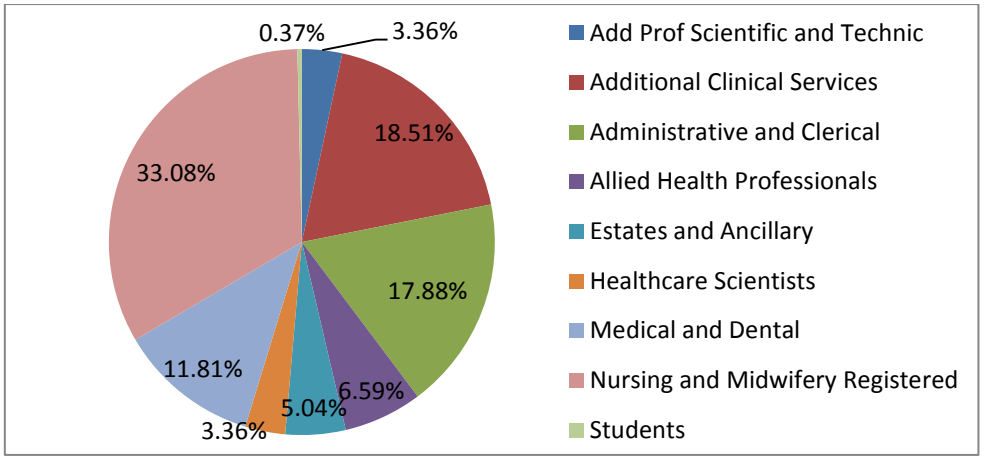
The Clinical Coding is of a generally good standard, but it was recognised that a reduction in the percentage for primary diagnosis and primary procedure needs to be addressed. The lower percentage in the primary diagnosis was attributed to histology results either being late or not filed correctly for coders to record. The lower primary procedure was due to some incorrect recording of the 4th digit, which means the procedure is correct however the depth if coding is not accurate. There is an action plan in place to address the required actions.

Staff

Workforce profile

Worcestershire Acute Hospitals NHS Trust employs just under 6,000 staff across all professions and disciplines. The Trust's annual expenditure on pay is approximately 70% of the total budget.

The largest single staff group is nursing and midwifery, which accounts for over 32% of the workforce, with medical and dental staff comprising just under 12%. The relative size of all staff groups within the Trust is shown in the diagram below:



Over 45% of our staff are within the 26 to 45 age group, whilst over 44% are 46 and over which means that the Trust is reviewing its retirement profile and planning for replacement.

The workforce is predominately female, with only 19% male. The Trust offers a range of flexible working practices which is demonstrated by the fact that we have over 35% of staff on part-time or flexible contracts.

Recruitment and retention

Throughout 2015/16 the substantive workforce capacity has remained relatively stable following an increase of 138.26 full-time equivalent (FTE) in the previous year due to radiotherapy development. However, we still have a shortfall against the budgeted establishment of 378.98 FTE as of February 2016 despite active recruitment.

Within the context of staff recruitment and retention, the term 'turnover' is used to refer to the totality of leavers from the organisation. The current overall turnover rate of 12.71% is an upward trend over the past financial year, which can in part be attributed to uncertainty over planned reconfiguration of services in Worcestershire, and the impact of negative press reports following a poor CQC report.

We have held active recruitment campaigns across many main staff groups, with the introduction of assessment centres for band 5 nurses and health care assistants (HCAs). However, as a consequence of continued retention issues in key areas such as middle grade doctors, surgery, radiography, and theatres, this is not keeping pace with turnover. Therefore, shortfalls in capacity are being partially met through the continued use of bank and agency staffing.

There is no single 'quick fix' solution but actions are being taken which aim to address the key issues affecting the Trust's ability to attract, recruit and retain high quality staff in sufficient numbers. This includes the analysis of direct feedback from staff via local and national surveys, the Friends and Family Test, and exit interviews. Current initiatives include:

- A 10% over-recruitment target in key areas (namely medicine and surgery)
- Agreement with Worcester University to increase numbers of student placements from 2016 intake
- Recruitment events
- Development of an internal transfer process to retain staff

- Band 5 and HCA assessment centres scheduled throughout the year
- Business case for another round of international recruitment
- Development of internal banks in some departments
- Return to Practice Campaign
- Introduction of a Recruitment and Retention Premia in theatres
- Widening participation – development of more B4 Assistant Practitioner posts
- Creating and sustaining the right culture and environment

Within the context of significant national staff shortages, which are predicted to continue for the foreseeable future, and additional pressures of the Trust's rural catchment area and uncertainty surrounding the Future of Acute Hospital Services in Worcestershire review, we anticipate recruitment and retention of staff to be challenging. Competition for staff is exacerbated by the pull to larger teaching Trusts which are easily commutable from Worcestershire.

Engagement

The degree to which staff are effectively engaged with the organisation is a key success criterion in meeting the Trust's objectives and in ensuring the knowledge, skills, experience and innovation of teams and individuals is utilised to the greatest effect. It is widely recognised that a workforce that is engaged, empowered and well-led will provide better care and a more positive experience for patients and services users.

Effective staff engagement is achieved in a variety of ways but the principal enabler is establishing and maintaining an organisational culture which is built on shared values and common goals. This begins with the recruitment process and 'values based recruitment'.

The Trust recognises that it is imperative to improve staff engagement, and therefore the quality of its services, by:

- Launching a new HR and OD Strategy underpinned by an OD Staff Engagement Plan which is supported by a myriad of communications, leadership, and health and wellbeing actions.
- Staff Engagement Group (SEG)
- Big Conversation
- Quarterly Pulse surveys
- Listening into Action (LiA) which is applied as a conversation tool at local and corporate levels, enabling teams to become more directly involved in making change happen in their areas. LiA events are to be launched in 2016.

NHS Staff Survey

The NHS Staff Survey is primarily intended for use by Trusts to consider feedback from staff regarding their experiences in the workplace. The findings of the annual survey are used in several ways, namely:

As a measure of staff engagement, informing the trust at organisation level on what is being done and where to focus attention for improvement

At a directorate and divisional level to provide data on staff experience alongside indicators such as patient surveys, complaints and compliments to inform and shape integrated plans to improve quality and patient experience.

As a benchmark with other acute Trusts

In total 372 staff at Worcestershire Acute Hospitals NHS Trust took part in the 2015 survey. This is a response rate of 44% which is average for acute trusts in England, and compares with a response rate of 38% in this Trust in the 2014 survey.

In summary the results of the national 2015 staff survey show no improvement and in many areas a decline against the Trust's 2014 position and the national average score for acute trusts. The Trust was in the bottom 20% of acute trusts for 23 of the 32 key findings and was worse than average in 4; average in 4 key findings and better than average in 1. At the time the survey in October – December 2015, the Trust was taking part in CQC and TDA reviews and the temporary move of birthing services from the Alexandra to Worcestershire Royal took place.

The results provide an indication that:

- There is evidence of a healthy reporting culture
- The results are statistically similar to last year

Three areas that have deteriorated specifically:

- KF22 – physical violence from patient/public increased from 14% to 22%
- KF6 – good communication between senior managers and staff deteriorated from 28% to 19%
- KF21 – agree that equal opportunities to career progression/promotion deteriorated from 90% to 80%

This position is being addressed with urgency as employee engagement is seen as fundamental to the Trust's improvement journey.

Staff Friends & Family Test

The degree to which staff are willing to recommend the trust both a place for their friends and families to be treated, and as a place to work, are strong indicators of staff engagement and motivation. These key areas of staff advocacy are tested quarterly through the annual staff opinion survey and the staff friends and families test which was first introduced in 2014. The results, including fee text comments are reported at the Workforce Assurance Group and to the Divisional management teams.

With respect to the two key advocacy questions in the annual staff survey compared with the national scores the Trust's performance has been as follows:

Staff who would recommend the Trust as a place for treatment			
WAHT scores in national staff survey			Average Acute Trusts
2013	2014	2015	2015
62%	67%	56%	70%

Staff who would recommend the Trust as an employer			
WAHT scores in national staff survey			Average Acute Trusts
2013	2014	2015	2015
59%	58%	51%	61%

Equality and diversity

The Trust complies with the Equality Act 2010 public sector equality duties and uses the Equality Delivery System (EDS2) developed within the NHS as a means by which to review and improve its equality performance. During 2015/16 the Trust has revised its Dignity at Work Policy and processes and Raising Concerns (Whistleblowing) Policy. It has developed its Staff Engagement and OD plan which aligns with the EDS2 and the Workforce Race Equality Standard (WRES).

All Trust workforce policies and procedures include an Equalities Impact Assessment (EIA) to ensure that any implications relating to diversity or inclusivity are considered. This is overseen by the Equality and Diversity Committee and the Workforce Assurance Group and any corrective action is taken.

The Trusts holds the “two ticks” disability symbol employer status. This accreditation recognises commitment to good practice in employing people with disabilities both in terms of recruitment and adjustments for those who become disabled during their career.

The Trust has recently extended its mandatory training matrix to include equality and diversity training. As at the end of March 2016 43% of staff had received this training. The vision and values are included in all mandatory and management development training sessions and 59% staff have attended Ace with Pace (customer care) training. Dignity at Work and “kNow Bullying” training sessions have been held on the three main sites. We have Staff Support Advisers who are able to offer informal support any staff who feel that they are experiencing inappropriate behaviour by colleagues or patients.

Staff health and wellbeing

A focused programme of sustainable initiatives was delivered in 2015/16 overseen by the OH and Wellbeing team. Our aim is to promote healthier lifestyle choices for all staff including physical activity using discounted gym and leisure facilities. The Trust achieved Level 1 accreditation in “Worcestershire Works Well” which is an initiative developed with the government, public, private, and voluntary sector to set a recognised standard for employers in respect of their staff health and wellbeing.

We are committed to improving mental health and wellbeing and provide resilience training and self care programmes as well as counselling and support. The OH and wellbeing team also provide roadshows and health promotion events including lifestyle advice, information and signposting to external organisations.

Sickness absence management

The Trusts sickness absence rate is in line with other acute trusts in the NHS but is higher than the local stretch target of 3.5%. Over the past year there has been an increased focus on supporting managers in dealing with long term sickness absence, and in widening access to counselling through the OH service to include personal stress as well as work related stress. This was in recognition of a spike in staff being absent with stress in December 2014. Around £30k was invested in additional counselling sessions for staff who were off sick with stress or anxiety with 31% being due to personal/home related stress which was exacerbated by the failure of GP's to provide timely access to counselling. We have seen our work related stress in the annual Staff Survey drop from 39% to 36% in 2015 which we believe to be in part related to our investment in counselling for home related stress.

Sickness rate for past 3 years

Worcestershire Acute Trust Cumulative 12 month Sickness Rate		**Acute Trust Benchmark *(Cumulative % rate taken from HSCIC website)***
April 2015 – Feb 2016	4.33% (4.28% as at November 2015)	4.28% (as at November 2015 which is the most up to date information published)
Apr 2014 – Mar 2015	4.09%	4.03%
Apr 2013 – Mar 2014	3.87%	3.84%
Apr 2012 – Mar 2013	3.87%	4.01%

In the winter of 2015 we saw our highest levels of sickness in the past 4 years. However, this was in line with other acute Trusts in England at 4.28% as at November 2015.

Appendix 1: List of clinical audits

The national clinical audits and national confidential enquiries respectively which Worcestershire Acute NHS Trust was eligible to participate in during 2015/16, are as follows:		
Eligible National Audits	**Participation**	**% or No's cases submitted**
Peri and Neonatal		
National Intensive and Special Care (NNAP)	Yes	100%
Children		
Diabetes (Paediatric) (NPDA)	Yes	100%
Paediatric Asthma	Yes	WRH - 26 ALX - 22
Acute Care		
Case Mix Programme (CMP)	Yes	WRH - 489 ALX - 293
National Cardiac Arrest Audit (NCAA)	Yes	WRH - 107 ALX - 61
National Emergency laparotomy Audit (NELA)	Yes	259
Vital signs in children (Care in emergency Department)	Yes	WRH - 50 ALX - 50
Procedural sedation (Care in emergency Department)	Yes	WRH - 50 ALX - 50
VTE in lower limb immobilisation (Care in Emergency Department)	Yes	WRH - 50 ALX - 50
Emergency Oxygen	Yes	WRH - 26 ALX - 9
National Complicated Diverticulitis Audit (CAD)	Yes	>10
UK Parkinson's Audit	Yes	Neurology - 20 Physiotherapy - 26
UK Cystic Fibrosis Registry	N/A	Included in Birmingham Childrens Hospital Data
Long Term Conditions		
Inflammatory Bowel Disease IBD (Programme) Biological Therapies	No	>75%
Pulmonary rehabilitation National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	TBC
National Vascular Registry	Yes	100%
Rheumatoid and inflammatory Arthritis	Yes	ALX - 56 KTC - 91 WRH - 69
National Diabetes Programme		
National Inpatient audit Diabetes (Adult)	Yes	119

National Foot care audit	Yes	21
National Pregnancy in diabetes	Yes	WRH - 10 ALX - 13
Cardiovascular Disease		
Cardiac Rhythm Management (CRM)	Yes	>10
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	700
Coronary Angioplasty/National Audit of PCI	Yes	1069
National Heart Failure Audit	Yes	394
Sentinel Stroke National Audit Programme (SSNAP)	Yes	90%+
Cancer		
Bowel Cancer (NBOCAP)	Yes	>100%
Lung Cancer (NLCA)	Yes	0
National Prostate Cancer Audit	Yes	. 100%
Oesophago- Gastric Cancer (NAOGC)	Yes	>90%
Trauma		
Major Trauma- The Trauma & Audit Research Network (TARN)	Yes	WRH - 278 ALX - 152
National Joint Registry (NJR)	Yes	ALX - 754 WRH - 183 KTC - 143
Falls and Fragility Fractures Audit Programme (FFFAP)		
Fracture Liaison Database		Not yet resourced
Inpatient Falls	Yes	30
National Hip Fracture database	Yes	ALX - 298 WRH - 418
Blood Transfusion		
Audit of blood management in scheduled surgery (National Comparative Audit of Blood Transfusion Programme	Yes	47

National Confidential Enquiry into patient Outcome and Death (NCEPOD)					
Name of Study	**Cases included**	**Clinical Q Returned**	**Case notes returned**	**Sites Participating**	**Org Q returned**
Mental Health General	10	4	9	3	2
Acute Pancreatitis	10	3	10	2	2
Sepsis	6	3	6	3	3
Gastrointestinal Hemorrhage	9	5	8	3	2

There was no data collection during 2015/16 for the following audits:

Audits
Paediatric Pneumonia
Non Invasive Ventilation (NIV)
Adult Asthma
National Audit of Ophthalmology
National Adult Bronchiectasis Audit
National Paediatric Bronchiectasis Audit
National Pleural Procedures Audit
National Adult Community Acquired Pneumonia Audit

Worcestershire Acute NHS Trust was not eligible to participate in the following national audits:	
Chronic Kidney Disease in primary care	Audit applies only to Primary Care
Adult Cardiac Surgery	Specialist Audit
Congenital Heart Failure (CHD)	Specialist Audit
National Audit of Intermediate Care	Specialist Audit
National Audit of Pulmonary Hypertension	Specialist Audit
Paediatric Intensive Care (PICANET)	Specialist Audit
Prescribing Observatory for Mental health (POMH)	Audit only applies to mental health
Renal Replacement Therapy (Renal Registry)	Specialist Audit

Title of National Audit	Summary from report – best practice and actions
National Intensive and Special Care (NNAP)	The individual unit results show that data entry has improved significantly in a number of key areas from 2013 to 2014. In particular areas such as administration of antenatal steroids, ROP screening, and parent consultation.
Case Mix Programme (CMP)	The Trusts QI value is "better than expected than by chance alone" which is below 3SD category.
National Emergency laparotomy Audit (NELA)	The Trust has a case ascertainment rate of over 80% of estimated case load entered which therefore is a green rating. A pathway is being developed for all emergency laparotomy patients.
UK Cystic Fibrosis Registry	This service is shared care with Birmingham Childrens Hospital including joint clinics. The data is collected January – January and a report will be available in July.
National Inpatient audit Diabetes (Adult)	Report published action plan being developed.
National Diabetes Foot-care audit	This is a joint project with the Health & Care Trust nurses. No report has been published.
National Pregnancy in diabetes	New proforma specifically for DKA – available on the intranet

Title of National Audit	Summary from report – best practice and actions
	Education of junior doctors in Trust – Introduction of ketone monitors – in place Alex and WRH in A&E and MAU
Inflammatory Bowel Disease IBD (Programme) Biological Therapies	The Trust is currently purchasing the IBD Registry Patient Management System (PMS), a computerised information system that feeds data automatically into the IBD Registry, and in future, the UK IBD Audit.
Pulmonary rehabilitation National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Patients who received their initial assessment and had a primary diagnosis of COPD were invited to consent to take part in the audit. 73 patients were consented across the county.
National Vascular Registry	We are 100% compliant with the registries and are currently retrospectively inputting 3 years' worth of data onto the system.
Rheumatoid and inflammatory Arthritis	The Trust was an outlier in meeting Nice Quality Standard 2. People with suspected persistent synovitis are assessed in a rheumatology service within 3 weeks of referral. The Trust is assessing the waiting times and developing an EIA service
Cardiac Rhythm Management (CRM)	Practice is in line with the rest of the UK
Coronary Angioplasty/National Audit of PCI	• 118 PCI Centres – WRH in top 18 performing 950+ procedures • All clinicians on call same number of days whether weekend or week • Clinicians exceeding 100 procedures national average 75 • All of the fields data completeness 99-100% (Only 18 achieved 100%) • 33% of procedures all elective • Complication rates Femoral 1.3% Radial 0.3% • Call to balloon <150 min 79% • Door to balloon <90 min 90% • Mortality to discharge 1.7% • In hospital mortality 4.78%
National Heart Failure Audit	The audit has identified that a Specialist heart failure nurse is needed and therefore a business case has been produced. Worcestershire Acute Hospitals are in line with other Trusts in England against the standards.

Title of National Audit	Summary from report – best practice and actions
Sentinel Stroke National Audit Programme (SSNAP)	The SSNAP summary report published in March which details the October to December 2015 showed that the Trust had moved to an overall banding of D for SSNAP, which is an improvement from the previous quarter (July-September 2015) in which the band overall was E. The improvements made over the quarter have included the response times to the thrombolysis standards and processes and the increased effectiveness of the discharge process. Worcester has also increased our general SSNAP reporting process which has increased the case attainment which effects the overall scoring. The trust continues to be very challenged with the direct admission to the stroke unit which under SSNAP standards is measured from the point of ambulance crew handover to the stroke unit within 4 hours. This standard is in a bundle which the scoring of that bundle can then not be recovered / improved and has consistently seen the Trust banded at E. The Trusts capacity issues and the downstream flow have had, and continue to have, a detrimental effect on the SSNAP scoring. A large percentage of the patients are moved directly to ASU as their first ward but do not achieve the 4 hour standard. There is an action plan for the improvements required regarding the SSNAP standards for with the ability to improve upon (not capacity related). • Speech and language therapy have now recruited extra staff following the success of their business case and these staff are now in post. They have previously been banded at E due to the response times, but would be looking at an improvement to Band A/B on the reporting quarter that covers April to June 2016 as the service will be fully staffed. There may be a part quarter improvement in the next report. The new staff have also allowed the Trust to start to provide a robust plan of training nursing staff across stroke, ED and MAU on swallow assessments which will also increase the timely response and quality of patients swallow and nutritional assessments. • Continence assessment (part of a larger bundle) has been addressed with staff education and followed up with ward based Matron spot audit to ensure the process is embedded. The paperwork has also been uploaded to EZ notes to ensure a consistent approach across the pathway. • Assessment of mood and cognition: the assessment process has been modified to report on the AMT as a cognitive assessment which reducing repetition and is in line with standards and the dementia targets, and the mood assessments are now being routinely completed by the OT department. The trust would expect to see a next quarter increase in this target. • Completion and follow up of NIHSS scores: a best

Title of National Audit	Summary from report – best practice and actions
	practice ward round checklist has been developed and is now in use with this standard included amongst others. The Trust would expect to see an increase in the scoring of this standard in the next reportable quarter. The stroke team has monthly speciality meetings to discuss the service, patient pathway and governance issues. The SSNAP standards and the audit improvement tool are discuss as a monthly agenda item
Bowel Cancer (NBOCAP)	The report demonstrates that Worcestershire Acute Hospitals NHS Trust is one of the largest resection centres in the country with index measures such as length of stay, proportion of surgery undertaken by laparoscopic surgery and 90 day post-surgery mortality rates being amongst the best currently being achieved in the UK. The report does document a higher than national average 18 month post-surgery stoma rate which appears to be related to historic data entry.
Lung Cancer (NLCA)	Lung cancer data was not uploaded to LUCADA last year and that resulted in Worcester being excluded from the 2014/2015 national report? The reason being LUCADA is no longer the platform for submitting the lung cancer audit data and as per guidance from the NCRS all audit data has been submitted on a regular monthly basis through the COSD dataset. Trusts in England have been offered a one-time opportunity to refresh lung cancer data for the first five

Title of National Audit	Summary from report – best practice and actions
	months of 2015. Worcester submitted before the deadline of 7/1/16 and will be included in the appendices due in May 2016.
National Prostate Cancer Audit	It is clear that the trust has done very well in this audit. However, we need to speed up our robotic project to be able to sustain our position
Oesophago- Gastric Cancer (NAOGC)	All of Worcestershire Acute hospitals gastric cancer patients have a management plan that has been agreed by the MDT team and referred to a specialist centre
Major Trauma- The Trauma & Audit Research Network (TARN)	This is a registry of on-going data collection; If the Trust was to become an outlier against any of the standards measured it would receive notification from the provider of the audit. The Trust would then tackle the issue in the form of an action plan.
National Joint Registry (NJR)	This is a registry of on-going data collection; If the Trust was to become an outlier against any of the standards measured it would receive notification from the provider of the audit. The Trust would then tackle the issue in the form of an action plan
Fracture Liaison Database	Obtaining resources to fulfil the requirements of this audit
Inpatient Falls	Action plan has been develop to incorporate national recommendations
National Hip Fracture database	The Trust regularly inputs data into the National Hip Fracture database and improves services based on the results.
Audit of blood management in scheduled surgery (National Comparative Audit of Blood Transfusion Programme	Pathways being developed, communication package being developed

Local Clinical Audits

During 2015/16 WHAT undertook 281 local Clinical Audits.

The below table demonstrates the 37 completed clinical audits, their actions and any improvements that have been made. 'Completed' audits are classified as those that have been finalised, including closure of all outstanding actions. In addition to these completed audits there are a further 69 audits that have been completed and have actions that are being actively managed to closure.

ID No	Audit Title	Division	Actions/Improvements
1	Review of Photic Stimulation Protocol	Medicine/ Neurology	A review of the departmental policy was undertaken as a result of the audit and based on BSCN/ANS standards.
5	Audit of consent for clinical photography	Surgery/Oral & Max Fax	Continue to follow local Trust policy or aim to achieve national best practice guidance as per the British Orthodontic Society.
15	Percentage Compliance for Glucose Blood Test Results for NSTEMI Patients	Medicine/ Cardiology	To continue to improve compliance with obtaining Glucose results and will remind all staff in clinical areas of the importance of obtaining bloods for risk assessment. Continue to adhere to Trust Policies and NICE Guidance regarding care of ACS patients
18	Complex cardiac device implantations, our experience so far	Medicine/ Cardiology	• Formal MDT discussion for all complex device implants • Implant letter for all procedures carried out • Uf plasmablade and or diathermy for patients on antiplatelets
22	Use Of Endocrine Blockade For Men Diagnosed With ER+ Breast Cancer	Surgery/ Breast	The audit has highlighted that the Trust is non-compliant with the NICE guidance, however a high percentage are having adjuvant treatment
36	Prevention of retention of nasopharyngeal packs: Reaudit of Trust Policy	TACO/ Anaesthetics	Policy on throat packs introduced Jan 2014, available via Anaesthesia Guidelines on the intranet. Since introduction there have been no instances recorded. It is now a Never Event
38	Management of patients post Thyroidectomy for Grave's disease	Surgery/ Upper GI	The benefits of using a harmonic Scalpel for Graves' disease is Less operative time, Less haematoma, Less hypocalcaemia.
41	Audit of CT whole body trauma times from patients attending the Emergency department at WRH	Clinical Support/ Radiology	The actions highlighted and completed as a result of this audit are: • A pathway has been developed to provide earlier CT requesting from A&E. The department has decided not to wait for creatinine results to provide a CT due to the delay in SIP • Strategies been developed for optimising times by prioritising trauma reports over other scans from wards and A&E

ID No	Audit Title	Division	Actions/Improvements
			• Finally a written proforma has been agreed in line with RCR guidance to provide a primary report immediately
46	ID 46 Re-excision rates after Breast Conservation Surgery	Surgery/ Breast	For patient undergoing BCS, the unit has achieved a 100% target for no residual disease at radial margins following 3 or less operations. The Trust needs to maintain the high standard level of care as per NICE and the literature guidelines. This information will be used when discussing treatment with patients.
53	ID 53 Standards for the Treatment of Chronic Immune (idiopathic) Thrombocytopenic Purpura	Haematology/ Clinical Support/TACO	Re-audit NICE guidance for use of Eltrombopag & Romiplostim (TA 221 & 293) in chronic Immune Thrombocytopenia. This is required to confirm on-going compliance with this NICE guidance with particular reference to standard 1 which requires clear documentation in the medical notes or clinic letter of the reasons a patient may not be suitable for splenectomy.
59	ID 59 Surveillance Mammography after DCIS and Breast Cancer Treatment	Surgery/ Breast	• Perform annual mammography's • As a team to consider and discuss enrolling patients in the mammo 50 study (A study of mammographic surveillance in women older than 50 at the time of treatment) conducted by Warwick Medical School.
67	ID 67 Appropriateness of usage of CTPA and isotope perfusion scans in the investigation of suspected pulmonary embolism in pregnancy.	Clinical Support/ Radiology	The results against the standards were 95% and above, The only action identified was the Algorithm for the investigation and initial management of PE in pregnancy to be displayed in reporting rooms and CT control rooms on both sites
80	ID 80 Annual Phototherapy Audit	Surgery/ Dermatology	When comparing to 'minimum standards for phototherapy services' most points are met and those that are not currently are being address as detailed in the action plan.
82	Head Injury	Medicine/ Emergency Department	The audit identified the department was failing to triage patients within 15mins and highlighted a need for a Triage nurse this has now been addressed. There was an issue with receptionists not checking demographics when booking in the patients. A training session was delivered and the matter has been addressed.
96	Risk Stratification in patients with Pulmonary Embolism	Acute Medicine	The audit highlighted that PESI or sPESI are not used, therefore cardiology cannot stratify patients into the intermediate high or intermediate

ID No	Audit Title	Division	Actions/Improvements
			low risk categories according to ESC guidelines, we therefore do not know which patients should be 'monitored for early detection of haemodynamic decompensation. A PE proforma is currently being developed.
109	Anticoagulation after stroke due to Atrial Fibrillation/Atrial flutter	Medicine/ Stroke	• To use a sticker for CVA patients with AF • To develop a stroke handbook for junior doctors and re-audit in the future
116	Child Safety	Medicine/ Emergency Department	• Further training of the triage nurses • Reminder in the weekly update
140	Regional audit into the use and effectiveness of investigations performed on in-patients	Medicine/ Neurophysiology	The results are regional and the following recommendations were suggested. Results are thoroughly questioned prior to the investigation being performed, Know the specific question that needs answering prior to performing the test. Check the patient's actual state before the test.
141	Recording of Adult Vital Signs and Actions Taken in the Major Areas of the Emergency Department	Medicine/ Emergency Department	90% Compliance was not reached for any of the criteria audited against, education will be cascaded using weekly brief and nurse and doctor teaching sessions
144	Pain In Children	Medicine/ Emergency Department	• Use of the observation sheet or second observation line • Use of the declined/offered box on the front clerking sheet (even if it by the doctor clerking not at triage) • Possibly include an additional box next to the NAI questions to put in a pain score, time and action • More awareness of appropriate analgesia for moderate and severe pain
146	Emergency management of hyperkalaemia	Medicine/ Emergency Department	The audit shows good compliance against the NICE guidance, and identified that all patients with severe hyperkalaemia received Insulin/Dextrose but not all Salbutamol
170	Asthma Audit 2014	Women's and Children's/ Paediatrics	The audit highlighted that we are administering Steroids within a 60 minute timeframe. The improvements completed are an asthma stamp to be used as a checklist, updated clinical guidelines and a management plan for asthma.
178	The role of breast MRI in altering pre-planned treatment in elderly women with lobular cancer	Surgery/ Breast	We conclude that MRI was efficacious in evaluating the extent of disease and in changing the surgical plan towards a more radical operation and hence it is a useful (but expensive) tool in the

ID No	Audit Title	Division	Actions/Improvements
			evaluation of elderly women with ILC.
396	Compliance of Asking Safeguarding Questionnaire	Medicine/ Emergency Department	The emergency department are not 100% compliant with the NICE guideline standards. Not all members of staff are aware of which designated professional to seek help from regarding child protection. The emergency department does have the NICE guideline available, but it is not being read during child protection training
399	Management of Renal Colic Pain	Medicine/ Emergency Department	• Awareness among nursing and junior staff regarding prompt analgesia and re evaluation • Teaching session of junior and senior doctors for documentation and re-evaluation of analgesia • Explore and address the reason for more than 4hrs stay
400	Acute kidney injury (AKI) CQUIN 2015 – FY doctor audit	Medicine/ Renal	• Staff members are aware of the AKI CQUIN and need to document the AKI CQUIN targets • Staff members are now prompted to fill in AKI details for GP according to CQUIN standards. • Staff members have been made aware of AKI CQUIN and need to document specific data for standards. • Bluespier has been modified to prompt staff to fill in specific data required
419	Re Audit Airway Alert Follow Up	TACO/ Anaesthetics	The audit highlighted a need to change practice to ensure the patients could retain the information given. The anaesthetist has initial discussion with patient, the form is completed and the doctor contacts the patient for discussion. A credit card size document has been produced and a re-audit will take place in Oct 2016.
432	Audit of the Hysterosalpingogram service provided at the Alexandra Hospital	Clinical Support/ Radiology	• Work to reduce screening times • Work to reduce dose • Re-audit
441	Hand Injury Management in the Emergency Department	Medicine/ Emergency Department	Documentation needs to be improved especially pain scores. Due to the sample size it will need to be re-audited with a larger sample for meaningful results
452	VTE Risk Assessment	Haematology/ Clinical Support/TACO	Results showed non-compliance against the VTE policy and education is needed for all staff to highlight the need for VTE assessment and prevention. This will be a regular audit from April 2016.
474	Re-audit of management of	Medicine/	Re audit shows we are not doing well

ID No	Audit Title	Division	Actions/Improvements
	fracture neck of femur within the Emergency Department at Redditch Alexandra Hospital	Emergency Department	in managing the pain in patients with neck of femur fracture as compared to our previous audit, especially in recording the pain score, initial analgesia and re-evaluation of pain. We did improve CEM standard for radiology investigations. Overall admission rate under4 hours gone worse from 83% to 54%, this is mainly due to bed situation in trust.
483	A Retrospective Clinical Audit of Falls at Timberdine Nursing and Rehabilitation Centre	Medicine/ Geriatric Medicine	The nursing staff are now able to perform the neurological examination
523	RCPCH guideline about managing admitted children	Women's and Children's/ Paediatrics	Better compliance with RCPCH standards in re- audit
647	Audit of viscosupplementation injections for Osteoarthritis of the Knee	Surgery/T&O	Validate local protocol with the rest of the department

Appendix 2: Care Quality Commission Ratings

Overall ratings for Worcestershire Acute Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Ratings for Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Inadequate	Requires improvement	☆ Outstanding	Requires improvement	Inadequate	Inadequate
Services for children and young people	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Ratings for Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Inadequate	Requires improvement	☆ Outstanding	Requires improvement	Inadequate	Inadequate
Services for children and young people	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Ratings for Kidderminster Hospital & Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Ratings for Evesham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging						
Overall	Good	Good	Good	Good	Good	Good

Appendix 3: Statements

Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

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

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

By order of the Board

NB: sign and date in any colour ink except black

John Burbeck
Chairman ..... Date: .....

Chris Tidman
Acting Chief Executive ..... Date: .....

External review statements

Worcestershire Health Overview and Scrutiny Committee (HOSC)

Worcestershire HOSC regrets that it is unable to provide a commentary on the 2015/16 Quality Account due to changes in its committee membership.

Worcester CCGs

The response detailed below is a collective response from the three Clinical Commissioning Groups (CCG) in Worcestershire. (NHS South Worcestershire CCG, NHS Wyre Forest CCG and NHS Redditch & Bromsgrove CCG). All three CCGs welcome the opportunity to comment on the 2015/16 Quality Account for Worcestershire Acute Hospitals NHS Trust.

Commissioners recognise that this has been a particularly challenging year for the Trust during which it has managed a significant programme of transition and transformation of its services. This includes the redesign of the Emergency Department at the Worcester Acute Hospital site and the temporary relocating onto one site of the Maternity and Neonatal Services. This year has also seen the Trust placed into 'special measures' following its Care Quality Commission (CQC) Inspection in July 2015. Throughout, the Trust has been open and transparent regarding the challenges and concerns they face and the CCGs would like to acknowledge this.

During 2015/2016 the Worcestershire healthcare economy has faced a number of significant challenges which have impacted upon the Trusts ability to make and sustain quality improvements across the organisation. It is acknowledged that the Trust is working hard to address these issues however progress has been slow which is reflected throughout the Quality Account and demonstrated by the Trusts failure to fully achieve any of the quality priorities that were set for 2015/16. It is also acknowledged that despite the work undertaken significant concerns still remain in relation to the performance and sustainability of some services, workforce capacity and patient flow through the Trust.

The CCG recognises the capacity and demand challenges faced by the Trust and welcomes the Trusts commitment to prioritising improvements through the work they are undertaking with the Emergency Care Improvement Programme (ECIP). This will also be strengthened by the implementation of the 2016/2017 local CQUIN programme which has been developed with a specific focus on improving patient flow and reducing the number of avoidable Hospital admissions.

Despite the challenges faced by the Trust the CCGs would like to acknowledge some positive quality initiatives/outcomes achieved in relation to attaining the national Clostridium Difficile Infection (CDI) trajectory. Also the work undertaken, following the CQC inspection, to strengthen both corporate and local governance arrangements in relation to the reporting of quality concerns, management of Serious Incidents and complaints. These initiatives are still in the process of being fully implemented and there remains work to do in terms of embedding

learning across the organisation. Nevertheless they demonstrate a commitment by the Trust to improving and sustaining quality and safety across the organisation. In relation to mortality reviews the CCGs support the implementation of the Trusts improvement programme and will continue to monitor the metrics to ensure improvements in avoidable mortality.

Commissioners support and welcome the specific priorities for 2016/17 to improve on patient safety, patient experience and effectiveness which the Trust has highlighted in the Quality Account. All are appropriate areas to target for continued improvement and build on the achievements in 2015/2016.However given the limited progress seen against the targets set in 2015/16 the Trust should consider how they intend to ensure the monitoring processes are more robust this year in order to prevent a recurrence.

Our view is that the Quality Account is largely presented in a clear and easy to read format. It includes all essential elements and incorporates the NHS England's 2015/16 presentation guidance and to the best of our knowledge appears to be factually correct. The Quality Accounts are intended to help the general public understand how their local health services are performing. With that in mind it is strongly recommended that the Trust reviews some sections in relation to the use of unqualified acronyms, grammar and whether some of the sections are written in plain English which can be understood by the general public.

The CCGs will continue to work collaboratively with the Trust monitoring quality improvements on a monthly basis, through the Clinical Quality Review Meetings. The CCG will also continue to undertake Quality Assurance visits to enable the Trust to showcase improvements and identify areas on which to focus improvements and embed learning Trust wide.

Overall Commissioners are happy to accept this Quality Account as an accurate and fair reflection of the Trusts quality profile with a balance of positive and negative results. The CCGs look forward to continuing to work in partnership with the Trust during 2016/17 developing relationships to help deliver the Trust’s vision of providing safe, effective, personalised and integrated care for local people, delivered consistently across all services by skilled and compassionate staff.

Healthwatch

Healthwatch narrative is due for board approval on 3rd June 2016 and will be included once approved input has been received by WAHT.

Independent Auditors' Report

To follow

Acknowledgements and feedback

Acknowledgments

Worcestershire Acute Hospitals NHS Trust wishes to thank its entire staff, the contributors to this Quality Account and our external stakeholders who have provided commentaries on it.

Feedback

Readers can provide feedback on the report and make suggestions for the content of future reports to the Communications Department.

Contact details:

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 08 June 2016 **Enc E3**

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

Key Messages

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

Despite significant effort by staff, progress with the PCIP has been slow and it is evident that capacity and capability to deliver improvement programmes at the Trust is underdeveloped.

Incremental progress has been made and a new improvement approach has been adopted by the Trust. 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.

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

Date of meeting: 08 June 2016 **Enc E3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JUNE 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 May 18th 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 required improvement plans. This report will next be updated for publication in time for the June 2016 meeting of the QIRG and the updated version will be available at the July meeting of the Trust Board.

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

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 progress with the PCIP has been steady but slow, as staff have responded willingly to the challenge but with limited headroom.

The Trust has purposely focussed on the three priority programmes described above to develop sufficiently detailed project plans, governance structures and improvement measures to create the right conditions for sustainable improvement and it is imperative now that these programmes start to show step improvement. An updated report will be available later in June in time for the next meeting of the QIRG. In the interim, the Trust Improvement Board will be reviewing the PCIP on June 15th to assess the current status of each of the improvement plans and steps required to demonstrate that we are making sustainable progress.

The operational and governance improvement plans which alongside the priority programmes form part of the overall PCIP, need to be further developed in line with the format of the priority programmes and, by the time of the next report, there needs to be greater consistency in terms of reporting

format.

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 further work to do increase staff engagement and understanding of the Trust plans and priorities.

3.2 Controls in place

The Trust has developed an improvement framework in terms of the approach to improvement programmes which is starting to be consistently adopted. There is further work to do to ensure that this becomes embedded.

The lack of pace with the delivery of the PCIP has been recognised and there is additional resource in place to ensure that the programme management approach is driving delivery and 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, although the latter needs to better integrated with the improvement plans and governance arrangements.

The Trust 2016/17 Control Plan will be published shortly 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

There are recognised capacity and capability issues in delivering the required levels of improvement activity across Trust programmes, and performance issues continue to impact on day to day staff capacity. A resource plan has been developed and rapidly implemented to provide dedicated improvement support.

Staff engagement remains a key issue and the Trust is looking to simplify the messages around priorities and programmes.

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

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

Enc E3

Worcestershire Acute Hospitals NHS Trust

Patient Care Improvement Plan

April 2016 report as presented to May 13th meeting of Combined Quality Improvement Review Group

Our Improvement Plans

Worcestershire NHS
Acute Hospitals NHS Trust

Urgent Care and Patient Flow – Workstreams & Measures

Worcestershire NHS
Acute Hospitals NHS Trust

SAFER bundle	% stranded patients (NEL LoS > 7 days)	% discharges before 12 midday	% of patients with an EDD who are discharged on the day of EDD (Non Elective)				
ED and Acute Care	Increase in % NEL 0 – 24 hour LoS	Reduction in NEL admission conversion rate	Time to initial assessment in ED for ambulance/all arrivals (95th %tile)	% of all patients receiving an initial assessment within 15 minutes of arrival	% of patients referred by GPs attending ED	% of patients spending > 12 hours in ED	- % Patients reviewed by speciality in <1 hour
Frailty	% of >75 year olds who are Stranded Patients	Reduction in NEL LoS > 75 years					
Patient Flow Centre	Delays to transfers of care	Stranded patients	Number of complex discharges from Acute and community				

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

SAFER CARE BUNDLE WORKSTREAM

SITUATION

The WAHT SAFER bundle has been rolled out but application is inconsistent and the benefits are not being realised.

TASK

By December 2016 the task is: To embed the SAFER bundle on all wards through effective change management arrangements with clear objectives, milestones, measures and review arrangements; To ensure senior clinician and MDT engagement in daily Board and Ward rounds (80% attendance); To ensure 99% of patients have an agreed EDD; To ensure each ward discharges 2 patients before 10am and 33% of patients are discharged by 12; To ensure weekly review and escalation of stranded patients.

ACTION (including milestones)

30 days: 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.

60 days: 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.

90 days: Embed the SAFER bundle performance framework at ward, Directorate, Division and Trust level.

RESULTS

The KPIs are tabled below. 97% of patients had an EDD in March 2016 against a target of 99% (100% on the WRH pilot wards). 66% of Non-elective patients on the pilot wards were stranded in March 2016 compared with the Trust average (52.4%). The pilot wards achieved 23.2% discharges before midday compared to the Trust average of 16.6% in March.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

SAFER BUNDLE METRICS

Metric 1.1 - % stranded patients (NEL LoS > 7 days) — **Target: 45% (September 2016)**

Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	01/16	65.1%											
Trajectory		55%	55%	55%	54%	53%	51%	50%	48%	45%	45%	45%	45%
Actual		65.1%	41.6%	52.4%									
RAG													

Definition: Numerator – The total number of Non Elective patients who have been in hospital (all Sites) for 7 days or longer from admission to discharge.
Denominator – The total of all Non Elective patients who have been in hospital (all sites) regardless of length of stay.
Data Source: OASIS

Metric 1.2 - % discharges before 12 midday — **Target: 33% (September 2016)**

Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	March 2015	18.5%											
Trajectory					20%	23%	25%	27%	30%	33%	33%	33%	33%
Actual		18.0%	17.2%	16.5%									
RAG													

Definition: Numerator – The total number of Non Elective patients discharged before midday (excluding Obstetrics and Paediatrics)(All Sites)
Denominator – The total number of discharged Non Elective patients regardless of time of discharge (excluding Obstetrics and Paediatrics)
Data Source: OASIS

Metric 1.4 –% of patients with an EDD who are discharged on the day of EDD (Non Elective) — **Target – 50%**

Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	March 2015	31.7%											
Trajectory					32	34	36	40	45	47	50	50	50
Actual		30.6%	28.0%	27.2%									
RAG													

Definition: Numerator – The total number of Non Elective patients that were discharged on the day of their EDD (last recoded)(All Sites)
Denominator – The total number of Non Elective patients who had an EDD recorded on OASIS
Data Source: OASIS

Risks to delivery	Corrective actions
• Engagement of clinicians to participate in early board rounds and setting EDD • If staffing levels reduced no nurse on ward rounds • Wards not being allowed to select pts from MAU due to pressures in ED • Stranded patients do not reduce despite Best Practice Ward Rounds	• Engagement with champions consultants to test and pilot board rounds • Development of champions on each ward to direct board and ward rounds who communicate progress/success • Ensure bed management team aware of the need to "pull" from MAU • Stranded patient reviews led weekly by DDN for medicine

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

ED AND ACUTE CARE WORKSTREAM

SITUATION

Best practice in Urgent and Emergency care is not consistently implemented at WAHT. A significant number of ED attendances and emergency admissions through EDs at WAHT could be treated more appropriately in specialty Ambulatory facilities. In March 2016 WAHT had a small scale, impermanent, part time ambulatory emergency care service on one site only (WRH). The Medical Admissions Unit at WRH was small and operated from temporary facilities adjacent to ED, and MAU at AGH functioned only rarely due to high nurse vacancy levels. Exit block from ED, particularly at WRH resulted in delayed ambulance handover and delays in patient triage. Only 46% of patients referred to specialty doctors were seen in ED with an hour.

TASK

By December 2016 at the latest, the task is: To implement a permanent AEC service on both acute sites (Mon-Fri 8am-8pm); Increase the number (15 new pts per day) and scope (specialty clinic slots) of emergency admissions/attendances; To ensure MAU functions consistently at AGH (24/7); To ensure MAU on both sites treats more patients as ambulatory (60% and currently this shows 51.6%); Ensure 75% of GP referrals are seen in specialty clinics not ED; Ensure triage in ED is undertaken consistently (95% triaged in 15 mins); To minimise ambulance handover delays (95th %ile patient gets initial assessment in ED within 15 minutes); To ensure 75% of patients referred to specialty doctors are seen within an hour.

ACTION (including milestones)

30 days: AEC relocated to a dedicated facility at WRH on 14th March. From 31 May a directory of services will be implemented for internal referrals to specialty clinic appointments from ED, MAU and AEC. A trial of Senior Immediate Assessment Nurse triage was implemented at WRH in the week commencing 25th April. A trial of an ambulatory model for medical admissions at AGH MAU will be completed by 15th May. An escalation process has been implemented for specialty review delays, and a breach report has been developed.
60 days: 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
90 days: Embed the Urgent Care and Patient Flow performance framework at ward, Directorate, Division and Trust level.

RESULTS

The Senior Initial Assessment Nurse trial improved triage times in WRH ED, (an average of 7 minutes to initial assessment over 12 hours). The Trust average improved over the last three weeks as a consequence from 71% to 80% receiving an initial assessment within 15 minutes. AGH performance on specialty triage and ambulatory emergency care improved in the last two weeks. MAU has operated on 16 out of 19 days up to 10th May and processed 111 new GP referrals and 21 'urgent review' patients. Only 8 were admitted, avoiding 6.5 admissions per day.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

ED AND ACUTE CARE METRICS

Metric 2.1 – Increase in % NEL 0 – 24 hour LoS											Target 60%		
Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	Sep 2015	51.6%											
Trajectory					52	53	54	55	57	59	60	60	60
Actual		50.4%	51.3%	51.6%									
RAG													

Definition: Numerator – The total of Non Elective patients who have been in the hospital (all Sites) between 0-24 hours before discharge, including admissions to assessment areas.
Denominator – The total Non Elective patients in hospital (all Sites) regardless of length of stay.
Data Source: OASIS

Metric 2.2 - Reduction in NEL admission conversion rate											Target: 18%		
Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	March 2015	22.9%											
Trajectory					23	23	22	21	20	19	18	18	18
Actual		23.27%	22.28%	20.95%									
RAG													

Definition: Numerator – The total number of patients attending the ED or Assessment areas who are then admitted to a Ward at WRH or the ALX.
Denominator – The total number of patients attending the ED or Assessment areas at WRH or the ALX.
Data Source: Patient First and OASIS

Metric 2.3 - Time to initial assessment in ED for ambulance/all arrivals (95th %tile)											Target: 15 minutes		
Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
ARRIVALS BY AMBULANCE													
Baseline	04/2015	45											
Trajectory		Is for all patients - see below											
Actual		35	49	54									
RAG													
AMBULANCE AND WALK IN ARRIVALS													
Baseline	04/2015	37											
Trajectory					37	37	30	30	25	25	20	20	15
Actual		32	42	46									
RAG													

Definition: Numerator – 95th percentile in minutes of patients attending ED by arrival type who received an initial assessment within 15 minutes of arrival time.
Denominator – 95th percentile in minutes of patients attending ED by arrival type regardless of the time take to receive their initial assessment.
Data Source: Patient First

Metric 2.4 - % of all patients receiving an initial assessment within 15 minutes of arrival											Target: 95%		
Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	March 2015	66%											
Trajectory					80%	80%	85%	85%	85%	90%	95%	95%	95%
Actual		82%	77%	77%									
RAG													

Definition: Numerator – The total number of patients attending ED by any arrival type who received an initial assessment within 15 minutes of arrival time.
Denominator – The total number of patients attending ED by arrival type regardless of the time take to receive their initial assessment.
Data Source: Patient First

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

ED AND ACUTE CARE METRICS

Metric 2.5 - % of patients referred by GPs attending ED **Target: 45% (December 2016)**

Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	April 2015	79%											
Trajectory					70%	70%	65%	65%	60%	55%	55%	50%	45%
Actual		69%	70%	72%									
RAG													

Definition: Numerator – The total number of patients referred by a GP to the ED at WRH or ALX. (Excludes the patients referred to the Assessment areas)
Denominator – The total number of patients referred by a GP to the ED or assessment areas at WRH or ALX.
Data Source: Patient First

Metric 2.6 - % of patients spending >12 hours in ED **Target: 3.7%**

Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	April 2015	3.75%											
Trajectory					5%	4.9%	4.8%	4.6%	4.3%	4%	3.9%	3.8%	3.7%
Actual		4.96%	4.08%	5.17%									
RAG													

Definition: Numerator – The total number of patients who have been in ED for more than 12 hours (>720 minutes) from arrival to discharge/admission
Denominator – The total number of patients who have attended ED

Metric 2.7 - % Patients reviewed by speciality in <1 hour **Target: 75%**

Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	April 2015	46.2%											
Trajectory					45%	50%	50%	50%	60%	60%	70%	70%	75%
Actual		44.5%	50.4%	44.3%									
RAG													

Definition: Numerator – The total number of patients attending ED that were then seen by a Specialist within 60 minutes of referral from ED.
Denominator – The total number of patients attending ED for whom a Specialist referral was made regardless of the length of time taken to be seen.
Data Source: Patient First

Risks to delivery

- Number of Acute physicians to lead AEC model will decrease due to turnover from June 2016
- Dependency on locum Acute Physicians may affect continuity of service
- MAUs not able to function as assessment areas used as G&A beds
- Wards not allowed to pull from MAU due to pressures in ED

Corrective actions

- Task and finish group established to secure short term and long term recruitment plan
- Recruitment of permanent substantive Acute Physicians
- Divisional daily capacity plans to be implemented from 16th May
- The new SOP for the Capacity hub prioritises assessment areas

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

FRAILTY WORKSTREAM

SITUATION

Out of a complement of 8 consultants in elderly medicine WAHT has two full time permanent members of staff and 2 locum consultants. In a successful two week test of an Older Persons Assessment and Liaison (OPAL) service at WRH in March, the OPAL team saw 56 emergency patients referred from either GPs or ED for admission. The team discharged 40, admitting only 16. The pilot has not been implemented permanently as the consultants and other members of the team essential for Comprehensive Geriatric Assessment have other essential clinical duties.

TASK

By December 2016, the task is to implement OPAL at both WRH and AGH 5 days pw; To close an elderly medicine base ward in Aconbury East, WRH which is a sub-optimal physical ward environment off the main hospital campus at WRH, to release staff to deliver OPAL; To ensure OPAL reviews 10 patients per day and discharges 80% of patients seen; To establish a new Silver ward on MSSU at WRH with a 72hr LOS facility and ambulatory facility for the OPAL service; To establish OPAL at AGH as part of MAU; To establish a regular Liaison session with primary and community care to support independence at home for the frail elderly, to manage complex cases (regular ED attenders and fast-track referrals).

ACTION

30 days: Elderly Medicine team transfers from Aconbury East (scheduled 10th May); Create SOPs and referral criteria for OPAL and 72hr beds; begin recruitment of an elderly medicine nurse consultant; develop and agree success/monitoring criteria for OPAL; Launch OPAL at WRH; Pilot OPAL at AGH.
60 days: Implement OPAL in MAU at AGH.
90 days: Embed the OPAL performance framework at ward, Directorate, Division and Trust level.

RESULTS

On 10th May 2016 the silver unit nursing and medical team transferred to the MSSU, to begin the mobilisation of the new Silver Unit template (72hr LOS unit and Opal ambulatory care area). Aconbury East ward (formally Silver) remains open and is currently being used as surge capacity to deal with Acute flow and capacity pressures. The plan will be to close the ward to admissions, supported in the interim with GP medical cover.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

FRAILTY METRICS

Metric 3.1 - % of >75 year olds who are Stranded Patients Target: reduction by 45%

Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	Feb 2015	56.8%											
Trajectory					55%	55%	55%	50%	50%	50%	45%	45%	45%
Actual		57.2	59.6	55.7									
RAG													

Definition:
Numerator – The total number of non-elective patients aged over 75 years old who are in hospital longer than 7 days.
Denominator – The total number of all non-elective patients over 75 years old.
Data Source: OASIS

Metric 3.2 - Reduction in NEL LoS > 75 years Target: 7 days

Month	Baseline Date	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Baseline	March 2015	9.2 days											
Trajectory					8.5	8.3	8.1	7.9	7.5	7.3	7	7	7
Actual		8.9	8.5	8.3									
RAG													

Definition:
The average number of days that non elective patient over the age of 75 years old stay in the hospital for – from admission to discharge.
Data Source: OASIS
Note: Baseline Date –March 2015 (Unannounced Inspection)

Risks to delivery

- Number of Geriatricians to lead the Opal, silver and Avon 4 services
- Dependency on locum Physicians may affect continuity of service
- The ambulatory bay not able to function as assessment areas as it may be used as surge capacity due to pressures in ED
- The Aconbury ward (previously Silver) remains open and staff are pulled from elsewhere (nursing and medical)
- If staffing levels reduced across the pathway it will affect streamline of service, discharge processes and flow
- Pathway criteria will need sign up and adherence to ensure flow and LOS reductions. The wrong patients will cause bottlenecks

Corrective actions

- Band 7 nurse practitioner recruited to assist with medical shortfall and provide ED in reach and assessment
- Recruitment of permanent substantive Acute Physicians
- Task and finish group established to work through production of SOP, criteria and pathway documents
- Ensure ambulatory are once established is not use as bedded spaces during heightened capacity issues, request executive support and sign up for this
- Ensuring bed management/ clinical site lead team aware of the pathway and criteria to ensure patients are placed and moved correctly

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

PATIENT FLOW WORKSTREAM

SITUATION

The Worcestershire Patient Flow Centre has been reviewed and a number of improvements are required to ensure Acute ward sisters and consultants receive the right support for complex discharges. Patients experience delays waiting for acute hospital assessments particularly Mental Capacity Assessments, and there are contradictory medical, nursing and therapy assessments of fitness for discharge. Pathway 1 capacity (supported discharge to home) does not match or meet demand, and there is an imbalance of expenditure on assessment compared to hands on care. Pathway 2 (community hospital) capacity has carve out, and capacity is inconsistent with geographical demand. Pathway 3 (nursing home or CHC) has lengthy delays and is subject to carve out, capacity is insufficient to meet demand, and trusted assessment does not work with nursing homes. All three pathways fail to meet specified turnaround times. Fast-track referrals for discharge of dying patients are subject to delays waiting for brokerage or assessment.
Site coordination at WAHT has been in escalation mode for 18 months, with Director of Operations, Matron, and senior manager supervision of the capacity hub on a daily rota. There is an onerous on call arrangement for senior managers and Matrons, which requires on site presence till 9pm week days and 9am – 9pm at weekends.

TASK

By December 2016, the task is to revise the Patient Flow Centre to minimise delays in complex discharges and deliver integrated multi-agency discharge support; To transfer hosting arrangements for the PFC to WAHT; To increase pathway 1 capacity to meet demand; To integrate pathways 2 and 3; To establish a team of discharge liaison nurses attached to specific wards to support all discharges with a focus on all complex discharges including fast-track and out of area; To implement a team of clinical site coordinators at WRH, with a new SOP for coordinating capacity and flow.

ACTION

30 days: A Divisional Director for Nursing Capacity and Flow was appointed in April and starts at WAHT on 4th July; ECIP facilitated workshop to redesign PFC held on 24th March; A workshop was held with staff to review current work practices on 20th 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;
60 days: PFC to transfer to new host arrangements by 1st July;
90 days: Pathway 2 and 3 integrated; Embed the PFC performance framework at ward level and monitor performance at Best Practice Urgent Care Board and System Resilience Group.

RESULTS & METRICS

Results will follow on from changes made from June onwards, and metrics to track performance improvement will include: delays transfers of care, stranded patients, the number of complex discharges from Acute and community,

Risks to delivery	Corrective actions
• Pathway 1 capacity continues to be limited by workforce supply/cost pressures • Insufficient rigour in implementing SOPs allows variation in practice and performance • Multiple organisations' change processes delay implementation	• Review of contract and source potential alternative providers • Rigorous performance review • Minimise TUPE, maintaining current employment status, and direct engagement of staff in service improvement

Reducing Mortality – Workstreams & Measures

Worcestershire NHS
Acute Hospitals NHS Trust

Management of Sepsis	% of patients with completed early warning score	% of patients who met the criteria for sepsis screening and were screened for sepsis	% eligible patients who received antibiotics within 1 hour of presentation	Sepsis Bundle Compliance	HSMR Septicaemia		
Mortality Reviews	% of patient deaths for which primary review form sent	% primary review forms sent within Target time (10 days from date of death)	% primary review forms received within 14 working days from dispatch	% primary review forms completed	% secondary review forms received and presented within 60 days of request	% secondary review forms received and presented	% of completed primary review forms – audit of 10 reviews per month
National Early Warning Score (NEWS)	# Cardiac Arrests per 1000 Admissions	% patients with recorded resuscitation status and discussed with relatives	Proportion of clinical areas to which NEWS has been rolled out against plan	Proportion of staff trained	% of 2222 calls where earlier intervention was indicated		
Fractured Neck of Femur (#NOF)	% patients undergoing surgery within 36 hours of admission (total patients)	- % eligible patients undergoing surgery within 36 hours (as per national exceptions)	% of patients whose first in-patient bed was an orthopaedic bed	% of patients discharged to normal place of residence	HSMR # NOF	Length of stay # NOF	

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Management of Sepsis

Situation

It is nationally recognised that rapid identification and treatment of patient with both suspected and confirmed sepsis could be improved. Audit data demonstrated considerable room for improvement at WAHT. Sepsis contributes significantly to our mortality rates within the trust. Last year 663 patients died as a result of various causes of sepsis. This is over 10% higher than our case-mix would indicate. Opportunities exist to improve assessment of patient acuity through the consistent use of the PARS score and use of NEWs in future. Observations have demonstrated delays to patients assessment, inconsistent recording of PARS and delays to antibiotic treatment from when the decision has been made to treat.

Actions undertaken this month

- Chief Medical Officer has been appointed as sepsis lead
- Sepsis screening criteria have been reviewed and a unified screening tool for pilot in both Emergency Departments agreed
- 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
- Weekly audit data detailing screening rates is now sent to key members of the clinical team

30 days

- Agree single 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 info from other providers
- Pilot and evaluate in both Emergency Departments and Medical Assessment Units
- Develop communication to Surgical, Gynae and Paediatric units
- Develop training and awareness sessions in each unit
- Work with ED team at each site to ensure specific focus on improving sepsis care at each site
- Collate audit data and display within each unit
- Revitalise communications campaign – include videos from Ron Daniel
- CMO handover

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Management of Sepsis

60 days

- Agree roles and responsibilities for ongoing data capture
- Develop easy to use data capture tool that provides immediate feedback to clinical teams
- Define and agree standards for identification and treatment of sepsis
- Identify barriers to delivery of the agreed standards and develop solutions

90 days

- Implement solutions to overcome barriers to achieve best practice standards using PDSA cycle methodology in all front door areas
- Scope roll out of sepsis identification and management methodology to in-patient areas

Risks to Delivery

Sufficient engagement of medical and nursing teams

Competing priorities of project clinical leads impacting on the ability to deliver actions to time

Mitigation

Work directly with CMO and CNO to outline programme requirements, thus defining sepsis as a priority for improvement.

Arrange sepsis presentation at QG

Management of Sepsis

Worcestershire NHS
Acute Hospitals NHS Trust

Metric S.1 - % of patients with completed early warning score - Target 90%												
Month	Base Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory	50	50	50	50	55	60	65	70	75	80	85	90
Actual	48.2	39.9	18.7									
RAG	R	R	R									

Metric S.2 - % of patients who met the criteria for sepsis screening and were screened for sepsis - Target: 90%												
Month	Base Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory	50	50	50	50	55	60	65	70	75	80	85	90
Actual	34	38	34									
RAG	R	R	R									

Metric S.3 – % eligible patients who received antibiotics within 1 hour of presentation – Target: 95% within less than one hour													
Month	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Trajectory	50	50	50	50	55	60	65	70	75	80	85	90	95
Actual	29	32	38										
RAG	R	R	R										

Metric S.4 – Sepsis Bundle Compliance - Target: 80%													
Month	Base	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory					30	40	50	55	60	65	70	75	80
Actual													
RAG													

Metric S.5 - # HSMR Septicaemia - Target: 100 (or less)													
Month	Base Jan – Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100
Actual		118											
Rolling 12 month	110.8	105											
RAG		A											

This metric relates to the HSMR for the bundle of diagnoses included in the Septicaemia grouping. The value is taken from the HED system and is approximately 3 months in arrears. The RAG rating relates to the 12 month rolling value. Red: ≥2SD from expected. Amber: ≤2SD from expected but ≥ than 100. Green: < 100

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Mortality Reviews

Situation

Current state review of the Mortality Review Process highlighted a number of areas for improvement. Significant delays were found from notification of a patient death until a primary review form was received by the responsible consultant. Less than 1% of secondary review forms were sent to consultants for whose patient required further review. Direct observation of the weekly mortality review meeting identified a number of improvements that could be made to ensure lessons are learned to guide improvement in patient care across the trust.

Actions undertaken this month

- Mortality review process redesigned
- A demand and capacity review of the administrative process supporting mortality review determined sufficient capacity is available to manage workload. An agreement has been reached to provide 2hrs cross - cover within the teams to ensure vital value adding tasks are undertaken during periods of annual leave and sickness.
- Metrics have been established to provide visual management of demand, capacity and backlog thus enabling better process management. The principle of "todays work today" has been adopted.
- 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. In the event of the wrong consultant recorded at time of death the Divisional Medical teams responsible for the patients care will be responsible for ensuring a review is undertaken.
- Backlog of outstanding primary review forms has been reduced from 41 to 0
- All outstanding secondary review forms since Jan 2016 have been reissued to the responsible consultant
- Option to develop an automated notification of patient death along with the requirement for primary review has been investigated. This is not an option that can be delivered within the next 90 days. The team are working with the ICT team with a review to developing automated notifications by Dec 2016

30 days

Review the structure of Trust Divisional Governance team meetings to confirm each has dedicated slots to enable the secondary review process to be undertaken
A rapid test of change has been 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. Ensure data is accessible to consultants and test access.

60 days

Review access to available information - ensure consultant KPIs are accessible for review.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

90 days

Develop Trust Mortality Newsletter – to include avoidable mortality reasons, proportion of death that could be avoided, related current stats and local metrics, explain how measured for improvements, ongoing updates of avoidable

Risks to Delivery

Engagement of Clinical Teams to continue to undertake reviews within a timely manner

Mitigation

Mortality review is now part of the revalidation criteria at WAHT, a dashboard is under development to provide individual consultants and their Divisional Medical Director with key performance indicators. This provides an incentive to take part in the process. The CMO will target poor performing consultants directly.

Mortality Reviews

Worcestershire NHS
Acute Hospitals NHS Trust

Metric M.1 - % of patient deaths for which Primary Review form sent - Target: 100%

Month	Base Jun–Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		100	100	100	100	100	100	100	100	100	100	100	100
Actual	92	100	100	100	100								
RAG		G	G	G	G								

*in month deaths

Metric M.2 - % primary review forms sent within target time (10 days from date of death) - Target: 90%

Month	Base Jun – Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		65	70	75	80	85	90	90	90	90	90	90	90
Actual	59	39.6	13.1	20.7	27.5								
RAG		R	R	R	R								

Metric M.3 - % primary review forms received within 14 working days from dispatch - Target: 55% by end March 2017

Month	Base Jun – Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		30	30	30	35	35	35	40	40	40	45	45	45
Actual	17.0	31.5	29.2	28.7	28.2								
RAG		G	R	R	R								

Metric M.4 - % primary review forms completed- Target: 75% in Q4 2016/17

Month	Base Jun – Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		50	50	50	60	60	60	65	65	65	70	70	70
Actual	46.9	71.0	62.8	56.7	36.2								
RAG		G	G	G									

*Rolling data – will update as forms are returned to the mortality co-ordinator

Metric M.6 - % secondary review forms received and presented within 60 days of request - Target: 75%

Month	Base Jun – Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		10	10	10	20	20	20	40	40	40	60	60	60
Actual	0	0	0	0	0								
RAG		R	R	R	R								

Metric M.7 - % secondary review forms received and presented - Target: 75%

Month	Base Jun – Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		10	10	10	20	20	20	40	40	40	60	60	60
Actual	0	0	0	0	0								
RAG		R	R	R	R								

Metric M.8 – % of completed Primary Review Forms – Audit of 10 Reviews per month - Target: 90% of planned reviews completed

Month	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory				60%	60%	60%	70%	70%	70%	80%	80%	80%
Actual												
RAG												

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

National Early Warning Score (NEWS)

Situation

WAHT uses the PARS score to assess patient acuity. The score was phenomenally successful when originally launched at WAHT giving the trust a robust method monitoring patient risk of deterioration. The trust has recognised that escalation and response to escalation is not consistently meeting the patients' needs. To start to resolve these gaps in care the Trust is committed to implementing a nationally recognised scoring tool – the National Early Warning Score (NEWS). Review of the current state in anticipation of the NEWS introduction has identified a number of areas for improvement across each of our patient areas:

- Correct training and understanding of use of the tool and associated scoring systems
- Consistent documentation of the score and its use in ensuring appropriate early escalation
- Escalation for patients at risk of deterioration
- Developing a robust and rapid response from the appropriate professional when a patient is escalated for further review or intervention

Actions this month

- Project team has met to scope the NEWS implementation project plan. Project work streams have been established.
- Current state review underway to determine the changes required for successful implementation. 26 existing trust forms has been identifies where the existing early warning is used.
- Training events have been scheduled adopting the "world café " approach 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
- Areas of existing good practice identified, The Emergency Department have described their internal systematic approach to monitoring and improving usage of the PARS Score
- PARS and subsequently NEWS scoring has been developed as part of the ward level performance dashboard. This, for the first time, enables live status of ward performance, facilitating ward managers to actively improve usage at ward level.

30 days

- Launch ward level performance metrics for early warning score (currently PARS) adherence and usage
- Hold first of the "world café " training sessions
- 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

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

- Engage support from Jan Stevens CNO, ensuring development and training re NEWS is seen as a high priority
- 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 communications plan to support launch

60 days

- Begin training programme for all staff
- Develop detailed roll out plan
- Develop the skills and understanding of local champions
- Modify all relevant forms from PARS to NEWS
- Continue multi-media communication programme
- Risk assessment/FMEA approach to understanding risks of roll out
- Begin to populate current state metrics to facilitate monitoring of safe implementation
- Monitor adherence to NEWS roll out objectives

90 days

- Implement roll out plan
- Continue training
- Monitoring of roll out programme
- Monitoring of impact on patients to ensure no deterioration in quality of care during roll out
- Establish triggers for scale down of monitoring to 'business as usual' level
- Monitor adherence to NEWS roll out objectives

Risks to Delivery

Sufficient engagement of medical and nursing teams

Mitigation

Work directly with CMO and CNO to outline programme requirements, thus defining NEWS as a priority for improvement.

National Early Warning Score (NEWS)

Worcestershire NHS
Acute Hospitals NHS Trust

Metric N.1 - # Cardiac Arrests per 1000 Admissions - Target: ≤1.4/1000 bed days								
Month	Base Upper quartile for 15/16	Apr – Dec 2015	Jan – March 2016	April – June 2016	July - Sept 2016	Oct – Dec 2016	Jan – March 2017	March – April 2017
Trajectory								
Actual – AGH		1.39						
RAG		G						
Actual – WRH		1.98						
RAG		A						

Data is provided quarterly for each quarter.

RAG rating Red: Value ≥2SD from national mean. Amber: ≥1.4 but within 2SD of national mean. Green: ≤1.4. No trajectory (unless consistently below 1.4 at both sites is set as the trajectory)

Metric N.2 – % patients with recorded resuscitation status and discussed with relatives– Target: 90% By April 2017									
Month	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory	30	30	30	50	50	50	70	70	70
Actual									
RAG									

First Data point will be April 2016 – data to be confirmed (SG)

Metric N.3 - Proportion of clinical areas to which NEWS has been rolled out against plan - Target: 100% by August 1st, 2016									
Month	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory				Immersion	100				
Actual									
RAG									

*to be tracked by clinical areas

Metric N.3.1 - Proportion of staff trained - Target: 95%									
Month	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory				Immersion	90	95	95	95	95
Actual									
RAG									

Metric N.4 - % of 2222 calls where earlier intervention was indicated - Target 0% by April 2017								
Month	Base Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Nov 16	Dec 16
Trajectory	≤20	≤20	≤20	≤15	≤15	≤15	≤10	≤10
Actual								
RAG								

First Data point will be April 2016 – data to be confirmed (SG)

*As discussed with patients and patient family

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Fractured Neck of Femur (#NOF)

Situation

Process and outcome with respect to #NOF has been a focus for improvement for a number of months but progress appears to have stalled. A number of metrics relating to process and outcome have been monitored through the national hip fracture database and the #NOF best practice tariff process. Renewed focus has been recognised as being required by the Trust to ensure consistently high performance with respect to the care of this vulnerable group of patients.
The project is focussed on the processes relating to:

- Ensuring care in the best clinical environment i.e. orthopaedic bed first time
- Ensure early surgical intervention
- Ensuring care closer to home – with short length of in-hospital stay

And outcome relating to:

- Relative risk of death
- Successful rehabilitation such that the patient returns to their normal place of residence

Actions this month

- 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

30 days

Establish project management board
Establish weekly forum for review of patients who:Don't have surgery within 36 hours

- Don't have an orthopaedic bed as their first bed
- Do not survive

Establish process for documenting reasons for delay in surgery with action plan to expedite surgery

60 Days

Establish # NOF ring fenced beds
Establish ring fenced operating slots

Fractured Neck of Femur (#NOF)

Worcestershire NHS
Acute Hospitals NHS Trust

Metric NOF.1 - % patients undergoing surgery within 36 hours of admission (total patients) – Target: TBA												
Month	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory	70	70	75	75	75	80	80	85	85	85	90	90
Actual	59	76	63									
RAG												

Metric NOF.2 - % eligible patients undergoing surgery within 36 hours (as per national exceptions) – Target: TBA												
Month	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory	70	70	75	75	75	80	80	85	85	85	90	90
Actual	68	80	75.9									
RAG												

Metric NOF.3 - % of patients whose first in-patient bed was an orthopaedic bed - Target: 90% By Jan 2017												
Month	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory	50	50	50	60	60	60	70	70	70	80	80	80
Actual	54	50	40.6									
RAG												

*Only includes BPT #NOF patients whose primary diagnosis within the first episode of care was the fracture – ie Excl 'in hospital' fracture and where the patient had a more serious comorbidity

Metric NOF.4 - % of patients discharged to normal place of residence Target TBA												
Month	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory	50	50	50	50	55	55	55	60	60	60	60	60
Actual	36.5	40	45.5									
RAG												

Metric NOF.5 - HSMR # NOF - Target Score: ≤100													
Month	Baseline 2015	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100	≤100
Actual in month		79											
Rolling 12 month	115	115											
RAG based on rolling 12 month	A												

*The RAG rating relates to the 12 month rolling value. Red: ≥2SD from expected. Amber: ≤2SD from expected but ≥ than 100. Green: < 100

Metric NOF.6 – Length of stay # NOF													
Month	Base 2015	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory	2015												
Actual		17.7	17.7	19.8									
Rolling 12 month		15.7	15.9	16.0									
RAG													

Organisation Development and Staff Engagement – Workstreams & Measures

Worcestershire NHS
Acute Hospitals NHS Trust

Leadership	Staff Turnover %	Exit Interview Data. Number of comments relating to poor leadership	Staff Opinion Survey Key Factor 1 – Recommending Trust as a place to work and receive treatment.	Staff Opinion Survey KF5- Recognition and valued by managers and organisation.	Staff Opinion Survey KF10 – support from Managers.	Chat-Back Survey results.	
Culture	Staff Opinions Survey- KF31- staff confidence to report unsafe practise	Chat-Back Survey results	Reported Patient safety incidents	HR Case work B&H cases	Occupational Health Referrals • No of Stress referrals • No of counseling referrals		
Workforce Plans	Vacancy Numbers	No of New roles implemented • PA • Band 4 Nurse • Ward Administrator • Ward Housekeeper	Number of Agency shifts. • M&D • N&M	Number of compliant rotas • M&D • N&M	Staff Opinion Survey KF15- Staff satisfaction with working patterns		
Policies and Standards	B & H concerns raised.	Mandatory Training compliance rates	Staff Opinion Survey – KF11 – staff received an appraisal in last 12 months.	Appraisal Compliance % • Medical • Non-Medical	Staff Opinion Survey KF12 – Quality of Appraisals	Sickness Absence % • Long Term Cases • Short Term	Staff. Opinion Survey KF20 – Staff experiencing discrimination.
Communic -ation and Engage- ment	National SOS Results - Total engagement Score	Chat-Back Survey Results	Staff Turnover %	Sickness Absence % • Long Term Cases • Short Term	Exit Interview Data. Number of comments relating to poor communication		
New Roles	Vacancy Numbers	Patient complaints • No of complaints regarding staff shortages.	Number of compliant rotas • M&D • N&M	Number of Agency shifts. • M&D • N&M	Staff Opinion Survey Q49 – There are enough staff to do the job.		

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Leadership

Situation

Our ambition is to create an organisation with effective leaders and an effective leadership culture. To achieve this we will:

- **Strengthen and equip our existing leaders to improve and raise current leadership capability.**
  - Defining roles and responsibilities at each leadership level
  - Developing bespoke leadership programmes
  - Developing core skills training
  - Development of programmes supporting senior nurse leadership
  - Developing "Managing self" skills.
  - 360 Degree Feedback
  - Develop coaching programmes.
- **Implement a Trust Board Leadership Plan**
  - Review Deloittes feedback
  - Undertake gap analysis tool
  - Undertake Gap analysis exercise.
  - Develop key areas into board development programme
- **Develop a Talent Management Strategy**
  - Complete Managers TNA
  - Development capability framework
- **Develop "Understanding your Trust Programme**
  - New consultant's Development Programme
  - Divisional Triumvirate Development Programme.

Actions Undertaken this month:

- 1:1 Exit interviews offered to all exit interviewees who have expressed reasons or leaving in relation to poor leadership.
- Coaching Programmes implemented commenced in May 2016.
- Coaching skills Programme implemented and commenced in April 2016.
- Scoping of Snr Nurse Leadership programmes commenced and discussed with CNO.
- Managers Training Needs Analysis commenced.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

30 Days

- Draft Talent Management Strategy for consultation with Execs and Divisional Directors.
- Co-ordinate Job Descriptions and review for Divisional Medical Directors, Divisional Operations Directors, Divisional Nurse Directors, Matrons and Directorate Managers.
- 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

60 Days

- Consider Bespoke Nursing Leadership programmes and agree programme content and delivery.
- Draft Core skills training programmes for all managers.
- Draft New" Consultants" development programme with Divisional Medical Directors and Clinical Leads.
- Draft Board Development Programme.
- Implement Coaching and Mentoring Scheme.

90 Days

- Commence delivery of bespoke nursing leadership programmes with Launch event.
- Commence delivery of Board Development Programme
- Commence delivery of Core skills programme for all managers.

Risks to Delivery

- Operational Pressures for leaders / stroke managers to engage in proposed development opportunities.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

LEADERSHIP

Metric 1.1 - Staff turnover % — Target: 10%

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		12.8%	12.7%	12.65%	12.6%	12.55%	12.5%	12.0%	11.5%	11%	11%	10.5%	10%
Actual		12.76%	12.71%	12.97%	13.01%								
RAG													

Metric 1.2 Exit Interview – no of comments relating to poor leadership — Target: 0%

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		55%	50%	45%	40%	35%	30%	25%	20%	15%	10%	5%	0%
Actual		53%	47%	10%									
RAG													

Metric 1.3 Staff Opinion Survey KF1 – Recommend Trust as a place to work and be treated — Target: 3.76

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-		3.67			3.52			3.64			3.76
Actual		-	3.64	3.52									
RAG													

Metric 1.4 - Staff Opinion Survey KF5 – Staff feel recognised and valued by managers and the organisation — Target: 3.42

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.42			3.27			3.32			3.42
Actual		-	-	3.27									
RAG													

Metric 1.5 - Staff Opinion Survey KF10 – Staff feel supported by their manager — Target: 3.69

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.69			3.52			3.62			3.69
Actual		-	3.62	3.52									
RAG													

Metric 1.6 - Internal Chat-Back Survey Results KF5 regarding feeling valued by manager — Target: 3.42

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.42			3.27			3.32			3.42
Actual		-	-	3.27									
RAG													

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Safety Improvement Culture

Situation

Our ambition is to create an organisation with a true safety culture which is achieved by building the confidence and capability of our leaders and our workforce by making continuous improvement everyone's business. To achieve this we will

- Launch LiA
- Create internal improvement faculty
  - Build an internal programme of QI approaches offering 4 levels of expertise – the basics for all, Innovation Champion, Change Agent , Maser Practitioner. We will target their skills to the PCIP challenges
  - Utilise a range of change techniques including rapid cycles improvement, human factors,
- Design & launch Trust Safety Campaign
  - Provide an overarching framework to bring together the key safety challenges including Sepsis, Preventing deterioration by introducing NEWS, #NOF, VTE, \safety Thermometer SAFER Bundle etc
  - Agree work programme (including Care out of Hours)
  - Secure external support to kick start programme
- Implement quality & safety dashboards
  - Build on work to date and align dashboards to CQC domains. Establish series of SPC/run chants
- Develop new patient & public engagement strategy
  - Hold summit with patients/public to co0design new relationship and way of working
- Strengthen governance & assurance processes
  - Use known good governance to review and establish effective floor to Board assurance
  - Redesign SI & Complaints process to ensure lean, responsive & evidence of learning & improvement clear

Actions Undertaken this month:

- LiA launched
- External support identified to work with Improvement team - finalise arrangements
- PID , plan , project team for Care out of hours agreed - scoping phase commenced
- Commenced work with Oxford to review governance

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

30 Days

- 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
- Source complaints and SI training

60 Days

- Hold patient summit
- Launch safety campaign
- Introduce new clinical governance arrangement
- 60 staff to undertake SI/Complaints training
- QI training commenced with Innovation Champions

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Safety Improvement Culture

Metric 2.1 - Staff Opinion survey – KF31 – Staff confidence to report unsafe practise. Target: 3.62

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.62			3.47			3.55			3.62
Actual		-	3.55	3.47									
RAG													

Metric 2.2 - Chat-Back survey score KF31 – regarding confidence to report incidents. Target: 3.62

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.62			3.47			3.55			3.62
Actual		-	3.55	3.47									
RAG													

Metric 2.3 Reported patient safety incidents Target:

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory													
Actual		820	838	835	830								
RAG													

Metric 2.4 - HR Case Work – No of live Bullying and Harassment cases Target:0

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		10	9	9	8	8	7	7	6	6	5	5	4
Actual		7	7	9	11								
RAG													

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Metric 2.5 - Occupational Health Referrals – Number of work - related stress referrals												Target:10	
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		20	19	18	17	16	15	14	12	11	10	10	10
Actual		20	20	14	9								
RAG													

Metric 2.6 - Occupational Health Referrals – Number of counselling referrals re workplace stress												Target:5	
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		10	10	9	9	8	8	7	7	6	6	5	5
Actual		13	13	8	6								
RAG													

Metric 2.7 - KF17 - Percentage of staff reporting suffering work related stress												Target: 34%	
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	36%			36%			35%			34%
Actual		-	-	36%									
RAG													

Metric 2.8 - KF16 - Percentage of staff working extra hours												Target: 70%	
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory				72%			73%			72%			71%
Actual				73%									
RAG													

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Workforce Plans

Situation

The Trust commissioned a review of the Medical Staffing Workforce back in April 2015. Aim of this workstream is to produce effective workforce capacity plans to support recruitment and retention of workforce.

Actions undertaken so far:

- The November/December round of Performance Reviews saw presentations from each division of their 1,3 and 5 year visions and aspirations for services.
- Strategic Service Development Planning (SSDP) Workshops were held in December and January where each Division outlined its business/operational
- plans for 1, 3 and 5 years
- Senior members of the HR team met with Divisions to agree the baseline highlighting the key issues across the breadth of the medical workforce.
- Divisional Medical Workforce KPI's were produced as a baseline template and presented to WAG in January 2016
- Tactical plan to reduce medical and corporate locum spend has been implemented including the TDA agency cap rates from November 2015 and a further reduced cap from February 2016. This is monitored weekly.
- Joint Meetings have taken place with HR, Strategy and Planning, and Finance colleagues to agree a co-ordinated approach to the development of all workforce and finance plans.
- 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.

30 Days

- Hospital at Night project to report on staffing changes
- Jane Ball (Deputy Director of Strategy and Planning) is continuing meeting with Divisions to ensure that plans for 3 and 5 years are robust and will be backed up by timely Business Cases
- Head of HR to continue working with Divisions to explore the impact on their workforce of their SSDP's, 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

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

60 Days

- Active recruitment to new roles including making job offers to 12 of the current cohort of Physicians Associates

90 Days

- Draft integrated Workforce Plan to be developed for each division by September 2016
- Once SSDP is agreed for each Division a full 1, 3 and 5 year Trust wide workforce plan can be finalised by October 2016 ensuring that all Professional Groups are included in the plan

Risks to Delivery

- Sufficient engagement of divisional teams to SSDP and workforce planning process.
- Sign off of Strategic Business Plans being delayed further – currently anticipated to be end of June
- Management of locum co-ordinators have not transferred as agreed to HR which limits the ability to identify and rectify discrepancies, cost pressures and adherence to protocols in utilisation of HCL locum booking system

Mitigation

- Working directly with Director of Strategy and Planning and Finance colleagues to ensure that Strategic Trust Business Plan and Divisional Plans are signed off

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Workforce Plans

Metric 3.1 - Vacancies													Target:
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory													
Actual		392.32	378.98	394.37	521.74								
RAG													

Metric 3.2 - Number of new roles implemented –Physicians Associates										Target:12			
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	-	-	-	-	-	-	-	12	12	14
Actual		-	-										
RAG													

Metric 3.3 - Number of new roles implemented – Band 4 Nurse										Target:42			
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	-	-	-	-	-	-	42			
Actual		-	-	-	-	-	-	-	-				
RAG													

Metric 3.4 - Number of new roles implemented – ward administrator ward housekeeper											Target:59		
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory						6	12	25	32	48	59	59	59
Actual													
RAG													

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Metric 3.5 - – Number of agency shifts – Medical and Dental and Nursing													Target:
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory													
Actual			2827 1348	2826 1521									
RAG													

Metric 3.6 - Number of compliant rotas Medical and Dental													Target:100%
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Actual		98%	98%	98%	98%								
RAG													

Metric 3.7 – Staff Opinion Survey KF15 Staff satisfaction with working patterns													Target:49%
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	49%			47%			48%			49%
Actual		-	-	47%									
RAG													

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Policies / Standards

Situation

It is our aim to develop a set of Human Resources Policies and Processes, in partnership, which support a culture of openness and trust that issues will be tackled and acted upon as they arise; creating an opportunity for early interventional resolutions handled in line with Trust values. To achieve this we will:

- Create a culture of awareness of what constitutes bullying and harassment and how to resolve issues in a timely and supportive manner.
  - Review Dignity at Work Policy and process to simplify and reinforce early interventional support for resolution.
  - Appoint and publicise Trust Board Champion.
  - Advertise for Bullying and Harassment Support Advisers with clearly identified roles; equipping them with appropriate training.
  - Develop awareness of bullying and harassment and how to raise an issue through development workshops for line managers and employees.
  - Develop monitoring process for issues resolved informally as well as formally and identify lessons learnt through Workforce Insurance Group.
- Create of culture where staff feel confident to raise issues as they arise and have confidence that they will be acted upon.
  - Review Raising Concerns – Whistleblowing Policy.
  - Appoint and publicise Board Champion and Staff Support Adviser Roles in conjunction with the Dignity at Work Policy.
- Develop model to reduce timeframes on formal investigations.
  - Review Disciplinary and Grievance Policies to include 'Fast Track processes'
  - Look at alternative model for formal investigations with the capacity to deliver timely investigations
  - Train a larger group of investigators.
  - Educate and train members for panel hearings to give confidence to participate more easily.
  - Develop HR Team in line with amended policies to ensure peer support and coaching development processes are in place.
  - Strengthen case management methodology to demonstrate the impact of amended policies and processes.
- Create a culture of awareness of impact of behaviours to ensure personal responsibility and accountability
  - Review Appraisal/PDR Policy to incorporate behaviours and values.
  - Review Statutory and Mandatory Training delivery and monitoring.
  - Review induction training to ensure key messages are incorporated to cascade key messages from policy changes.
- Review recruitment and retention policies and strategies to ensure organisational learning is captured and acted upon.
  - Review Recruitment Policy with an aim of reducing time to hire.
  - Strengthen Trust Banks of Staff to support a more flexible workforce to underpin service requirements.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

– Work with Divisional Teams to triangulate feedback from ChatBack, KPI's, etc... to facilitate organisational learning and action planning for cultural change.

Actions Undertaken this month:

- 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 on Mandatory and Statutory Training

30 Days

- 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.

60 Days

- Scope and develop investigation model to reduce formal timeframes.
- Train and develop Staff Support Advisers.
- Implement simplified job evaluation processes.

90 Days

- Promote and publicise the roles of Staff Support Advisers
- Review appraisal and mandatory training policies and processes.
- Review recruitment policy and develop central HR monitoring.
- Review and refresh exit interview methodology.

Risks to Delivery

- Insufficient engagement to policy development and training programmes by line management.
- Competing priorities if current case load increases further.

Mitigation

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Policies/Standards

Metric 4.1 – B & H concerns raised to HR							Target:0					
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory													
Actual		1	1	1	2								
RAG													

Metric 4.2 – Mandatory training compliance %							Target:90%					
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		87%	88%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Actual		86.7%	87.2%	88.8%	82.6%								
RAG													

Metric 4.3 – Staff Opinion Survey KF11 – Staff received an appraisal in last 12 months										Target: 86%			
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	86%			83%			85%			86%
Actual		-	86%	83%									
RAG													

Metric 4.4 – Appraisal compliance % - Medical staff							Target:85%					
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		82%	83%	83%	84%	85%	85%	85%	85%	85%	85%	85%	85%
Actual		81.6%	83.2%	82.4%	80.2%								
RAG													

Metric 4.5 – Appraisal compliance % - Non-Medical Staff							Target:85%					
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		78%	79%	80%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Actual		78.2%	76.2%	79.42%	82%								
RAG													

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Metric 4.6 – – Staff Opinion Survey KF12 Quality of Appraisals.										Target:3.05			
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.05			2.76			2.86			3.05
Actual		-	-	2.76									
RAG													

Metric 4.7 – Sickness Absence % - Long Term Sickness										Target:2%			
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		3.0%	2.9%	2.8%	2.7%	2.6%	2.5%	2.4%	2.3%	2.2%	2.1%	2%	2%
Actual		2.80%	2.84%	2.85%	2,83%								
RAG													

Metric 4.8 – Sickness Absence % - Short Term Sickness										Target:1.5%			
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Actual		1.47%	1.49%	1.49%	1.53%								
RAG													

Metric 4.9 – Staff Opinion Survey – KF20 Staff experiencing discrimination												Target:8%	
Month		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	10%			10%			9%			8%
Actual		-	11%	10%									
RAG													

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Engagement & Communication

Situation

Employee engagement is a property of the relationship between an organisation and its employees. An 'engaged employee' is one who is fully absorbed by and enthusiastic about their work and so takes positive action to further the organisation's reputation and interests. Employee engagement is based on trust, integrity, two way commitment and communication between an organisation and its members. It is an approach that increases the chances of business success, contributing to organisational and individual performance, productivity and well-being. It can be measured. It varies from poor to great. It can be nurtured and dramatically increased; it can be lost and thrown away. For several years staff engagement, as measured by the NHS national staff survey has been in the bottom quartile of all trusts. This is something we wish to address as a matter of urgency. There is a growing wealth of evidence that engaged, happy staff deliver safer services and higher patient experience.

Actions Undertaken this month:

- ChatBack launched and first survey underway
- LiA launched including:
  - Sponsor group formed and meeting schedule in place
  - 10 first LiA ideas confirmed and groups formed
  - Formal launch with LiA first 10 teams
  - LiA Navigation Day completed
  - 100 LiA Champions underway
  - LiA events advertised
  - LiA Pulse Check launched and underway
  - LiA Leadership Scorecard™ launched and underway
- Commissioning of the new website and intranet underway with initial designs and concepts developed
- Induction
  - Staff handbook drafted
  - Corporate slides for induction drafted and trialled
- Staff Engagement Group
  - Initial group formed
  - First phase of work to raise awareness and communicate results from the national staff survey developed
- Communication Enablers
  - Media and social monitoring tool sourced and commissioned

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

  - Inside Track Blog Posts launched (estates, ICT, SAFER., LiA, CNO)
  - Monthly multi media campaign programme established – Nurse Day
  - 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
  - Life Channel – opportunities explored
- Staff Reward and Recognition Programme
  - Scoping of opportunities investigated and tested
  - Planning commenced for the key big events (staff recognition and awards; volunteers celebrations; long service awards; and achievement awards)
- Health and Wellbeing programme of events
  - Preliminary discussions and ideas investigated

30 Days

- ChatBack
  - Communications programme to deliver wide awareness of results
  - Results analysed and shared with the teams
  - Plan and programme developed and delivery commenced with those areas highlighting additional work required
- LiA
  - LiA Pulse Survey completed
  - LiA Leadership Scorecard™ completed
  - LiA second Navigation day completed
  - LiA events delivered (one to be completed in July)
  - Communications celebrating achievements delivered by the first 10 LiA teams
  - Second group of LiA teams underway
  - LiA champions progamme developed
- Website and Intranet
  - User group (internal and external) identified and testing of options delivered
  - Designs initiated and site map developed
  - Content build commenced – first phase centred on consultant directory and updated pictures with a people focus representing all sites
- Induction
  - Staff handbook trialled with a wider user group and finalised
  - Corporate slides finalised

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

- Work commenced on generic induction materials and presentations

- Staff Engagement Group
  - Widen membership of the Staff Engagement Group
  - Hold first open staff engagement session
- Communication Enablers
  - Trust-wide communication materials of values lunched to include the high level strategic direction
  - Audit of all poster boards in the Trust
  - Life Channel – Programme of work to upgrade and repair existing screens
  - Team Brief - Improve on podcast and accessibility
  - Look for innovated ways for staff speaking in confidence - scope options
  - Weekly digest delivered with metrics and evaluation and a monthly Board level report delivered
  - An additional four blog posts established
  - Day in the life programme established
  - Communications cascade scoped
  - Effective communications sessions and materials (how to guide) for all Band 7 and above developed
  - Scope executive and senior leaders shadowing programme
- Staff Reward and Recognition Programme
  - Programme publicised
  - Detailed planning of events completed
- 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

60 Days

- ChatBack
  - Continue to deliver the plan and programme with those areas highlighting additional work required
- LiA
  - Completion of LiA events
  - Findings of LiA Pulse Survey reviewed and assessed
  - Findings of LiA Leadership Scorecard™ reviewed and assessed

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

- Outputs of LiA events communicated
- Continue to communications celebrating achievements delivered by the first 10 LiA teams
- Second group of LiA teams communicated
- Outputs of LiA champions programme promoted

- Website and Intranet
  - Wider staff engagement group feedback
  - Wider user testing
  - Copy developed
  - Trust-wide style guide completed and published
- Induction
  - Staff handbook trialled with a wider user group and finalised
  - Corporate slides 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
- Communication Enablers
  - Trust-wide communication materials of values lunched to include the high level strategic direction
  - Audit of all poster boards in the Trust
  - Life Channel – Programme of work to upgrade and repair existing screens
  - Team Brief - Improve on podcast and accessibility
  - Look for innovated ways for staff speaking in confidence - scope options
  - Weekly digest delivered with metrics and evaluation and a monthly Board level report delivered
  - An additional four blog posts established
  - Day in the life programme established
  - Communications cascade scoped
  - Effective communications sessions and materials (how to guide) for all Band 7 and above developed
  - Public facing CEO message
  - Launch additional staff speaking in confidence activity

Exception Report

Worcestershire NHS
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  - Trust wide communications ambassadors launched
  - Effective communications sessions and materials (how to guide) for all Band 7 developed
  - Deliver executive and senior leaders shadowing programme
- Staff Reward and Recognition Programme
  - Deliver programme
- Health and Wellbeing programme of events
  - Deliver events programme

90 Days

- ChatBack
  - Commence planning for the second ChatBack survey
  - Continue working with 'challenged teams'
  - Communicate and celebrate key improvements made as a result of the first Chatback feedback.
- LiA
  - Promote the next phase of LiA teams and the work they are undertaking
  - Celebrate and share the work of the Sponsor Group and the first LiA teams
- Website and Intranet
  - External website delivered and Intranet finalised for delivery in September
- Induction
  - Test generic induction materials and presentations
  - Test programme for presenters
- Staff Engagement Group
  - Continue to promote work and changes made as a result of the group
  - Continue to widen membership of the Staff Engagement Group
  - Deliver a sustainable staff engagement session programme
- Communication Enablers
  - Launch additional staff speaking in confidence activity
  - Trust wide communications ambassadors programme of activity developed
  - Effective communications sessions and materials (how to guide) for all Band 7 launched

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

- Staff Reward and Recognition Programme
  - Deliver programme including celebrating successes
- Health and Wellbeing programme of events
  - Deliver events programme
  - Publicise outcomes of events

Risks to Delivery

ICT and outdated browsers
Disengagement of middle management
External pressures – crisis comms/resources
Financial and operational pressures

Mitigation

Working with ICT on developing solutions to user issues
Develop co designed communications materials
Deliver communications ambassadors

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

Engagement and Communication

Metric 5.1 - National Staff Opinion Survey results – Engagement Score **Target:3.79**

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.79			3.64			3.71			3.79
Actual		-	3.71	3.64									
RAG													

Metric 5.2 - Chat-Back survey scores – Engagement Score **Target:3.79**

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.79			3.64			3.71			3.79
Actual		-	3.71	3.64									
RAG													

Metric 5.3 - Staff turnover % **Target:10%**

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		12.8%	12.7%	12.65%	12.6%	12.55%	12.5%	12.0%	11.5%	11%	11%	10.5%	10%
Actual		12.76%	12.71%	12.97%	13.01%								
RAG													

Metric 5.4 - Sickness absence % **Target:3.5%**

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		4.5%	4.4%	4.4%	4.3%	4.3%	4.2%	4.2%	4.0%	3.9%	3.8%	3.7%	3.5%
Actual		4.64%	4.42%	4.30%	4.06%								
RAG													

Metric 5.5 - Exit interview comments – reasons for leaving communication **Target:0**

Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		55%	50%	45%	40%	35%	30%	25%	20%	15%	10%	5%	0%
Actual		53%	47%	20%									
RAG													

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

New Roles

Situation

Development of new roles is imperative due to the current skills gap and vacancies the Trust is experiencing. The development of the following new roles has been agreed and divisions are ensuring these roles are factored into their work force plans. Physicians Associate, Band 4 Associate Nurse, Ward Administrator and Word housekeeper recruitment processes have commenced in May 2016.

Actions Undertaken this month:

- Each ward identified number of posts required for Band 4 Nurse.
- Job Description and Profile for Band 4 Nurse developed and agreed and "what's in it for me "event arranged for early June.
- Foundation Degree Associate Nurse Band 4 Programme agreed with UW and entry requirements agreed.
- Job Description for Ward Administrator agreed and matched.
- Job Description for Ward Housekeeper agreed and matched.
- 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.

30 Days

- Hold "What's in it for me "event for Associate Nurse Role – 1st and 6th June.
- Brief Ward Managers on implementation plan for new role implementation.
- 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.
- Divisional Training plans and commissions with Universities agreed to support skills development and programmes to support new roles.

60 Days

- UW Band 4 Foundation Degree programme 1st Cohort to commence September 2016.
- Hold Physicians Associate recruitment event with UW PA students.
- Agree final commissioned training plan with UW.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

90 Days

- Conditional offers to be made to successful Physicians Associate for commencement October 2016.
- Ward Administrators and Ward Housekeeper appointments to commence.

Risks to Delivery

- Ability to recruit required numbers to new roles
- Lack of Engagement for new roles with existing managers and staff.

Mitigation

- Offer all nurse students post upon successful completion of training.
- Engage fully with UW Physicians Associate programme.
- Communcation/managers briefings arranged to explain new roles.

Exception Report

Worcestershire NHS
Acute Hospitals NHS Trust

New Roles

Metric 6.1 - Vacancies													Target:
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory													
Actual		392.32	378.98	394.37	521.74								
RAG													

Metric 6.2 - Patient complaints – number of complaints regarding staff shortages										Target:0			
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		2	2	2	2	1	1	1	1	0	0	0	0
Actual		2	0	2	1								
RAG													

Metric 6.3 - Number of compliant rotas Medical and Dental										Target:42			
Month	Baseline Jan 2016	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		42	42	42	42	42	42	42	42	42	42	42	42
Actual		41	41	41	41								
RAG													

Metric 6.4 - Staff Opinion Survey KF14 – Satisfaction with Resourcing and Support												Target:3.3	
Month	Baseline mm/yy	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Trajectory		-	-	3.30			3.18			3.25			3.30
Actual		-	-	3.18									
RAG													

Women and Children's Improvement Plan Phase II

Worcestershire NHS
Acute Hospitals NHS Trust

- Women and Children's services – recognised by CQC and 'buddy' Trust that there have been huge strides in terms of safety, governance and learning lessons
- Phase II Improvement Plan being developed with work streams around:
  - Workforce
  - Governance and safety
  - Caesarean section rates
  - Gynaecology capacity

Women and Children's – High - level Improvement Plan / Measures

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Acute Hospitals NHS Trust

1.Workforce	Number of out of hours Consultants acting down	Number of filled posts on Middle Grade rota: Alex establishment 6WTE WRH establishment 8WTE	Number of filled posts on Junior grade rota: Alex establishment 9WTE WRH establishment 10 WTE	Trained Nursing numbers sufficient to manage 2 in patient sites
2. Governance/ Safety	Interval from incident to draft report is <4 weeks (externally reportable)	Initial Case reviews % completed within 72hours (bi-monthly)	Compliance with trust Complaint response times 95%	
3. Caesarean Section rates	Total caesarean section rate <27%	Elective caesarean rate <13%	Emergency caesarean rate <14%	
4. Gynaecology capacity	Incomplete RTT	Total number of patients on waiting list		

Outpatients Programme – High - level Improvement Plan / Workstreams

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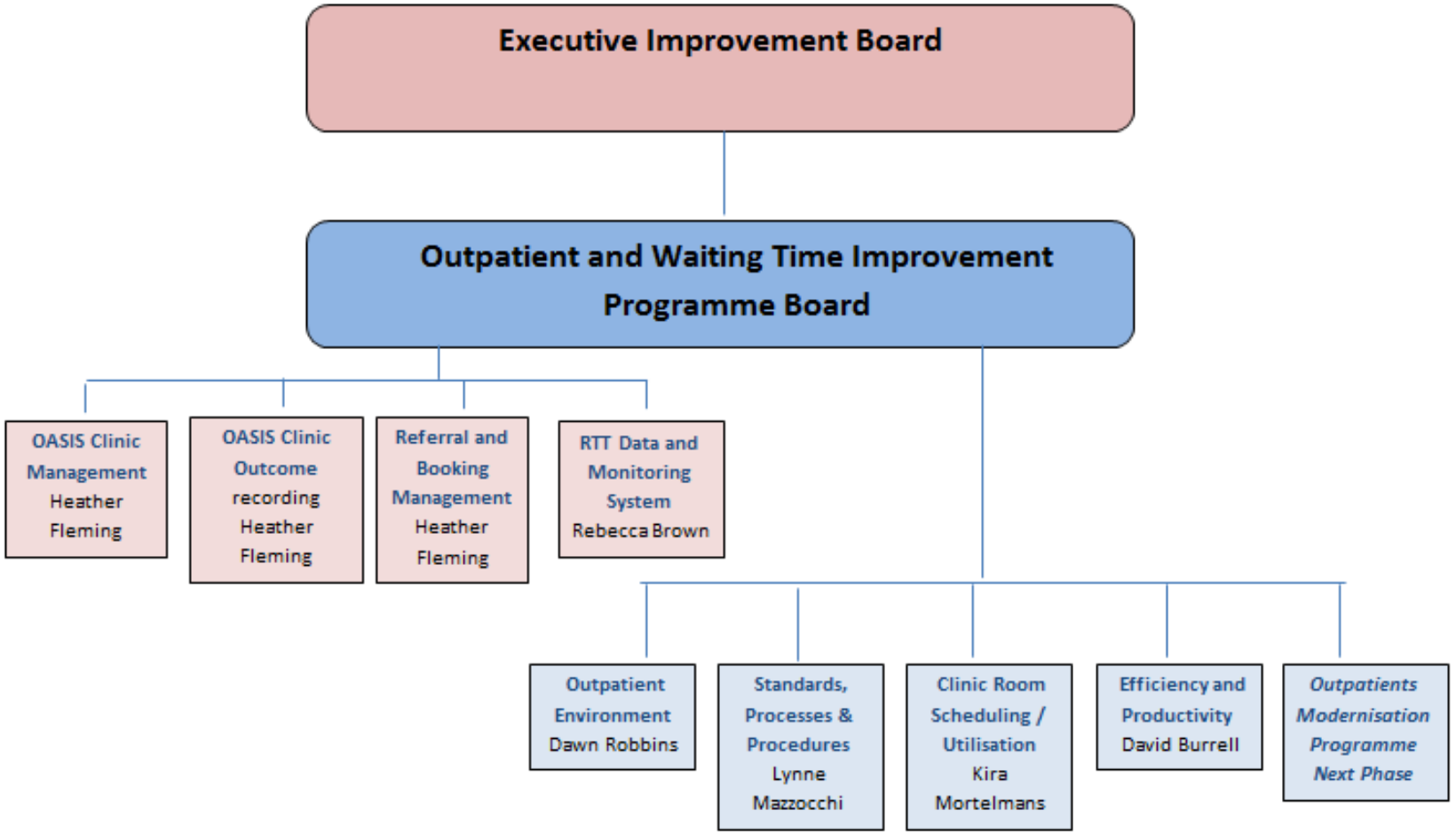
Acute Hospitals NHS Trust



Outpatient Improvement Programme – Next Steps

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Acute Hospitals NHS Trust

- Outpatient and Waiting Time Improvement Board in place
- Recruit a dedicated project manager
- Develop work stream improvement measures
- Develop granular project plans
- Create exception reports

High Dependency Care Unit Review

Worcestershire NHS
Acute Hospitals NHS Trust

- Multidisciplinary Task and finish group established
- Risk assessment completed against Faculty of ICM standards
  - Staffing
  - Estates
- Four work streams
  - Audit of patient acuity
  - Nurse education and training & rotational posts
  - SOP's – including medical cover
  - Governance
- Project management support identified
- Visit to Gloucester Post Anaesthetic Care Unit

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High Dependency Care Unit Review

Worcestershire NHS
Acute Hospitals NHS Trust

- Analyse audit data; 1st report back w/c 2nd May 16
- Scope wte required to enter additional (8 beds worth) of data to ICNARC
- Develop JD & PS for B6 Practice Development Nurse
- Review ward quality dashboards and separate HDU areas
- Review current operational policy
- Scope joint governance arrangements for HDU's and CCU
- Scope current therapy, pharmacy and dietetic support to each unit

Appendix One

PCIP: Programme status report, Governance and Safety Improvement plan

GOVERNANCE AND SAFETY IMPROVEMENT PLAN May 2016	Executive Sponsor:	Jan Stevens (Interim CNO)
	Project Lead:	Lisa Miruszenko (Deputy CNO)

Aim: Improve the Trust Board's assurance that appropriate governance processes are in place to deliver safe care that also complies with CQC and other national standards.

Objective(s):

- Assess and review ward to board quality reporting
- Assess and review the governance support structure
- Develop a performance framework for governance & safety
- Evaluate the impact of changes made against the aim using pressure ulcers and falls as example

	PROJECT MEASURES	TARGET	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	APR-16	COMMENTS/ MITIGATION
	Serious Incident process - achieve and maintain 0 investigation reports open > 60 working days (as per the NHSE SI Framework)	0	10	6	6	5	14	5	3	3	8	9	4	7	*Small deterioration to 7 overdue SI reports due to delays in investigation and deferral of approval for reports requiring further work. Oxford colleagues are assisting the improvement of the process.*
	Datix incidents - percentage of total incidents open >20 working days	Less than 50%				77 %	70%	74%	55%	53%	50%	60%	60%	66%	*Deterioration in the indicator despite fewer incidents being open (1010). Agreement to devise improvement trajectories for each Division with an expectation to meet it.*
	Pressure Ulcer Rate – Hospital acquired per 1000 bed days		0.24	0.52	0.35	0.39	0.46	0.24	0.31	0.55	0.35	0.34	0.53	0.31	*Pressure Ulcers – Accountability meetings with DCNO and ward manager and matron. New documentation currently being reviewed with implementation planned in June* *Falls - 1:1 meetings with ward managers arranged to review the incidents with individual action plans devised to*
	Avoidable grade 3 Pressure Ulcers	0	0	2	1	0	3	2	0	1	0	0	2	1	
	Avoidable grade 4 Pressure Ulcers	0	0	0	1	0	0	0	0	0	0	0	0	0	
	Falls per 10,000 bed days		48.5	43.8	51.4	46.5	57.8	51.4	50.1	55.4	53.8	40.3	49.08	n/a	
	Falls resulting in Serious Harm	< 24 p.a.	5	2	2	1	3	0	2	2	6	2	0	3	

	PROJECT MEASURES	TARGET	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	APR-16	COMMENTS/ MITIGATION
															address any identified gaps in care
	The number of trained investigators (incidents & complaints)	350 by Dec 16										84	84	84	*Will confirm trajectory when dates confirmed for training – Oxford will assist with training delivery*
	The number of staff trained in quality improvement techniques	225 by Dec 16													*Will confirm trajectory when dates confirmed for training*
	Percentage of approved risks overdue for review	Less than 15%	30%	24 %	21 %	19 %	27 %	17 %	14 %	11%	18%	12%	18%	9%	*Target achieved through ongoing prompts & reminders.*
	Percentage of approved risks with overdue actions	Less than 15%	30%	25 %	26 %	29 %	32 %	23 %	18 %	26%	29%	20%	23%	20%	*Remains amber (between 15-29).Guide to risk review distributed to divisions & services. Automated Datix action alert to be implemented May 2016.*
	Responses to complaints within 25 days of receipt	90%	59.0 %	53. 0%	53. 0%	64. 0%	86.0 %	81.0 %	62.0 %	77.0 %	81%	61%	n/a	n/a	*2015-16 67% of Category 2 responded to within 25 working days. (66% 14-15) Complaints Action Plan delivery on-going including new investigation and response writing training being sourced along with further DATIX improvements.*
	Percentage of complaints reopened per month (by month the complaint was reported in)	Less than 10%	8.0%	3.8 %	13. 8 %	17. 0%	14.0 %	11.1 %	8.8 %	11.1 %	19.0 %	1.8 %	n/a	n/a	*Amendments to previous figures show changes due to lag time in patient response to the Trust – this will be amended to the **number** re-opened each month.*
	Ward Dashboard • Use at Divisional Governance Meeting	100 %												n/a	*Information team supporting implementation visiting Matrons meetings to explain the dashboard.*
	Ward dashboard – phase 3 implementation	100 % wards													*Due to be implemented May 2016 – metrics are being included as they are developed*

	PROJECT MEASURES	TARGET	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	APR-16	COMMENTS/ MITIGATION
	Ward dashboard – performance 90% adherence to dashboard measures	90%													*The ability to measure the performance is being developed. Aim to introduce in May 16 Audit in July / August*

Successes this month	RAG Status	A	Planned Activity (Next Period)	RAG Status	G
• Review of Operational Governance Meeting and Investigation management / report approval held which will guide further development. • Datix Duty of Candour recording / monitoring section developed in Datix. Roll out in May. • Actions agreed to be closed at the Safe Patient Group: ○ Revised Quality Review Visits ○ Clinical risks - improve pro-active review of significant risk areas ○ Ensure that risk registers are reviewed regularly in a timely fashion. ○ Security / confidentiality of health records ○ Security at Kidderminster • 34 out of 40 clinical audit forward plans received – Surgery and Medicine have 3 outstanding each. An improved performance from 14/15			• Deputy Director of Governance post – to be readvertised and interim support sought. • Revise incident reporting and investigation policies following review at OGM • Roll out Duty of Candour monitoring function in Datix • Continue to target poor performing areas for support for appropriate and timely review and closure of patient safety incidents – agree trajectories for improvement • review action required to reduce back log of old incidents and develop remedial plan • Source additional training to build capability to undertake robust investigations • Further review of the governance arrangements and framework • Complete review of quality KPIs and inclusion in dashboards • Complete revision of Complaints policy and procedure with the new Interim CNO. • Medicines Optimisation Committee to create action plan for medicines training for patients and storage • Phase 3 of Ward Dashboard roll-out in May 2016		

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

Support required
• Support is being provided through a number of routes and the clinical governance system is being assessed. Further support will be identified during this process and the PCIP reframed to capture workstreams and actions.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 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 controls in place to manage nurse agency spend • Receive assurance on the processes in place for medical recruitment • Note the position with respect to the introduction of the junior doctors contract • Note that the Committee considered the Nursing and Midwifery report and the assurance that this gives • Note the assurance in respect of the BAF risks
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**

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

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JUNE 2016

1. Situation

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

2. Background

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

3. Assessment

3.1 Medical Workforce

The Committee were assured on the controls in place to ensure rapid advertisement for vacant posts. There was understanding shown in relation to the hard to recruit posts and the work being undertaken with divisions on ensuring a more proactive and innovative approach to solving difficult medical workforce issues. This included the use of physician associates.

The low fill rate for trainee posts was discussed. Mitigations include the remodelling of contracts and the use of agency staff.

Medical appraisals continue to rise and all consultants should have a job plan by the next meeting in June.

3.2 Agency staff

The Committee received assurance that the expenditure continued to fall. A recent independent report has shown that whilst controls are in place, they are not uniformly used. Nursing controls are more embedded than medic controls. It was agreed that the performance management of the implementation of the controls should rest with the performance management meetings, chaired by the Interim COO.

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.

3.4 Junior Doctor Contract implementation

The Committee were appraised of the current situation which was advice from NHS I to wait until the outcome of the ballot was known (8 July) before undertaking any further implementation. The implementation date is now October.

3.5 Workforce report for Professional, Clinical Support and Corporate staff

The Committee received the first report in relation to this group of staff. Further work is required to include trends and trajectories.

3.6 BAF risks

The Committee can assure the Board on the progress against all the BAF workforce risks.

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

3.7 **Other items considered:**

- **Workforce KPIs**
- **Workforce Race Equalities Standard Update report for CCGs** which we noted and approved the report for submission to the CCGs and were assured of the actions being taken.
- **PCIP** which the Committee were assured by the progress and agreed to monitor the progress by way of the KPIs with the Improvement Board progressing the detailed actions.

4 **Recommendations**

The Board is requested to:

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

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: 8 June 2016 **Enc F2**

Report to Trust Board (public)

Title	**Nursing and Midwifery Workforce Report**
Sponsoring Director	**Jan Stevens, Chief Nursing Officer**
Author	**Lisa Miruszenko, Deputy Chief Nurse**
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: 8 June 2016 **Enc F2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 8 June 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.

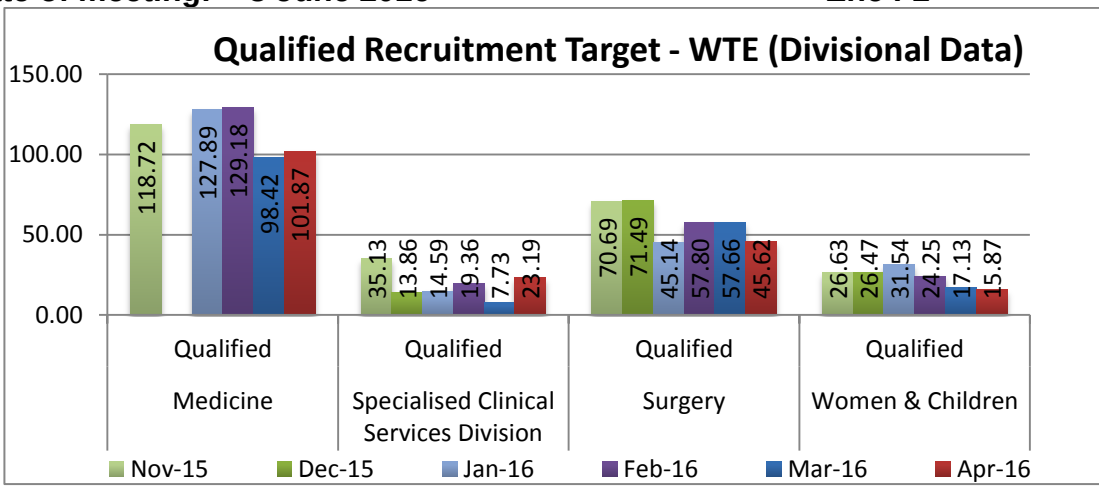
Key points within the new National Quality Board guidance will be :

- 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

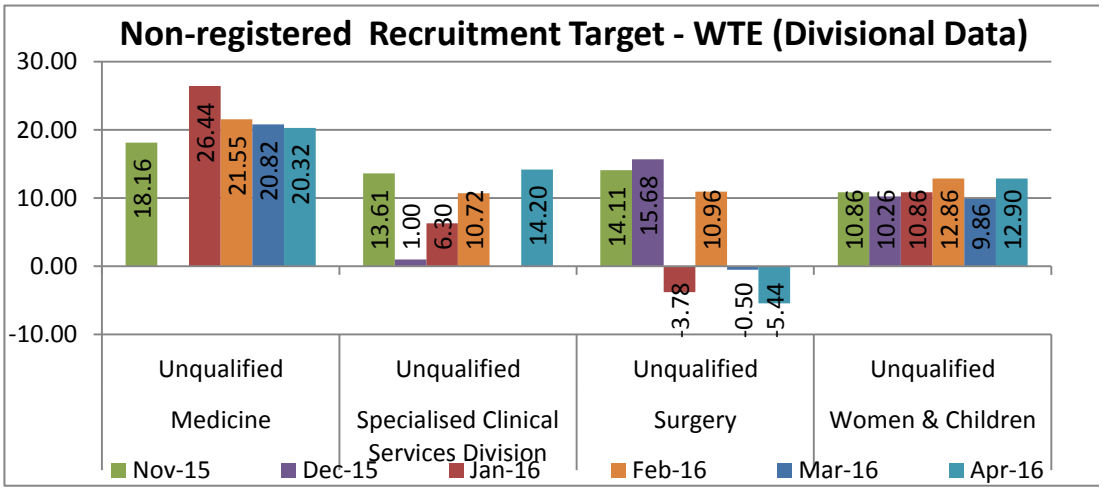
3 Assessment

3.1 **Registered nurse vacancies – Nov – April 2016**

Date of meeting: 8 June 2016 **Enc F2**



Non-Registered nurse vacancies – Nov – April 2016



Surgery

The vacancies for registered nurses within Surgery are 45.62wte registered nurse vacancies, reported for April 2016 This is compared to 57.66wte for March 2016.

The vacancies for non –registered in surgery were -5.44wte for April 2016 This is compared -0.50wte for March 2016. This reflects the continued active over recruitment of HCSWs to support areas where there are registered nurse vacancies. Further work has been undertaken within the division regarding staffing ratios and skill mix.

The vacancy position next month should again have improved once the position is verified following the establishment changes implemented in April.

Medicine

The vacancies for registered nurses within medicine were 101.87 WTE in April 2016. This is compared to 98.42 WTE in March2016.

The vacancies for non- registered staff were 20.32 WTE in April 2016 and 21.82 WTE March 2016.

There continues to be active recruitment within the medical division. The challenges remain on MAU at the Alex and ward 5 (respiratory ward) at the Alex. MAU are reconfiguring the ward, this will provide them with an AEC and short stay area. These changes will improve patient flow as well as providing an improved working environment to support retention in this area.

Excellent feedback has been provided from newly appointed nurses regarding the rotational programme A&E, MAU and the medical wards.

A bespoke advert will be published shortly for nasal invasive ventilation (NIV) respiratory nurses for the Alex.

Specialist Clinical Services Division (SCS)

The vacancies were 23.19 WTE in April 2016 for registered staff and 7.73 WTE for March 2016. The vacancies for non-registered staff were 14.20 WTE in April 2016.

Theatres at Worcester and the Alex site continue to be a challenge in recruitment. There are currently 14.94 WTE vacancies. Following a successful recruitment campaign they have confirmed 15.0 WTE new starters.

The Theatre internal bank has shown a reduction in the use of second tier agency and this is continuing to decline. The recent recruitment drive has seen an increase in applications and offers of substantive posts as well as an increasing numbers joining the internal bank. This may be in response to the premium pay uplift to attract staff.

Women & Children

Within Women and Childrens Division the vacancy position was 15.87 WTE for April 2016 and 17.13 WTE in March 2016. The vacancies for non-registered staff were 12.90 WTE for April 2016 and 9.86 WTE for March 2016.

The midwifery workforce continues to remain stable with less than 2 WTE vacancies.
The Neonatal Unit continues to have shortfalls in qualified neonatal nurses. There has however been success in recruiting to registered nurses, and plans are in place to ensure that these staff complete the neonatal course.

Gynaecological speciality currently have a 7.0 WTE vacancies for registered staff and 6.0 WTE non-registered staff. This is largely due to the recent changes in the service with the speciality being co-located on a surgical ward. Active recruitment is underway to support this area and Womens and Childrens Division with Surgery are in collaboration to maintain adequate staffing levels on the area.

Recruitment Actions

We have held a recruitment event at the Alexandra Hospital on Saturday 21st May 2016 and 18 nurses were appointed during the day for medicine and surgery.

The Trust has attended a number of university recruitment events for soon to be registered staff at Birmingham City University and Keele University. We will also be attending Stafford University later this month

Both the Medical and Surgical Divisions have in place bespoke rotational programmes for Band 5 posts.
We will continue with our plans for recruitment events internally as well as attending local recruitment fairs at colleges and Universities around the region.

3.2 Safer staffing

Trust overall fill rates for April 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	90.6%	98.9%	89.3%	113.1%
KIDDERMINSTER HOSPITAL	91.2%	85.6%	99.8%	100.6%
WORCESTERSHIRE ROYAL HOSPITAL	93.7%	99.1%	92.5%	101.3%

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 April 2016. 9 out of the 43 wards required to report fill rates had a fill rate of less than 80% This remains unchanged from last month.

Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Ward 5 - Medicine AHD	88.3%	83.0%	116.2%	66.3%
Ward 11	79.4%	90.0%	118.4%	85.0%
Ward 16	93.8%	111.6%	91.6%	74.9%
Ward 17	98.0%	129.5%	78.2%	119.3%
Ward 18	97.1%	107.5%	74.1%	101.6%
SCDU & SHDU	110.3%	117.9%	79.4%	103.3%
Beech B	94.8%	117.2%	102.2%	78.9%
Chestnut	104.5%	75.5%	123.6%	83.5%
WRH Riverbank	84.7%	68.8%	93.3%	90.0%

Key

- 80%	
80-94.9%	
95% +	

Surgery

The low fill rates i.e. those under 80% within the Surgical Division are attributed to the unavailability of a third planned registered nurse on night shifts due to continued vacancies. Additional HCSWs were rostered to cover the shortfalls and maintain overall numbers of staff on duty. The division have reviewed this and on 1st April implemented the new establishments for the smaller surgical wards would change from to 3 RN and 1 HCSW to 2 RN and 2 HCSW's this has addressed the shortfall without compromising patient care. This was risk assessed prior to implementation and this continues to be monitored by the Divisional Director of Nursing.

Medicine

Within the Medical Division there was only one fill rate under 80% and that was on Ward 5 for HCA's at night Some overfill rates were due to patients requiring 1:1 supervision.

Women and Children

Low fill rates within the Women and Childrens Division on the paediatric wards have been due to vacancies which have now been recruited to. County wide working has helped to ensure that both wards remain open with the appropriate staffing levels to maintain patient safety.

3.3 Progress with the use of Bank and Agency Staffing

Controls have been implemented to ensure the use of nurse agencies are monitored. All agencies are with framework. Any agencies above the April cap can only be used with authorisation by a matron or above.

3.4 University Education for Foundation Degree and Nurse Training

As part of our work to create a culture of "Grow your own" the CNO in conjunction with local Universities have agreed a fast track foundation degree in Health and social care over one year. This will enable our existing non- registered work force to progress their career to a Band 4. In addition to we have secured a fast track 2 year programme for nurse training an update will be provided in the next report.

4 Actions

- Implementation of Ward house keepers and ward administrators is taking place in July this will enhance the existing ward teams and ensure our clinical staff are able to provide direct nursing care.

5 Recommendation

The Group is asked to receive the report on:

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

Jan Stevens
Interim Chief Nursing Officer

Worcestershire NHS
Acute Hospitals NHS Trust

8 June 2016 **Enclosure G1**

Report to Trust Board (in public)

Title	**Finance & Performance Committee Report**
Sponsoring Director	**Andrew Sleigh – Finance & Performance Committee Chairman/ Non-Executive Director**
Author	**Andrew Sleigh – Finance & Performance Committee Chairman/ Non-Executive Director**
Action Required	• Note the achievement of the planned outturn deficit for 2015/2016. • Note 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. • Note 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.
Previously considered by	*N/A*

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	It is expected that the F&P Committee will give assurance to the Trust Board that plans are in place to achieve the Trust's financial forecasts and performance targets The Trust has a statutory duty to breakeven over a 3 year period.
Glossary	

Key Messages

- The deficit outturn for 2015/16 has met the target of £59m. Excellent grip has been demonstrated in achieving the labour cost run rate reduction during Q4, giving £10m of the £24m savings for 2016/17 at 1 April 2016.

- All Divisions are addressing the current gap between planned improvement initiatives and the £24m reduction target. There is good focus within the Divisional Teams to close this gap, but it was recognised that tough decisions were likely to be involved and cross-Divisional charges will need coordination by the Executive team.

- There remain performance concerns with ED access targets, 62 day cancer treatment, the number of “stranded” patients, and the volume throughput of elective treatments (RTT). The Committee was not fully assured that the whole organisation has these aspects at the top of their agendas.

- The Budget process has a high degree of rigour and performance review through the levels of management has been tightened significantly.

Worcestershire NHS
Acute Hospitals NHS Trust

8 June 2016 **Enclosure G1**

REPORT TO TRUST BOARD

1. Situation

This report informs the Board of the actions, scrutiny and assurance undertaken by the Finance & Performance Committee (FPC) at its meeting on 27th May 2016.

2. Background

The FPC meets to review the financial and operational performance of the Trust and reviews forecasts and plans for future performance. It exists to undertake a more detailed assessment than will be possible in main Board, provides advice to the Board and exercises specific delegated authorities.

3. Assessment

3.1 Decisions Made Within Delegated Responsibilities

The Committee authorised the Director of Finance to sign off the reference cost submission.

3.2 Principal Areas of Performance Scrutinised

- The Committee received summaries from each Division on the issues driving performance, their plans for resolving issues and additional support they needed. Assurance was gained on the determination to achieve the budget targets, but significant development is still needed in Medicine and Surgery. The Director of Finance and the Chief Operating Officer gave assurance that the executive team will be addressing cross-divisional opportunities.
- The planned trajectories for 62 day cancer treatment, ED access and stranded patients were reviewed in depth.
- A preliminary view of the Long Term Plan was discussed.

4. Recommendation

The Board is recommended to:

- Note the achievement of the planned outturn deficit for 2015/16.
- Note 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.
- Note 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.

Andrew Sleigh
Non-Executive Director
Chair Finance and Performance Committee

Title of report	Finance & Performance Committee Report (Mth 1)
Name of director	Andrew Sleigh

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc G2**

Report to Trust Board (in public)

Title	**Annual Accounts and Annual Audit Letter**
Sponsoring Director	**Haq Khan** **Deputy Director of Finance**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	To receive the Annual Accounts and Annual Audit Letter which were approved by the Audit and Assurance Committee at its meeting on 1 June 2016
Previously considered by	**Audit and Assurance Committee**

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 2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service 3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances
Legal Implications or Regulatory requirements	
Glossary	

Worcestershire Acute Hospitals NHS Trust

Annual Accounts for the period

1 April 2015 to 31 March 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s	Consolidated 2015-16 £000s	Consolidated 2014-15 £000s
Gross employee benefits	9.1	**(254,707)**	(236,915)	**(254,707)**	(236,915)
Other operating costs	7	**(172,031)**	(145,667)	**(172,031)**	(145,667)
Revenue from patient care activities	4	**349,355**	341,925	**349,355**	341,925
Other operating revenue	5	**19,626**	22,731	**19,626**	22,731
Operating surplus/(deficit)		**(57,757)**	(17,926)	**(57,757)**	(17,926)
Investment revenue	11	**43**	43	**43**	43
Other gains and (losses)	12	**0**	21	**0**	21
Finance costs	13	**(11,804)**	(11,338)	**(11,804)**	(11,338)
Surplus/(deficit) for the financial year		**(69,518)**	(29,200)	**(69,518)**	(29,200)
Public dividend capital dividends payable		**(3,163)**	(3,739)	**(3,163)**	(3,739)
Transfers by absorption - gains		**0**	0	**0**	0
Transfers by absorption - (losses)		**0**	0	**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0	**0**	0
Retained surplus/(deficit) for the year		**(72,681)**	(32,939)	**(72,681)**	(32,939)

Other Comprehensive Income

	2015-16 £000s	2014-15 £000s	2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve	**(19,743)**	0	**(19,743)**	0
Net gain/(loss) on revaluation of property, plant & equipment	**12,545**	12,268	**12,545**	12,268
Net gain/(loss) on revaluation of intangibles	**0**	0	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0	**0**	0
Other gain /(loss) (explain in footnote below)	**0**	0	**0**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0	**0**	0
Other pension remeasurements	**0**	0	**0**	0
Reclassification adjustments				
On disposal of available for sale financial assets	**0**	0	**0**	0
Total Other Comprehensive Income	**(7,198)**	12,268	**(7,198)**	12,268
Total comprehensive income for the year*	**(79,879)**	(20,671)	**(79,879)**	(20,671)

Financial performance for the year

Retained surplus/(deficit) for the year	**(72,681)**	(32,939)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**63**	50
Impairments (excluding IFRIC 12 impairments)	**13,261**	6,900
Adjustments in respect of donated gov't grant asset reserve elimination	**(474)**	71
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**(59,831)**	(25,918)

The notes on pages 7 to 25 form part of this account.

Statement of Financial Position as at 31 March 2016

				Consolidated	Consolidated
		31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	NOTE	**£000s**	£000s	**£000s**	£000s
Non-current assets:					
Property, plant and equipment	14	**248,857**	266,840	**248,857**	266,840
Intangible assets	15	**1,733**	1,717	**1,733**	1,717
Other Investments - Charitable				**0**	0
Investment property	18	**0**	0	**0**	0
Other financial assets		**0**	0	**0**	0
Trade and other receivables	22.1	**1,669**	2,059	**1,669**	2,059
Total non-current assets		**252,259**	270,616	**252,259**	270,616
Current assets:					
Inventories	21	**7,081**	6,107	**7,081**	6,107
Trade and other receivables	22.1	**24,983**	28,335	**24,983**	28,335
Other financial assets	24	**0**	0	**0**	0
Other current assets		**0**	0	**0**	0
Cash and cash equivalents	25	**1,474**	2,107	**1,474**	2,107
Sub-total current assets		**33,538**	36,549	**33,538**	36,549
Non-current assets held for sale	26	**840**	840	**840**	840
Total current assets		**34,378**	37,389	**34,378**	37,389
Total assets		**286,637**	308,005	**286,637**	308,005
Current liabilities					
Trade and other payables	27	**(43,389)**	(42,969)	**(43,389)**	(42,969)
Other liabilities	28	**(320)**	(395)	**(320)**	(395)
Provisions	34	**(791)**	(813)	**(791)**	(813)
Borrowings	29	**(1,936)**	(1,970)	**(1,936)**	(1,970)
Other financial liabilities		**0**	0	**0**	0
DH revenue support loan	29	**(1,334)**	(1,334)	**(1,334)**	(1,334)
DH capital loan	29	**(2,436)**	(2,436)	**(2,436)**	(2,436)
Total current liabilities		**(50,206)**	(49,917)	**(50,206)**	(49,917)
Net current assets/(liabilities)		**(15,828)**	(12,528)	**(15,828)**	(12,528)
Total assets less current liablilities		**236,431**	258,088	**236,431**	258,088
Non-current liabilities					
Trade and other payables		**0**	0	**0**	0
Other liabilities	28	**(2,915)**	(3,157)	**(2,915)**	(3,157)
Provisions	34	**(1,363)**	(1,492)	**(1,363)**	(1,492)
Borrowings	29	**(72,055)**	(73,990)	**(72,055)**	(73,990)
Other financial liabilities		**0**	0	**0**	0
DH revenue support loan	29	**(67,944)**	(7,331)	**(67,944)**	(7,331)
DH capital loan	29	**(23,535)**	(24,188)	**(23,535)**	(24,188)
Total non-current liabilities		**(167,812)**	(110,158)	**(167,812)**	(110,158)
Total assets employed:		**68,619**	147,930	**68,619**	147,930
FINANCED BY:					
Public Dividend Capital		**184,564**	183,996	**184,564**	183,996
Retained earnings		**(169,404)**	(95,744)	**(169,404)**	(95,744)
Revaluation reserve		**54,320**	60,539	**54,320**	60,539
Charitable Funds Reserve				**0**	0
Other reserves		**(861)**	(861)	**(861)**	(861)
Total Taxpayers' Equity:		**68,619**	147,930	**68,619**	147,930

The notes on pages 26 to 48 form part of this account.

The financial statements on pages 2 to 6 were approved by the Board on 02.06.16 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**183,996**	**(95,744)**	**60,539**	**(861)**	**147,930**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(72,681)			**(72,681)**
Net gain / (loss) on revaluation of property, plant, equipment			12,545		**12,545**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial			0		**0**
Impairments and reversals			(19,743)		**(19,743)**
Other gains/(loss)				0	**0**
Transfers between reserves		(979)	979	0	**0**
Reclassification Adjustments					
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets			0		**0**
Reserves eliminated on dissolution		0	0	0	**0**
Originating capital for Trust established in year	0				**0**
Permanent PDC received - cash	568				**568**
Permanent PDC repaid in year	0				**0**
PDC written off	0	0			**0**
Transfer due to change of status from Trust to Foundation Trust	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension				0	**0**
Other pensions remeasurement				0	**0**
Net recognised revenue/(expense) for the year	**568**	**(73,660)**	**(6,219)**	**0**	**(79,311)**
Balance at 31 March 2016	**184,564**	**(169,404)**	**54,320**	**(861)**	**68,619**
Balance at 1 April 2014	**138,589**	**(64,917)**	**50,383**	**(861)**	**123,194**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		(32,939)			(32,939)
Net gain / (loss) on revaluation of property, plant, equipment			12,268		12,268
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			0		0
Other gains / (loss)				0	0
Transfers between reserves		2,112	(2,112)	0	0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource	0	0	0	0	0
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption		0	0		0
On disposal of available for sale financial assets			0		0
Originating capital for Trust established in year	0				0
New temporary and permanent PDC received - cash	79,907				79,907
New temporary and permanent PDC repaid in year	(34,500)				(34,500)
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension				0	0
Other pension remeasurement				0	0
Net recognised revenue/(expense) for the year	**45,407**	**(30,827)**	**10,156**	**0**	**24,736**
Balance at 31 March 2015	**183,996**	**(95,744)**	**60,539**	**(861)**	**147,930**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Consolidated					
	Public Dividend capital	**Retained earnings**	**Revaluation reserve**	**Charitable Funds Reserve**	**Other reserves**	**Total reserves**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**183,996**	**(95,744)**	**60,539**	**0**	**(861)**	**147,930**
Changes in taxpayers' equity for 2015-16						
Retained surplus/(deficit) for the year		(72,681)		0		**(72,681)**
Net gain / (loss) on revaluation of property, plant, equipment			12,545	0		**12,545**
Net gain / (loss) on revaluation of intangible assets			0			**0**
Net gain / (loss) on revaluation of financial assets			0			**0**
Net gain / (loss) on revaluation of available for sale financial			0			**0**
Impairments and reversals			(19,743)			**(19,743)**
Other gains/(loss)					0	**0**
Transfers between reserves		(979)	979		0	**0**
Reclassification Adjustments						
Transfers between Reserves in respect of assets transferred under absorption	0	0	0	0	0	**0**
On disposal of available for sale financial assets			0			**0**
Reserves eliminated on dissolution		0	0		0	**0**
Originating capital for Trust established in year	0					**0**
Permanent PDC received - cash	568					**568**
Permanent PDC repaid in year	0					**0**
PDC written off	0	0				**0**
Transfer due to change of status from Trust to Foundation Trust	0	0	0		0	**0**
Other movements	0	0	0		0	**0**
Revaluation and impairment of Charitable fund assets				0		**0**
Charitable Funds Adjustment				0		**0**
Net actuarial gain/(loss) on pension					0	**0**
Other pensions remeasurement					0	**0**
Net recognised revenue/(expense) for the year	**568**	**(73,660)**	**(6,219)**	**0**	**0**	**(79,311)**
Balance at 31 March 2016	**184,564**	**(169,404)**	**54,320**	**0**	**(861)**	**68,619**
Balance at 1 April 2014	**138,589**	**(64,917)**	**50,383**	**0**	**(861)**	**123,194**
Changes in taxpayers' equity for the year ended 31 March 2015						
Retained surplus/(deficit) for the year		(32,939)		0		(32,939)
Net gain / (loss) on revaluation of property, plant, equipment			12,268	0		12,268
Net gain / (loss) on revaluation of intangible assets			0			0
Net gain / (loss) on revaluation of financial assets			0			0
Net gain / (loss) on revaluation of assets held for sale			0			0
Impairments and reversals			0			0
Other gains / (loss)					0	0
Transfers between reserves		2,112	(2,112)		0	0
Reclassification Adjustments						
Transfers to/(from) Other Bodies within the Resource	0	0	0	0	0	0
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption		0	0			0
On disposal of available for sale financial assets			0			0
Originating capital for Trust established in year	0					0
New temporary and permanent PDC received - cash	79,907					79,907
New temporary and permanent PDC repaid in year	(34,500)					(34,500)
Other movements	0	0	0		0	0
Revaluation and impairment of Charitable fund assets				0		0
Charitable Funds Adjustment				0		0
Net actuarial gain/(loss) on pension					0	0
Other pension remeasurement					0	0
Net recognised revenue/(expense) for the year	**45,407**	**(30,827)**	**10,156**	**0**	**0**	**24,736**
Balance at 31 March 2015	**183,996**	**(95,744)**	**60,539**	**0**	**(861)**	**147,930**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s	Consolidated 2015-16 £000s	Consolidated 2014-15 £000s
Cash Flows from Operating Activities					
Operating surplus/(deficit)		**(57,757)**	(17,926)	**(57,757)**	(17,926)
Depreciation and amortisation	8	**10,247**	8,532	**10,247**	8,532
Impairments and reversals	17	**13,261**	6,950	**13,261**	6,950
Other gains/(losses) on foreign exchange	13	**0**	0	**0**	0
Donated Assets received credited to revenue but non-cash	6	**0**	0	**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0	**0**	0
Interest paid		**(11,803)**	(11,143)	**(11,803)**	(11,143)
PDC Dividend (paid)/refunded		**(4,244)**	(4,057)	**(4,244)**	(4,057)
Release of PFI/deferred credit		**0**	0	**0**	0
(Increase)/Decrease in Inventories		**(974)**	(1,046)	**(974)**	(1,046)
(Increase)/Decrease in Trade and Other Receivables		**3,742**	(8,412)	**3,742**	(8,412)
(Increase)/Decrease in Other Current Assets		**0**	0	**0**	0
Increase/(Decrease) in Trade and Other Payables		**1,325**	(4,480)	**1,325**	(4,480)
(Increase)/Decrease in Other Current Liabilities		**(317)**	768	**(317)**	768
Provisions utilised		**(677)**	(554)	**(677)**	(554)
Increase/(Decrease) in movement in non cash provisions		**(77)**	451	**(77)**	451
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows				**0**	0
Net Cash Inflow/(Outflow) from Operating Activities		**(47,274)**	(30,917)	**(47,274)**	(30,917)
Cash Flows from Investing Activities					
Interest Received		**43**	43	**43**	43
(Payments) for Property, Plant and Equipment		**(11,664)**	(18,387)	**(11,664)**	(18,387)
(Payments) for Intangible Assets		**(296)**	0	**(296)**	0
(Payments) for Investments with DH		**0**	0	**0**	0
(Payments) for Other Financial Assets		**0**	0	**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0	**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	0	**0**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0	**0**	0
Proceeds from Disposal of Investment with DH		**0**	0	**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0	**0**	0
Loans Made in Respect of LIFT		**0**	0	**0**	0
Loans Repaid in Respect of LIFT		**0**	0	**0**	0
Rental Revenue		**0**	0	**0**	0
NHS Charitable Funds - net cash flows relating to investing activities				**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(11,917)**	(18,344)	**(11,917)**	(18,344)
Net Cash Inflow /(Outflow) before Financing		**(59,191)**	(49,261)	**(59,191)**	(49,261)
Cash Flows from Financing Activities					
Gross Temporary (2014/15 only) and Permanent PDC Received		**568**	79,907	**568**	79,907
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**0**	(34,500)	**0**	(34,500)
Loans received from DH - New Capital Investment Loans		**1,783**	4,950	**1,783**	4,950
Loans received from DH - New Revenue Support Loans		**95,665**	0	**95,665**	0
Other Loans Received		**0**	0	**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(2,436)**	(1,446)	**(2,436)**	(1,446)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(35,052)**	(1,334)	**(35,052)**	(1,334)
Other Loans Repaid		**0**	0	**0**	0
Cash transferred to NHS Foundation Trusts or on dissolution		**0**	0	**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(1,970)**	(1,873)	**(1,970)**	(1,873)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	0	**0**	0
NHS Charitable Funds - net cash flows relating to Financing activities					
Net Cash Inflow/(Outflow) from Financing Activities		**58,558**	45,704	**58,558**	45,704
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(633)**	(3,557)	**(633)**	(3,557)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**2,107**	5,664	**2,107**	4,134
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**26**	**1,474**	2,107	**1,474**	577

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Going Concern

IAS 1 requires management to assess as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future cash support. The Trust Board confirmed the appropriateness of the going concern assumption for the 2016/17 accounts at its meeting on 6th April 2016. The Trust has submitted a financial plan for 2016-17 to the NHS Trust Development Authority (NHS TDA) which delivers a £51.5 million deficit after delivery of a £24.3 million savings programme. The plan recognises that the Trust has insufficient cash resources and includes a requirement for £66.1 million of cash support from the Department of Health to maintain the Trust's cash flow in 2016-17.

The Trust agreed a £15.4 million revenue support loan with the Department on Health on the 9th May 2016 which provides sufficient cash resources to meet planned commitments to the end of July 2016. The Directors have received confirmation from the NHS TDA that it supports the Trust's application for cash support and consider that there is sufficient evidence that the services the Trust provides will continue as a going concern for the foreseeable future.

1.4 Charitable Funds

Following Treasury's agreement to apply IAS 27 (now superseded by IFRS10) to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity (Worcestershire Acute Hospitals Charity), it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' notes.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014 for the anticipated or actual breach of financial duties). Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. Where a Trust ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis."

1.5.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying theTrust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

Asset lives

The Trust has to make assumptions and judgments when determining the length of an asset's estimated useful life . This will take into account the view provided during the professional valuation and also the Trust's assessment of the period over which it will obtain service potential from the asset.

In determining the estimated useful lives of assets the Trust has taken into consideration any future lifecycle replacement that will enhance and prolong the life of the asset; specifically in relation to assets capitalised under PFI contract arrangements. The Trust revised its UEL's in March 2016 following a review by DTZ. This is documented at Note 15.3

PFI Asset Valuation

From 31st March 2015, the Trust has accounted for the Valuation of its PFI Hospital on the basis of Depreciated Replacement Cost excluding VAT. When determining the change in treatment, the Trust sought advice from its appointed VAT Advisors to confirm the appropriateness of its judgement.

PFI Contract

The Trust is pursuing a claim with the PFI provider largely relating to an unavailability claim under the terms of the contract. The amount included in the accounts represents the agreed settlement value but is subject to finalisation of contract terms. The Trust is being advised by external consultants and its legal advisors in pursing this claim.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of (1.5%) in real terms for claims settled in 1-5 years, (1.05%) for 6 to 10 years and 2.2% for claims settling after 10 years.. For pensions the Trust uses actuarial tables to value provisions.

Property Valuation

Assets relating to land and buildings were subject to a formal valuation during the financial year ending 31st March 2016. This resulted in a £20.4m decrease in asset values during the period. The valuation for land increased by almost £4.1m, but the valuation for buildings fell by £24.5m. Further details are provided at note 15.3.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality. However, accruals for Consultant's leave, which is calculated from the date of appointment rather than the start of the financial year. is accrued on the basis of materiality.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the NHS trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.12 Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants
Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.14 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

Other assets contributed by the NHS trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.17 Inventories
Inventories (excluding Drugs) are valued at the lower of cost and net realisable value using the *first-in first-out* cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Drugs inventories are valued on an average cost basis.

1.18 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.19 Provisions
Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 0.8% in real terms (1.37% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.20 Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 35.

1.21 Non-clinical risk pooling
The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.22 Carbon Reduction Commitment Scheme (CRC)
CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.23 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.24 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset. The Trust has no separable embedded derivatives

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.25 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and

The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets.*

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.27 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.28 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.29 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.30 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had [NHS bodies] not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.31 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.32 Associates

Material entities over which the NHS trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.33 Joint arrangements

Material entities over which the NHS trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.34 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.35 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2 Operating segments

The Trust has only one operating segment; that is the provision of healthcare services. The total amount of income from the provision of healthcare services during the accounting period is £368,981k. Total operating expenditure from the provision of healthcare services during the accounting period is £426,738k

The Trust generated over 10% of income from the following organisations:

	£000s
NHS England	**58,403**
NHS Redditch and Bromsgrove CCG	**74,350**
NHS South Worcestershire CCG	**126,964**
NHS Wyre Forest CCG	**55,787**

3 Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - aggregate of all schemes	**2015-16 £000s**	2014-15 £000s
Income	**2,557**	2,291
Full cost **	**2,005**	1,636
Surplus/(deficit)	**552**	655

** Full cost for both financial years includes additional car park improvements and modernisation costs.

4 Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**7,531**	3,726
NHS England	**59,073**	50,442
Clinical Commissioning Groups	**279,733**	284,263
Foundation Trusts	**1,106**	1,320
NHS Other (including Public Health England and Prop Co)	**31**	422
Additional income for delivery of healthcare services	**0**	0
Non-NHS:		
Local Authorities	**149**	309
Private patients	**484**	652
Overseas patients (non-reciprocal)	**13**	3
Injury costs recovery	**1,186**	495
Other	**49**	293
Total Revenue from patient care activities	**349,355**	341,925

5 Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**0**	0
Patient transport services	**0**	0
Education, training and research	**11,142**	12,183
Charitable and other contributions to revenue expenditure - NHS	**535**	538
Charitable and other contributions to revenue expenditure -non- NHS	**0**	0
Receipt of donations for capital acquisitions - Charity	**1,098**	0
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**856**	4,790
Income generation (Other fees and charges)	**37**	2,670
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**93**	94
Other revenue	**5,865**	2,456
Total Other Operating Revenue	**19,626**	22,731
Total operating revenue	**368,981**	364,656

* Injury cost recovery income is subject to a provision for impairment of receivables of 18.9% to reflect expected rates of collection. This percentage is advised nationally by the Compensation Recovery Unit.

6 Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**13**	3
Cash payments received in-year (re receivables at 31 March 2015)	**0**	0
Cash payments received in-year (iro invoices issued 2014-15)	**1**	2
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**0**	0
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	**0**	0
Amounts written off in-year (irrespective of year of recognition)	**0**	0

7 Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**2,515**	0
Services from CCGs/NHS England	**0**	0
Services from other NHS bodies	**0**	0
Services from NHS Foundation Trusts	**0**	0
Total Services from NHS bodies*	**2,515**	0
Purchase of healthcare from non-NHS bodies	**1,435**	2,657
Trust Chair and Non-executive Directors	**62**	63
Supplies and services - clinical	**88,073**	73,971
Supplies and services - general	**5,554**	8,087
Consultancy services	**148**	157
Establishment	**8,838**	4,609
Transport	**394**	1,665
Service charges - ON-SOFP PFIs and other service concession arrangements	**13,393**	12,951
Service charges - On-SOFP LIFT contracts	**0**	0
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - Off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**2,155**	1,834
Premises	**14,230**	13,539
Hospitality	**13**	34
Insurance	**253**	290
Legal Fees	**1,341**	553
Impairments and Reversals of Receivables	**559**	80
Inventories write down	**0**	0
Depreciation	**9,690**	8,266
Amortisation	**557**	266
Impairments and reversals of property, plant and equipment	**13,261**	6,950
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Internal Audit Fees	**78**	0
Audit fees	**75**	68
Other auditor's remuneration [Internal Audit Fees]	**38**	95
Clinical negligence	**7,146**	7,367
Research and development (excluding staff costs)	**0**	33
Education and Training	**858**	940
Change in Discount Rate	**19**	65
Other	**1,346**	1,127
Total Operating expenses (excluding employee benefits)	**172,031**	145,667
Employee Benefits		
Employee benefits excluding Board members	**253,712**	235,974
Board members	**995**	941
Total Employee Benefits	**254,707**	236,915
Total Operating Expenses	**426,738**	382,582

*Services from NHS bodies does not include expenditure which falls into a category below

8 Operating Leases

8.1 Worcestershire Acute Hospitals NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**311**	332
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**311**	332
Payable:					
No later than one year	0	296	0	**296**	332
Between one and five years	0	2,959	0	**2,959**	2,403
After five years	0	6,214	0	**6,214**	7,398
Total	**0**	**9,469**	**0**	**9,469**	10,133
Total future sublease payments expected to be received:				0	0

8.2 Worcestershire Acute Hospitals NHS Trust as lessor

	2015-16 £000	2014-15 £000s
Recognised as revenue		
Rental revenue	0	0
Contingent rents	93	94
Total	**93**	94
Receivable:		
No later than one year	93	94
Between one and five years	0	0
After five years	0	0
Total	**93**	94

The Trust acts as a Lessor for the following assets:-

Asset	Lessee	2015-16 £000 Revenue	2014-15 £000 Revenue
Kidderminster Hospital - F Block	Worcestershire Health and Care NHS Trust	50	51
Alexandra Hospital GU Medicine	Worcestershire Health and Care NHS Trust	23	23
Worcester John Anthony Centre GU Medicine	Worcestershire Health and Care NHS Trust	19	19
Kidderminster Hospital - A Block (part)	Worcestershire Health and Care NHS Trust	1	1
		93	**94**

* Additional detail regarding these leased assets is provided at Note 14.3

9 Employee benefits and staff numbers

9.1 Employee benefits

	2015-16		
	Total £000s	**Permanently employed £000s**	**Other* £000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**222,130**	184,962	37,168
Social security costs	**13,489**	13,489	0
Employer Contributions to NHS BSA - Pensions Division	**20,210**	20,210	0
Other pension costs	**0**	0	0
Termination benefits	**383**	383	0
Total employee benefits	**256,212**	**219,044**	**37,168**
Employee costs capitalised	**1,505**	1,185	320
Gross Employee Benefits excluding capitalised costs	**254,707**	**217,859**	**36,848**

* The Other column includes those on inward secondment or loan from other organisations, agency staff and those engaged on a contract to undertake a project or other temporary task. It does not include amounts payable to contractors for services, that is, where the staff remain under the control of the contractor.

Employee Benefits - Gross Expenditure 2014-15	**Total £000s**	**Permanently employed £000s**	**Other £000s**
Salaries and wages	204,895	177,792	27,103
Social security costs	13,028	13,028	0
Employer Contributions to NHS BSA - Pensions Division	20,931	20,931	0
Other pension costs	0	0	0
Termination benefits	0	0	0
TOTAL - including capitalised costs	238,854	211,751	27,103
Employee costs capitalised	1,939	1,276	663
Gross Employee Benefits excluding capitalised costs	236,915	210,475	26,440

9.2 Staff Numbers

	2015-16			2014-15
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**676**	600	76	711
Ambulance staff	**0**	0	0	0
Administration and estates	**944**	910	34	959
Healthcare assistants and other support staff	**1,080**	1,079	1	999
Nursing, midwifery and health visiting staff	**1,961**	1,691	270	1,921
Nursing, midwifery and health visiting learners	**18**	18	0	14
Scientific, therapeutic and technical staff	**771**	743	28	717
Social Care Staff	**0**	0	0	0
Healthcare Science Staff	**0**	0	0	0
Other	**23**	23	0	25
TOTAL	**5,473**	**5,064**	**409**	5,346
Of the above - staff engaged on capital projects	**30**	2	28	26

9.3 Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	48,800	45,670
Total Staff Years	5,054	4,969
Average working Days Lost	9.66	9.19

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**3**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**90**	292

9.4 Exit Packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	0	0	6	42,351	**6**	**42,351**	0	0
£10,000-£25,000	0	0	11	204,053	**11**	**204,053**	0	0
£25,001-£50,000	0	0	4	131,984	**4**	**131,984**	0	0
£50,001-£100,000	0	0	0	0	**0**	**0**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**0**	**0**	**21**	**378,388**	**21**	**378,388**	**0**	**0**

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	0	0	0	0	**0**	**0**	0	0
£10,000-£25,000	1	13,920	0	0	**1**	**13,920**	0	0
£25,001-£50,000	0	0	0	0	**0**	**0**	0	0
£50,001-£100,000	0	0	0	0	**0**	**0**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**1**	**13,920**	**0**	**0**	**1**	**13,920**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the Mutually Agreed Resignation Scheme (MARS). Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

All of the above exit packages in 2015/16 were administered through a Mutually Agreed Resignation Scheme (MARS).

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

9.5 Exit packages - Other Departures analysis

The Trust had no other exit packages in 2015-16

9.6 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

10. Better Payment Practice Code

10.1 Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**100,120**	**209,148**	98,426	188,412
Total Non-NHS Trade Invoices Paid Within Target	**36,193**	**100,323**	34,464	85,574
Percentage of NHS Trade Invoices Paid Within Target	**36.15%**	**47.97%**	35.02%	45.42%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,164**	**30,424**	3,502	**25,124**
Total NHS Trade Invoices Paid Within Target	**1,418**	**22,247**	1,668	**11,802**
Percentage of NHS Trade Invoices Paid Within Target	**44.82%**	**73.12%**	47.63%	46.98%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**71**	272
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**71**	272

11. Investment Revenue

	2015-16 £000s	2014-15 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**43**	43
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**43**	43
Total investment revenue	**43**	43

12. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	21
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**0**	21

13. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**1,279**	622
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
- main finance cost	**6,260**	6,419
- contingent finance cost	**4,171**	3,830
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**71**	272
Total interest expense	**11,781**	11,143
Other finance costs	**0**	172
Provisions - unwinding of discount	**23**	23
Total	**11,804**	11,338

14 Property, plant and equipment

14.1 Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Cost or valuation:									
At 1 April 2015	32,706	203,750	1,761	5,366	50,771	315	21,494	0	**316,163**
Additions of Assets Under Construction				9,001					**9,001**
Additions Purchased	0	54	0		1,528	0	888	0	**2,470**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	1,098	0	0	0	0	0	0	**1,098**
Additions Leased (including PFI/LIFT)	0	0	0		0	0	0	0	**0**
Reclassifications	0	4,965	24	(7,397)	164	0	1,967	0	**(277)**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(2,633)	(3)	0	0	**(2,636)**
Upward revaluation/positive indexation	7,469	5,076	0	0	0	0	0	0	**12,545**
Impairment/reversals charged to operating expenses	(208)	(12,813)	(240)	0	0	0	0	0	**(13,261)**
Impairments/reversals charged to reserves	(3,169)	(15,969)	(605)	0	0	0	0	0	**(19,743)**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2016	**36,798**	**186,161**	**940**	**6,970**	**49,830**	**312**	**24,349**	**0**	**305,360**
Depreciation									
At 1 April 2015	0	0	0		34,760	315	14,248	0	**49,323**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(2,507)	(3)	0	0	**(2,510)**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0		0	0	0	0	**0**
Charged During the Year	0	3,676	38		3,081	0	2,895	0	**9,690**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0		0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0		0	0	0	0	**0**
At 31 March 2016	**0**	**3,676**	**38**	**0**	**35,334**	**312**	**17,143**	**0**	**56,503**
Net Book Value at 31 March 2016	**36,798**	**182,485**	**902**	**6,970**	**14,496**	**0**	**7,206**	**0**	**248,857**
Asset financing:									
Owned - Purchased	36,798	107,923	902	6,970	8,504	0	7,206	0	**168,303**
Owned - Donated	0	299	0	0	156	0	0	0	**455**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	74,263	0	0	5,836	0	0	0	**80,099**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2016	**36,798**	**182,485**	**902**	**6,970**	**14,496**	**0**	**7,206**	**0**	**248,857**

14 Property, plant and equipment

Revaluation Reserve Balance for Property, Plant & Equipment	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	18,003	40,562	1,102	0	868	1	3	0	**60,539**
Movements	4,300	(10,040)	(631)	0	152	0	0	0	**(6,219)**
At 31 March 2016	**22,303**	**30,522**	**471**	**0**	**1,020**	**1**	**3**	**0**	**54,320**

Additions to Assets Under Construction in 2014-15

Land	0
Buildings excl Dwellings	9,001
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**9,001**

14 Property, plant and equipment

14.2 Property, plant and equipment prior-year

2014-15	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	27,651	187,690	1,199	17,561	44,554	315	18,629	0	**297,599**
Additions of Assets Under Construction				12,053					**12,053**
Additions Purchased	0	2,059	20		1,839	0	2,931	0	**6,849**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	0	0		0	0	0	0	**0**
Reclassifications	0	17,761	0	(24,248)	5,746	0	741	0	**0**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,368)	0	(807)	0	**(2,175)**
Revaluation	6,038	(3,760)	542	0	0	0	0	0	**2,820**
Impairments/negative indexation charged to reserves	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments charged to reserves	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**33,689**	**203,750**	**1,761**	**5,366**	**50,771**	**315**	**21,494**	**0**	**317,146**
Depreciation									
At 1 April 2014	0	1	0	0	33,511	287	12,914	0	**46,713**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(1,368)	0	(807)	0	**(2,175)**
Revaluation	761	(10,172)	(37)		0	0	0	0	**(9,448)**
Impairments/negative indexation charged to operating expenses	222	6,657	13	0	56	0	2	0	**6,950**
Reversal of Impairments charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	3,514	24		2,561	28	2,139	0	**8,266**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0		0	0	0	0	**0**
At 31 March 2015	**983**	**0**	**0**	**0**	**34,760**	**315**	**14,248**	**0**	**50,306**
Net Book Value at 31 March 2015	**32,706**	**203,750**	**1,761**	**5,366**	**16,011**	**0**	**7,246**	**0**	**266,840**
Asset financing:									
Owned - Purchased	32,706	123,685	1,761	5,366	9,824	0	7,246	0	**180,588**
Owned - Donated	0	478	0	0	150	0	0	0	**628**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	79,587	0	0	6,037	0	0	0	**85,624**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**32,706**	**203,750**	**1,761**	**5,366**	**16,011**	**0**	**7,246**	**0**	**266,840**

14.2 (cont). Property, plant and equipment

A valuation of the Trust's land and buildings was undertaken by DTZ (RICS Registered Valuers), as at 31st March 2016.

The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the asset valuations were undertaken in 2016 as at the prospective valuation date of 31 March 2016.

The valuations have been carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property.

In line with HM Treasury guidance, the revaluation as at 31st March 2016 was based on the 'Modern Equivalent Asset' approach to valuation.

The Trust acts as a Lessor, detailed in Note 8.2 of the Accounts. The PPE note includes amounts associated with the leased assets as follows:-

	Gross Carrying Amount	**Depreciation 2015/16**
	£000	**£000**
Kidderminster Hospital - F Block	**1,083**	**10**
Worcester John Anthony Centre GU Medicine	**293**	**3**

The Trusts leases smaller areas as detailed in Note 8.2, however due the revaluation of Property on a Modern Equivalent Asset basis it is not possible to separately identify any of the values associated with these assets.

The valuation undertaken by DTZ calculates the useful economic lives based on a standard formula. In March 2013 the Trust undertook a full review of its asset base including a condition survey which informed the Trust's assessment of useful economic lives. After taking professional advice the Trust has revised the useful economic lives based on the condition survey to more accurately reflect the future economic benefit from property assets. The approach used is consistent with the principles of the Red Book and IAS16. Each site is now defined as the property asset with the 3 significant components defined as land, buildings and external works. This has had the overall effect of extending the useful economic lives. During the March 2016 valuation exercise, these Asset Lives were checked and revised where necessary.

15. Intangible non-current assets

15.1 Intangible non-current assets

2015-16	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	**2,189**	**707**	**0**	**0**	**0**	**2,896**
Additions Purchased	296	0	0	0	0	**296**
Additions Internally Generated	0	0	0	0	0	**0**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	0	0	0	0	**0**
Reclassifications	277	0	0	0	0	**277**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2016	**2,762**	**707**	**0**	**0**	**0**	**3,469**
Amortisation						
At 1 April 2015	**1,070**	**109**	**0**	**0**	**0**	**1,179**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	**0**
Impairment/reversals charged to reserves	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	**0**
Charged During the Year	557	0	0	0	0	**557**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2016	**1,627**	**109**	**0**	**0**	**0**	**1,736**
Net Book Value at 31 March 2016	**1,135**	**598**	**0**	**0**	**0**	**1,733**
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	1,135	598	0	0	0	**1,733**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	**0**
Total at 31 March 2016	**1,135**	**598**	**0**	**0**	**0**	**1,733**

Revaluation reserve balance for intangible non-current assets						
						£000's
At 1 April 2015	0	0	0	0	0	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**

15.2 Intangible non-current assets prior year

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	1,491	336	0	0	0	1,827
Additions - purchased	698	399	0	0	0	1,097
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(28)	0	0	0	(28)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2015	2,189	707	0	0	0	2,896
Amortisation						
At 1 April 2014	905	36	0	0	0	941
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(28)	0	0	0	(28)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	165	101	0	0	0	266
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2015	1,070	109	0	0	0	1,179
Net book value at 31 March 2015	1,119	598	0	0	0	1,717
Net book value at 31 March 2015 comprises:						
Purchased	1,119	598	0	0	0	1,717
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Finance Leased	0	0	0	0	0	0
On-balance Sheet PFIs	0	0	0	0	0	0
Total at 31 March 2015	1,119	598	0	0	0	1,717

15.3 Intangible non-current assets

Economic life of non-current assets

	Min Life Years	Max Life Years
Software Licences	5	5
Property, Plant and Equipment:-		
Buildings excl Dwellings	17	93
Dwellings	58	87
Plant & Machinery	4	15
Transport Equipment	4	15
Information Technology	3	10
Furniture and Fittings		

16. Impairments and reversals recognised in 2015-16

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	13,261
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**13,261**
Total Impairments of Property, Plant and Equipment changed to SoCI	**13,261**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Intangibles charged to SoCI	**0**
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Financial Assets charged to SoCI	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**13,261**
Overall Total Impairments	**13,261**
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	136
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

17. Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	**£000s**
Impairments and reversals taken to SoCI	0	0	0	0	
Loss or damage resulting from normal operations	0	0	0	0	**0**
Over-specification of assets	0	0	0	0	**0**
Abandonment of assets in the course of construction	0	0	0	0	**0**
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
	0	0	0	0	
Unforeseen obsolescence	13,261	0	0	0	**13,261**
Loss as a result of catastrophe	0	0	0	0	**0**
Other	0	0	0	0	**0**
Changes in market price	0	0	0	0	**0**
Total charged to Annually Managed Expenditure	**13,261**	**0**	**0**	**0**	**13,261**
Total Impairments charged to SoCI	**13,261**	**0**	**0**	**0**	**13,261**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**136**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

18. Investment property

The Trust held no Investment Property in 2015-16

19. Commitments

19.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	**1,541**	138
Intangible assets	**0**	0
Total	**1,541**	138

19.2. Other financial commitments

The trust has not entered into non-cancellable contracts (apart from leases or PFI contracts or other service concession arrangements) in 2015-16.

20. Intra-Government and other balances

	Current receivables	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000s	**£000s**	**£000s**	**£000s**
Balances with Other Central Government Bodies	0	0	4,267	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	11,502	0	980	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	13,481	1,669	38,142	0
At 31 March 2016	**24,983**	**1,669**	**43,389**	**0**
prior period:				
Balances with Other Central Government Bodies	126	0	4,203	0
Balances with Local Authorities	366	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	16,827	0	1,817	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	11,016	2,059	36,949	0
At 31 March 2015	**28,335**	**2,059**	**42,969**	**0**

As result of revised guidance for 2015/16 regarding the reporting of DH loans within intra-goverment balances, current and non-current payables figures in the above note exclude DH loans. For comparative purposes the note for March 2015 has been restated on the same basis.

21. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**3,054**	**2,927**	**120**	**6**	**0**	**0**	**6,107**	0
Additions	30,079	22,186	10	0	0	0	**52,275**	0
Inventories recognised as an expense in the period	(30,211)	(20,859)	(43)	0	0	0	**(51,113)**	0
Write-down of inventories (including losses)	(188)	0	0	0	0	0	**(188)**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**	0
Balance at 31 March 2016	**2,734**	**4,254**	**87**	**6**	**0**	**0**	**7,081**	**0**

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**10,231**	16,763	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**665**	2,196	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**13,740**	8,565	**587**	709
PDC Dividend prepaid to DH	**1,271**	190		
Provision for the impairment of receivables	**(2,041)**	(1,192)	**0**	0
VAT	**1,117**	808	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	1,005	**1,082**	1,350
Total	**24,983**	28,335	**1,669**	2,059
Total current and non current	**26,652**	30,394		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2. Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**3,623**	2,235
By three to six months	**493**	59
By more than six months	**1,671**	1,804
Total	**5,787**	4,098

22.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(1,482)**	(1,372)
Amount written off during the year	**0**	260
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(559)**	(80)
Transfers to NHS Foundation Trust on authorisation as FT	**0**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2016	**(2,041)**	(1,192)

23. NHS LIFT investments

The Trust had no LIFT Investments during the year ended 31st March 2016

24. Other Financial Assets - Current

The Trust had no Other Financial Assets during the year ended 31st March 2016

25. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**2,107**	2,107
Net change in year	**(633)**	0
Closing balance	**1,474**	2,107
Made up of		
Cash with Government Banking Service	**970**	973
Commercial banks*	**500**	1,132
Cash in hand	**4**	2
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**1,474**	2,107
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,474**	2,107
Third Party Assets - Bank balance (not included above)	**0**	0
Third Party Assets - Monies on deposit	0	0

* Balances in Commercial Accounts include £479,347.95 held in the Trust variation account. This account is jointly accessible by the Trust and the Trust's PFI Partner, Worcestershire Hospitals SPC. The purpose of the account is for the Trust to deposit specific sums to the value of agreed deed of variations for capital work to be undertaken within the PFI Hospital by Worcestershire Hospitals SPC for the Trust.

26. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	0	0	840	0	0	0	0	0	0	0	**840**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than d	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accoun	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2016	**0**	**0**	**840**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	840
Liabilities associated with assets held for sale at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2014	0	0	840	0	0	0	0	0	0	0	**840**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2015	**0**	**0**	**840**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	840
Liabilities associated with assets held for sale at 31 March 2015	0	0	0	0	0	0	0	0	0	0	0

For 2015/16 the Assets classified as Held for Sale in year are two Accommodation Blocks at the Alexandra Hospital Redditch, for which the process of disposal is still to be finalised.

27. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**3,236**	4,182	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Non-NHS payables - revenue	**15,414**	15,526	**0**	0
Non-NHS payables - capital	**3,365**	4,270	**0**	0
Non-NHS accruals and deferred income	**13,160**	11,571	**0**	0
Social security costs	**2,052**	2,112		
PDC Dividend payable to DH	**0**	0		
Accrued Interest on DH Loans	**195**			
VAT	**0**	0	**0**	0
Tax	**2,215**	2,091		
Payments received on account	**0**	0	**0**	0
Other	**3,752**	3,217	**0**	0
Total	**43,389**	42,969	**0**	0
Total payables (current and non-current)	**43,389**	**42,969**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved	**0**	0		
outstanding Pension Contributions at the year end	**3,048**	2,982		

28. Other liabilities

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
PFI/LIFT deferred credit	**320**	395	**2,915**	3,157
Lease incentives	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**320**	395	**2,915**	3,157
Total other liabilities (current and non-current)	**3,235**	**3,552**		

29. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
Loans from Department of Health	**3,770**	3,770	**91,479**	31,519
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**1,936**	1,970	**72,055**	73,990
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**5,706**	**5,740**	**163,534**	**105,509**
Total other liabilities (current and non-current)	**169,240**	**111,249**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	3,770	1,936	**5,706**
1 - 2 Years	3,770	1,941	**5,711**
2 - 5 Years	73,532	6,943	**80,475**
Over 5 Years	14,177	63,171	**77,348**
TOTAL	**95,249**	**73,991**	**169,240**

30. Other financial liabilities

The Trust held no other financial liabilities in 2015-16.

31. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**682**	355	**0**	0
Deferred revenue addition	**0**	682	**0**	0
Transfer of deferred revenue	**0**	(355)	**0**	0
Current deferred Income at 31 March 2016	**682**	682	**0**	0
Total deferred income (current and non-current)	**682**	682		

32. Finance lease obligations as lessee

The Trust held no finance leases during 2015-16 (as defined under IAS17). PFI finance leases as determined under IFRIC12 are disclosed in Note 37.

33. Finance lease receivables as lessor

The Trust did not lease any assets to a third party that were deemed to be a finance leases during 2015-16.

34. Provisions

		Comprising:						
	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Continuing Care**	**Equal Pay (incl. Agenda for Change**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**2,305**	1,706	183	0	0	0	416	0
Arising during the year	**500**	5	89	0	0	0	406	0
Utilised during the year	**(677)**	(231)	(30)	0	0	0	(416)	0
Reversed unused	**(16)**	(16)	0	0	0	0	0	0
Unwinding of discount	**23**	23	0	0	0	0	0	0
Change in discount rate	**19**	19	0	0	0	0	0	0
Transfers to NHS Foundation Trusts on being authorised as FT	**0**	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2016	**2,154**	**1,506**	**242**	**0**	**0**	**0**	**406**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**791**	197	231	0	0	0	363	0
Later than One Year and not later than Five Years	**0**	0	0	0	0	0	0	0
Later than Five Years	**1,363**	1,309	11	0	0	0	43	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2016	78,207
As at 31 March 2015	77,022

35. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(50)**	(50)
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other	**0**	0
Net value of contingent liabilities	**(50)**	(50)
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

36. PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	2015-16 £000s	2014-15 £000s
Total charge to operating expenses in year - Off SoFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**13,393**	12,951
Total	**13,393**	12,951

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI

No Later than One Year	**13,616**	13,284
Later than One Year, No Later than Five Years	**57,953**	56,539
Later than Five Years	**187,599**	202,628
Total	**259,168**	272,451

The estimated annual payments in future years are not expected to be materially different from those which the Trust had recognised in 2015-16.

Imputed "finance lease" obligations for on SOFP PFI contracts due:

	2015-16 £000s	2014-15 £000s
No Later than One Year	**8,033**	8,230
Later than One Year, No Later than Five Years	**31,591**	31,691
Later than Five Years	**97,184**	105,117
Subtotal	**136,808**	145,038
Less: Interest Element	**(62,817)**	(69,078)
Total	**73,991**	75,960

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2015-16 £000s**	2014-15 £000s
No Later than One Year	**1,936**	1,970
Later than One Year, No Later than Five Years	**8,884**	8,287
Later than Five Years	**63,171**	65,703
Total	**73,991**	75,960

Number of on SOFP PFI Contracts

Total Number of on PFI contracts	**1**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

Number of off SOFP PFI Contracts

Total Number of off PFI contracts	**0**
Number of off PFI contracts which individually have a total commitments value in excess of £500m	**0**

37. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	**2015-16 Income £000s**	**Expenditure £000s**	2014-15 Income £000s	Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges		2,442		2,573
Interest Expense		10,431		10,249
Impairment charge - AME		0		50
Impairment charge - DEL		0		0
Other Expenditure		18,663		12,590
Revenue Receivable from subleasing	(6,941)		0	
Impact on PDC dividend payable		1,597		(585)
Total IFRS Expenditure (IFRIC12)	**(6,941)**	**33,133**	**0**	**24,877**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		26,129		25,341
Net IFRS change (IFRIC12)		**63**		**(464)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		**1,450**		1,691
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		**1,667**		1,610

	2015-16 Income/ Expenditure IFRIC 12 YTD £000s	**2015-16 Income/ Expenditure ESA 10 YTD £000s**
Revenue costs of IFRS12 compared with ESA10		
Depreciation charges	**2,442**	
Interest Expense	**10,431**	
Impairment charge - AME	**0**	
Impairment charge - DEL	**0**	
Other Expenditure		
Service Charge	**13,393**	13,393
Contingent Rent	**3,820**	
Lifecycle	**1,450**	
Impact on PDC Dividend Payable	**1,597**	
Total Revenue Cost under IFRIC12 vs ESA10	**33,133**	**13,393**
Revenue Receivable from subleasing	**(6,941)**	**12,736**
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**26,192**	**26,129**

38. Financial Instruments

38.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 Mar 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

38.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0			**0**
Receivables - NHS		10,631		**10,631**
Receivables - non-NHS		9,859		**9,859**
Cash at bank and in hand		1,474		**1,474**
Other financial assets	0	0	0	**0**
Total at 31 March 2016	**0**	**21,964**	**0**	**21,964**
Embedded derivatives	0			0
Receivables - NHS		16,764		16,764
Receivables - non-NHS		2,195		2,195
Cash at bank and in hand		2,107		2,107
Other financial assets	0	0	0	0
Total at 31 March 2015	0	21,066	0	21,066

38.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
			£000s
Embedded derivatives	0		**0**
NHS payables		3,236	**3,236**
Non-NHS payables		24,880	**24,880**
Other borrowings		95,249	**95,249**
PFI & finance lease obligations		73,991	**73,991**
Other financial liabilities	0	0	**0**
Total at 31 March 2016	**0**	**197,356**	**197,356**
Embedded derivatives	0		0
NHS payables		4,182	4,182
Non-NHS payables		19,798	19,798
Other borrowings		35,289	35,289
PFI & finance lease obligations		75,960	75,960
Other financial liabilities	0	0	0
Total at 31 March 2015	0	135,229	135,229

39. Events after the end of the reporting period

The are no material events occuring after the reporting period.

40. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Mr. Harry Turner - Chairman of the Trust until March 2016 and: as Trustee of the Charles Hastings Education Centre	273,560	27,918	0	163,314

The Department of Health is regarded as a related party. During the year Worcestershire Acute Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

NHS England
NHS Redditch and Bromsgrove CCG
NHS South Worcestershire CCG
NHS Wyre Forest CCG
Worcestershire Health and Care NHS Trust
NHS Litigation Authority
NHS Business Services Authority

The Trust has also received revenue and capital payments from Worcestershire Acute Hospitals Charity amounting to £535,220 (£538,399 in 2014-15). 11 of the Trustees of Worcestershire Acute Hospitals NHS Trust Charitable Fund are also members of the Trust Board. The summary financial statements of the Funds Held on Trust are included in the annual report.

41. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	187,575	12
Special payments	100,102	84
Total losses and special payments	287,677	96

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	389,602	73
Special payments	61,352	60
Total losses and special payments	450,954	133

42. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years, and have not been restated to IFRS.

42.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	263,801	293,859	299,601	312,889	321,829	336,594	348,763	346,029	364,656	**368,981**
Retained surplus/(deficit) for the year	53	5,193	5,833	(2,179)	(1,193)	(1,193)	(312)	(14,271)	(32,939)	**(72,681)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	(1,059)									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			0	3,020	1,126	634	181	189	6,950	**13,261**
Adjustments for impact of policy change re donated/government grants assets						172	148	(109)	71	**(474)**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				2,294	354	475	0	0	0	**63**
Absorption accounting adjustment							0	0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	**0**	0	0	**0**
Break-even in-year position	**(1,006)**	**5,193**	**5,833**	**3,135**	**287**	**88**	**17**	**(14,191)**	**(25,918)**	**(59,831)**
Break-even cumulative position	**(32,880)**	**(27,687)**	**(21,854)**	**(18,719)**	**(18,432)**	**(18,344)**	**(18,327)**	**(32,518)**	**(58,436)**	**(118,267)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	-0.38	1.77	1.95	1.00	0.09	0.03	0.00	-4.10	-7.11	**-16.22**
Break-even cumulative position as a percentage of turnover	-12.46	-9.42	-7.29	-5.98	-5.73	-5.45	-5.25	-9.40	-16.02	**-32.05**

42.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

42.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**59,658**	50,552
Cash flow financing	**59,191**	49,261
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**59,191**	49,261
Under/(over) spend against EFL	**467**	1,291

42.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**12,739**	19,999
Less: book value of assets disposed of	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(1,098)**	0
Charge against the capital resource limit	**11,641**	19,999
Capital resource limit	**11,698**	20,402
(Over)/underspend against the capital resource limit	**57**	403

43. Third party assets

As at 31st March 2016 the Trust held no cash and cash equivalents which relate to third parties.

Our sites are completely SMOKEFREE

Worcestershire NHS
Acute Hospitals NHS Trust

Worcestershire Royal Hospital
Finance Department, 2nd Floor
No. 3 Kings Court
Charles Hastings Way
Worcester. WR5 1DD

Tel: 01905 760393
Fax: 01905 760494

2 June 2016

Grant Thornton UK LLP

Grant Thornton UK LLP
Colmore Building
20 Colmore Circus
Birmingham
B4 6AT

Dear Sirs

Worcestershire Acute Hospitals NHS Trust

Financial Statements for the year ended 31 March 2016

This representation letter is provided in connection with the audit of the financial statements of Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2016 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.
We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i As Trust Board members we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the Department of Health Group Manual for Accounts 2015-16 (Manual for Accounts) and International Financial Reporting Standards which give a true and fair view in accordance therewith.

ii We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

iv We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

vi We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the Manual for Accounts, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii Except as disclosed in the financial statements:

a there are no unrecorded liabilities, actual or contingent

b none of the assets of the Trust has been assigned, pledged or mortgaged

c there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

viii Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the Manual for Accounts.

ix All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the Manual for Accounts requires adjustment or disclosure have been adjusted or disclosed.

x We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

xi In calculating the amount of income to be recognized in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be received by the Trust in accordance with the International Financial Reporting Standards and the Manual for Accounts.

xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the Manual for Accounts.

xiii We acknowledge our responsibility to participate in the Department of Health's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

xiv We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xv We have considered the application of the going concern assumption to the financial statements and concluded that it is appropriate. This conclusion is based on the presumption that as a public sector body the Trust is a going concern. We acknowledge that the Trust will require cash support from the Trust Development Authority (TDA) to maintain its liquidity and the TDA has confirmed its intention to provide that support for 12 months from the date of this letter.

xvi We confirm to you that we are aware of the basis of estimation of the likely settlement value of the Trust's non-availability claim against the PFI provider which is included in the financial statements. We are satisfied that the latest view on settlement from the Trust's legal advisors does not indicate that this estimate is significantly misstated.

Information Provided

xvii We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
b. additional information that you have requested from us for the purpose of your audit; and
c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xviii We have communicated to you all deficiencies in internal control of which management is aware.

xix All transactions have been recorded in the accounting records and are reflected in the financial statements.

xx We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xxi We have disclosed to you all our knowledge of fraud or suspected fraud affecting the Trust involving:

a. management;
b. employees who have significant roles in internal control; or
c. others where the fraud could have a material effect on the financial statements.

xxii We have disclosed to you all our knowledge of any allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, regulators or others.

xxiii We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxiv We have disclosed to you the identity of all of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxv We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Annual Report

xxvi The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the financial statements.

Annual Governance Statement

xxvii We are satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance framework and we confirm that we are not aware of any significant risks that are not disclosed within the AGS.

Approval

The approval of this letter of representation was minuted by the Trust's Audit and Assurance Committee at its meeting on 1st June 2016.

Yours faithfully

Name..... Chris Tidman

Position..... Chief Executive

Date..... 1st June 2016

Name.....

Position..... Director of Finance

Date..... 1/6/2016

Signed on behalf of the Board

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 08 June 2016 **Enc G3**

Report to Trust Board in Public

Title	Integrated Performance Report (April 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 April 2016; the key performance issues and the mitigating actions.
Previously considered by	F&P Committee

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 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 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	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 around performance in April 2016, please refer to the IPR report and Trust Board 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

Date of meeting: 08 June 2016 **Enc G3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JUNE 2016

1. Situation

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

2. Background

This paper updates the Committee 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.

3. Assessment

3.1 Key risks

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 April 2016. In line with levels of pressure and resulting performance elsewhere in the country, performance remained below 90% at 84.4% in April, an increase from 82.3% in March 2016.

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 improved to 34 minutes compared to 46 minutes in March 2016, largely due to significant improvement in the last week of April. The median wait for treatment in the ED was 55 minutes in April 2016, which is within the national standard of 60 minutes.

18 weeks Referral to Treatment (RTT)

Following above target performance in previous months, since February 2016, the Trust has been unable to achieve compliance with the 92% 18 Week referral to treatment incomplete pathways target. Performance in April 2016 was 88.9%.

This significant performance challenge coincides with changes to the policy around ad hoc waiting list activity (leading to a temporary reduction in capacity) and the impact from on-going emergency pressures, cancelled activity due to Junior Doctors' Industrial Action and the early, long Easter Bank Holiday.

Cancer and diagnostic waiting time performance has also been adversely affected as follows:

Cancer Performance

The 62 - day target of 85% for cancer first treatment was not achieved in April 2016 and performance was 74.0%.

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 2016 and subsequently, in April 2016, performance as anticipated dropped to unprecedented levels; for all referrals under the 2 week rule performance was 39.4% in April 2016, and for breast symptomatic patients performance was 34.5%. Urgent work was undertaken in April and into May 2016 to tackle the backlog of 2 week waiters.

Diagnostics Waiting Time Standard
In April 2016, the Trust failed achieved the target of < 1% of patients waiting longer than 6 weeks for diagnostic tests; actual performance was 5.20%.

Finance
The Trust recorded a deficit of £4.84m in April. This is broadly in line with the planned deficit of £4.76m. Further detail including turnaround actions is provided in the Financial Performance report.

3.2 Controls in place

The Trust has urgently developed plans and trajectories at specialty level to recover elective operational performance through 2016/17, with the impact continuing in Q1 and potentially into Q2. These plans are being monitored by NHS Improvement and the local System Resilience Group.

These plans were reviewed by the Trust Finance and Performance Committee, where there was a particular focus on the 62 - day cancer performance issues in Urology and endoscopy (which impacts on both colorectal cancer performance and the achievement of the diagnostic waiting time standard). It was noted that the main driver for the RTT performance is specific outpatient activity/capacity and there are on-going discussions with commissioners around the Dermatology pathway.

Performance in the ED continues to be constrained by ‘exit block’ due to high levels of bed occupancy at both acute sites. This issue and in particular the concern relating to the levels of so called ‘stranded’ patients, is being addressed through the urgent care and patient flow programme within the Patient Care Improvement Plan (PCIP). For example, implementation of the SAFER patient flow bundle on pilot wards has increased the number of discharges taking place before 12 noon and the weekly meetings reviewing emergency patients with length of stay (LoS) > 7 days has contributed to a reduction in average emergency LoS from 5.3 days in April 2015 to 4.75 days in April 2016. As part of the PCIP, both acute sites are increasing the focus and the effort around ambulatory emergency care and admission avoidance.

The levels of attendances at Trust ED departments remains high and there is a particular issue with surges in attendances whereby the departments become overcrowded and the streaming of majors and minors is compromised. This is a particular issue at WRH and analysis shows that this leads to an increase in breaches of the 4 hour waiting time standard for non-admitted patients which should be consistently being met. This situation will be mitigated with the expansion of the WRH ED which is due to open fully in September 2016.

3.3 Gaps in controls and mitigation

There are recognised capacity and capability issues in delivering the required levels of improvement activity across Trust programmes and a resource plan has been developed and rapidly implemented to provide dedicated support.

Chronic issues around staffing levels in the Trust ED and Acute Medicine services are being actively addressed.

4 Recommendation

The Board is asked to review the Integrated Performance Report for April 2016; the key performance issues and the mitigating actions.

Sarah Smith
Director of Planning and Development

INTEGRATED PERFORMANCE REPORT

April 2016

May 25th 2016

Please note:

All data relates to April 2016 performance, unless stated otherwise.

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

Worcestershire Acute Hospitals NHS Trust (WAHT) is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register (Corporate risk 2908).

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

Sarah Smith, Director of Planning and Development

Overview

Performance, efficiency, quality, safety and workforce metrics

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

Performance on /above target with positive trend • Number of grade 3/4 pressure ulcers • CDifficile MRSA bacteremia • Friends and Family Test - Acute wards score • Friends and Family Test - Maternity score • Never events • Urgent operations cancelled for a second time • Delayed Transfers of Care (DTOC) • Workforce – Eligible staff attending induction	**Performance on /above target with negative trend** • Delayed Transfers of Care (DTOC)
Performance under target with positive trend • VTE • Friends and Family Test – A&E score • Pressure Ulcers – New pts – with hosp acq Grade 3 • *Bed occupancy WRH/AGH (DASHBOARD ONLY – REPORTED THROUGH EAS CAS)* • 28 day breaches as % of cancellation • A&E - Ambulance handover over 60 minutes • A&E - Ambulance handover within 30 minutes • A&E - Ambulance handover within 15 minutes • A&E - 4 hour Emergency Access Standard • *A&E - unplanned re-attendance within 7 days (DASHBOARD ONLY – REPORTED THROUGH EAS CAS)* • A&E - Time to initial assessment (all patients) – 95th percentile • Workforce – staff turnover • *Workforce – agency staff medics (DASHBOARD ONLY - MANAGED AND REPORTED THROUGH FINANCIAL PERFORMANCE REPORT)* • Workforce – sickness absence monthly • Workforce - % of eligible staff completing statutory and mandatory training • Friends and family test response rates	**Performance under target with negative trend** • Safety Thermometer • Falls with serious harm • Serious Incidents open over 60 days and awaiting closure • MRSA screening (high risk wards) • Primary Mortality and Secondary Reviews • Completion of Electronic Discharge Notices – (Managed through Data Quality Steering Group) • Hip fracture - time to theatre • Category 2 Complaints responded to within 25 days • 18 week Referral to Treatment – Incomplete • 31 day cancer – first treatment (all cancers) • Cancer - 2 week wait (breast symptomatic) • Cancer - 2 week wait (all cancers) • Cancer - 62 days wait for first treatment from all GP referral (all cancers) • 6 week wait for diagnostics • Workforce - % of medical staff that have had appraisal • Workforce - % of non-medical staff that have had appraisal • Workforce – nursing staff turnover (qualified) • Workforce – nursing staff turnover (unqualified)

Summary

National / NHS Constitution Standards

The Trust continues to experience some significant challenges in respect of key waiting time performance indicators, exacerbated by the temporary reduction in elective capacity due to the change in Trust policy in respect of additional 'ad hoc' clinical activity or waiting list initiatives. This was necessary to reverse the over - reliance on this as a means of achieving performance and to regularise the work required. This coincided with a reduction in capacity over the long Easter Bank Holiday weekend and the Junior Doctors Industrial Action that resulted in cancelled operations and cancelled outpatient clinics to allow Consultant staff to work on the front line. Together, in April, this has impacted significantly on RTT, Cancer and Diagnostic waiting time performance. The priority has been to recover the resultant backlog in patients waiting, develop the capacity plans to sustainably deliver the activity going forward and to ensure that there are on-going reviews of any potential for harm to patients. The Trust has developed trajectories to recover this performance during 2016/17 and there will be on-going adverse impact throughout Q1.

Whilst the Trust faces significant performance issues, there is a greater understanding of the issues leading to suboptimal performance and the actions required to improve the Trust position. The Trust is gradually building the capability to manage performance and deliver operational standards through strengthened operational management arrangements and frequent performance review.

For many months the Trust has struggled with patient flow in the EDs due to exit block and poor flow elsewhere in the hospital. These issues are being mitigated through the Patient Care Improvement Plan and this month there are early signs of some impact, especially in terms of ambulance handovers and time to initial assessment in the ED where there are still however significant pressures.

Key factors impacting performance

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

Poor patient flow and high levels of bed occupancy also impact the Trust's elective programme.

Quality, workforce and finance indicators

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

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

Corrective Action Statements: Performance and Efficiency

Key Performance Indicator:

- 18 Week referral to treatment (RTT) - incomplete pathways (CW3.0)
- A&E - 4 hour waits (%) Trust including MIU (CAE1.1a)
- Stranded Patients (% last week of month) (PIN2.3)
- Cancer – 62 days wait for first treatment from GP referral
- All patients with suspected Cancer being seen within two weeks (CCAN8.0)
- 2 week wait for symptomatic breast patients (Cancer Not initially Suspected) (CCAN9.0)
- Time to initial assessment (patients arriving by ambulance) (mins) – 95th percentile (inc Kidd MIU); Time to initial assessment (all patients) (mins) – 95th percentile (inc Kidd MIU)
- Ambulance Handover within 15 minutes (%) – WMAS data (CAE7.0); Ambulance Handover within 30 minutes (%) – WMAS data (CAE8.0); Ambulance Handover within 60 minutes– WMAS data (CAE9.0)
- 28 day breaches as a percentage of cancelled operations (PEL3.0)
- 6 Week Wait Diagnostics (Proportion of waiting list)(PW1.1.1)
- Theatre Booking and Utilisation (all sites) (PT2) – *Not provided this month due to Data Quality issue that was waiting to be resolved at the point of this document being published*

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

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

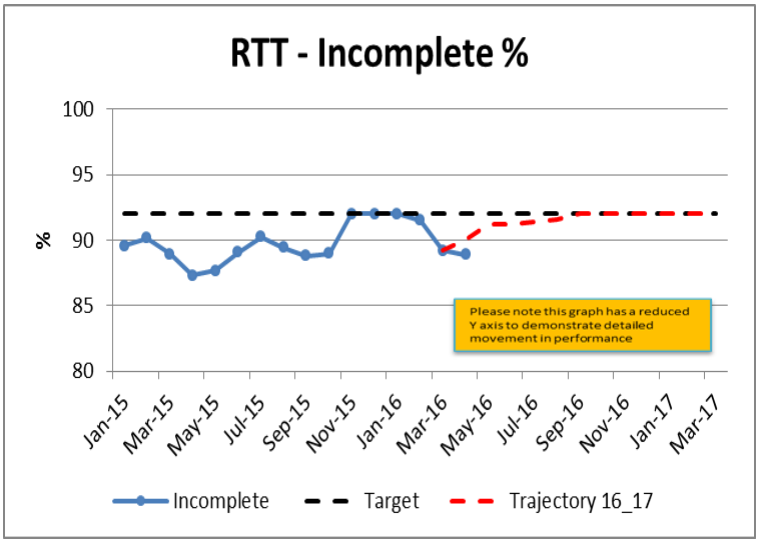
Historically, the Trust was consistently failing the RTT Incomplete standard between December 2014 and October 2015 inclusive. The target was met for three consecutive months in November 2015 (92.05%), December 2015 (92.05%) and January 2016 (92.04%). Following the implementation of the changes to the WLI policy combined with emergency pressures, the performance declined in February 2016 (91.53%) and deteriorated further in March to 89.2%. The total backlog of patients waiting over 18 weeks has increased by 1119; the main increase has been in Gastroenterology (+134) Oral Surgery (+129), Thoracic Medicine (+128), Urology (+94), Dermatology (+88), General Surgery (+87), T&O (+80), ENT (+77), Gynaecology (+59) and Ophthalmology (+51). The challenged specialties remain Dermatology (70.81%), Thoracic Medicine (73.30%), Oral Surgery (79.38%), Trauma and Orthopaedics (82.96%), Gynaecology (84.70%) and Gastroenterology (88.90%). The Trust has also reported one 52+week waiter as at the end of March 2016 in Gynaecology, the patient has since been treated (in April 2016) and a clinical review has identified no harm to the patient related to the extended waiting time. Current and forecast performance is RAG rated red as it is anticipated that the reduction of additional activity will continue to have an impact and the performance will not be recovered until Q3 2016/17 in line with the STP trajectory. Current year - end performance is RAG rated red due to the underperformance in Q1, Q2 and Q4.

Corrective Actions

A substantial validation exercise is on-going, however, significant data quality issues remain and further monthly waiting list validation is required on a specialty by specialty basis. In addition, telephone contact continues being made with patients waiting over 18 weeks who had not had their first appointment to establish if the patient still requires to be seen or if the patient's condition has changed and an appointment needs to be expedited. Partial booking letters are being sent to those patients that cannot be contacted by phone. Specialty specific action plans for reduction of 18+ week backlog are in place for all underperforming specialties and have been shared with the CCGs. The specialty level RTT performance is monitored via fortnightly PTL meetings and monthly Divisional Performance Reviews.

Risks to Delivery

Non - delivery of this target poses significant reputational, financial and patient safety risks. These are mitigated by the remedial action plans that are in place; in addition, long waiters over 18 weeks are reviewed at regular intervals and findings reported via Quality Governance Committee (QGC). Retrospective RCAs with a particular focus on harm reviews have been undertaken for all patients who had waited over 52 weeks for treatment. Following the temporary Trust wide reduction in WLIs and associated reduction in capacity, the Trust has a significant backlog of patients on cancer pathways; clearance of this backlog will have a direct impact on RTT and will pose a further risk that there will be insufficient short and medium term capacity to maintain this standard.



SRO:COO	Current Reporting Month: Apr 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	92%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	88.9%	↓	Forecast next reported month	
Last reported month performance	89.2%	↓	Forecast month after	
YTD performance	Not applicable		Forecast month after	
Revised date to meet the standard	September 2016		Forecast year end 16_17	

Key Performance Indicator: A&E - 4 hour waits (%) Trust including MIU (CAE1.1a)

Headlines

Trust performance on the Emergency Access Standard, (EAS) improved but remained below the national target in April (84.4%). There were 14,958 A&E attendances in April 2016 (0.14% higher than April 2015). We achieved the national 60 minute 'Time from Arrival to Treatment' target in April (Median 55 mins). There was a further slight improvement on the 5% target for 'Unplanned Re-attendance within 7 days of Original Attendance' in April at 5.1%. We continued to experience 'exit block' from A&E throughout April, but there were no breaches of the 12 hour trolley wait standard. Other key facts:

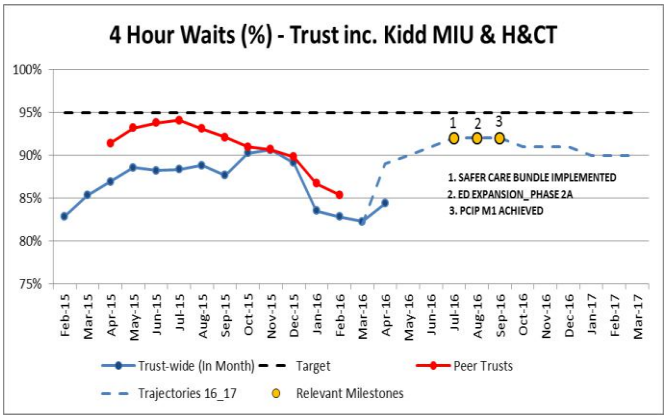
- Patients were triaged more quickly in ED in April, the 95th percentile wait improved from 46 minutes in March to 34 minutes in April
- Midnight bed occupancy remained high at 102% at WRH and 91% at AGH for the month on average.
- Emergency admissions rose by 2% in April 2016 compared to April 2015, from 3,857 to 3,933.
- Emergency Length of Stay was lower than the figure for April 2015 (4.75 days in April 2016 compared to 5.3 days in April 2015.

Corrective Actions

We re-introduced Senior Immediate Assessment Nursing at WRH from mid April which significantly improved triage times for the whole trust. We continued implemented a new model for Medical Admissions at AGH, reducing the number of beds, enhancing senior nurse input and treating more patients in an ambulatory care environment. With support from ECIP, we continued a programme of improvement work to embed the SAFER bundle on wards, improve assessment and implement admission avoidance measures in ED, review the Patient Flow Centre, and improve our frailty pathway for emergency elderly medicine.

Risks to Delivery

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



SRO:COO	Current Reporting Month: Apr 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	84.4%	↑	Forecast next reported month	
Last reported month performance	82.3%	↓	Forecast month after	
YTD performance	84.4%	-	Forecast month after	
Revised date to meet the standard	2017_18		Forecast year end 16_17	

Key Performance Indicator Name: Stranded Patients

Headlines

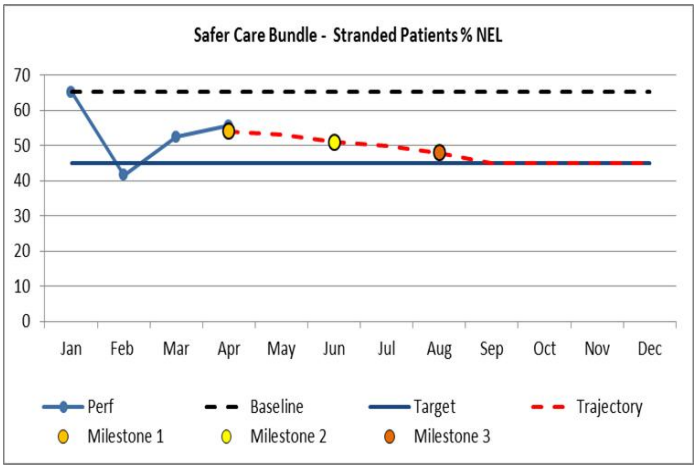
Working closely with the National Emergency Care Improvement Programme, we have worked with some success to reduce the number of stranded patients in the Trust. Stranded patients are those who were admitted as emergencies who have been in an acute bed for more than 7 days. Each case is worthy of review, particularly the frail elderly who are known to be at risk of harm with extended stay in hospital. We aim to achieve the ECIP average performance (45% of beds occupied by stranded patients), from a January baseline of 65% stranded patients. In April 2016 ,55.6% of acute beds were occupied by stranded patients.

Corrective Actions

The Divisional Director of Nursing for Medicine leads a weekly review of stranded patients. A multi-agency multidisciplinary team meets every week to review and expedite the treatment and discharge of the top 20 longest waiters, and to tackle and promote learning from any emerging themes. The Best Practice Urgent Care Board, a sub-group of senior officers from organisations across Worcestershire reviews and expedites discharge for the top 10 stranded patients.

Risks to Delivery

Failure to deliver this standard poses significant reputational and patient safety risks. These are mitigated by the remedial action plans that are in place; in Stranded patients are at greater risk of harm, particularly the frail elderly who are known to lose functional independence, to decompensate physically, and have an increased risk of falls or hospital acquired illness. The risk is mitigated by the above internal actions and the work programme of the System Resilience Group – a multi-agency committee chaired by the Medical Director of the CCG which is focussed on minimising delayed transfers of care from the acute to community settings.



SRO:COO	Current Reporting Month: Apr 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	45%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	55.6%	↑	Forecast next reported month	
Last reported month performance	48.8%	↑	Forecast month after	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard			Forecast year end 16_17	

Key Performance Indicator: 62 days – Wait for first treatment from urgent GP referral – All cancers (CCAN5.0)

Headlines

The Trust has not achieved the 62 day standard in April 2016; current unvalidated April 2016 performance stands at 74.89%. This is a planned underachievement in line with the STF trajectory of 72.48% for April 2016. The reasons for underachievement can vary by specialty and include increased numbers of 2ww referrals, capacity constraints at various stages of the pathways including the diagnostic phases, and sub-optimal patient tracking processes. Currently there are 27 breaches of the standard recorded for March 2016. The greatest number of breaches are in Urology (16) and Lung (5), the rest are spread out across the other specialties - Gynaecology (2.5), Head and Neck (1.5), Colorectal (1.5), Haematology (1), UGI (1) and Skin (1). It is forecast that performance will remain below standard during Q1 of 2016/17 as there has been a significant increase in waiting times and 62+ day backlog due to the following factors:

- A Trust- wide change in policy on 'Waiting List Initiatives' from mid-February 2016
- Cancelled activity due to Junior Doctors' Industrial Action
- Insufficient coordination and reprioritisation of cancer patient treatment lists (PTL)

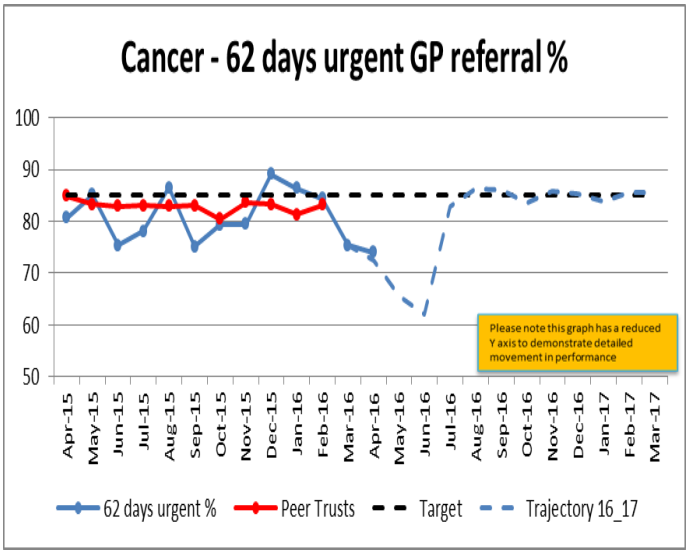
Corrective Actions

Weekly patient - level PTL meetings continue with dedicated time slots for each of the challenged specialties. All Divisions have produced remedial action plans and recovery trajectories which have been shared with the commissioners. There are on-going capacity issues in Urology which are being mitigated through plans for additional Consultant staffing and theatre realignment. A new policy covering payments for 'Additional Clinical Activity' will be presented to the Joint Negotiating Committee in May for agreement.

Risks

The achievement of the 62 day standard is high on the national agenda therefore there is a reputational risk to the organisation; also there is a potential risk for harm to patients due to extended waiting times. The latter is mitigated via weekly patient by patient review of patients who are waiting over 104 days for treatment. In line with the new national 'backstop' policy, formal harm reviews of patients with confirmed diagnosis of cancer that have been treated post 104 days commenced in November 2015.

It is anticipated that the deteriorating performance against 2ww standards will have a significant detrimental impact on the 62 day standard throughout Q1 of 2016/17. This is reflected in the Trust's trajectory linked to the sustainability and transformation fund.



SRO:COO	Current Reporting Month: April 2016			
	Perform-ance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	Year end - 85% April Target – 72.5%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	74.0%	⇩	Forecast next reported month	65.4%
Last reported month performance	75.3%	⇩	Forecast month after	62.1%
YTD performance	74.0%	-	Forecast month after	82.9%
Revised date to meet the standard	August 2016		Forecast year end 16_17	

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

Headlines

The Trust had a 12% increase in 2ww referral numbers in 2015/16 compared to 2014/15 (17117 versus 15309). The main specialties with increases in referrals year on year are Colorectal (+16%, 3168 v 2727), Skin (+16%, 3146 v 2706), Breast (+13%, 2989 v 2644), Head and Neck (+13%, 1742 v 1537) and Urology (+9%, 2393 v 2193). This combined with the change in policy in respect of waiting list initiatives from mid February 2016 to end of March 2016 resulted in significant capacity constraints in a number of specialties. Consequently a significant proportion of clinics continue to be set up ad-hoc and patients are contacted at short notice to be offered appointments. Subsequently a significant number of patients decline the offer to attend within the 14 day target; a smaller proportion of declined appointments are due to patient choice (holidays and other commitments).

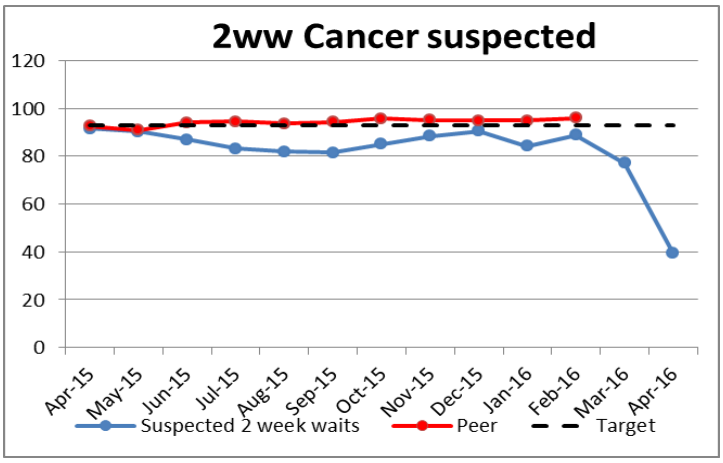
Current April performance shows significant deterioration compared to March (39.34% versus 77.3%) and is RAG rated red as it is below the standard. Current year - end performance is RAG rated red due to the under performance in April and anticipated underperformance in May 2016, which will have a significant detrimental effect on the overall year end performance. It is anticipated that the performance will improve in May to circa 60-70% but will remain significantly below the standard due to the extended impact of the Trust wide reduction in WLIs from mid-February to the end of March, Junior Doctors' Industrial Action, and reduced capacity over the Easter Bank Holiday. The largest numbers of breaches in April were in Colorectal (270), Skin (182), Urology (172) and Breast (149) followed by UGI (68) and Head and Neck (58).

Corrective Actions

The Directorates have implemented remedial action plans and all specialties with the exception of Skin have cleared the backlog of patients waiting over 2 weeks. Plans are in place to clear the backlog in Skin before the end of May 2016. Initial version of an electronic 2ww PTL/escalation report has been implemented and is available to all Directorates; further enhancements to this report were introduced in December 2015. Capacity and demand by specialty is being monitored via a fortnightly Cancer PTL meeting. Work is on-going with Commissioners to develop a project outline for implementation of the new 2ww NICE guidance and required changes to the referral forms. The Directorates are exploring all options to prioritise cancer including replacing routine activity with cancer appointments.

Risks to Delivery

This indicator has reputational risk for the organisation and also links to the 62 day cancer standard as it is the first stage in the 62 day referral to treatment pathway. The implication of not delivering this target will be a significant detrimental impact on the 62 day standard. Historically the risk was being mitigated with ad-hoc additional capacity; detailed specialty by specialty demand and capacity modelling is being undertaken to provide sustainable services and to mitigate the risk long term.



SRO:COO	Current Reporting Month: Apr 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	93%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	39.4%	⇩	Forecast next reported month	
Last reported month performance	77.3%	⇩	Forecast month after	
YTD performance	39.4%	-	Forecast month after	
Revised date to meet the standard			Forecast year end 16_17	

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

Headlines

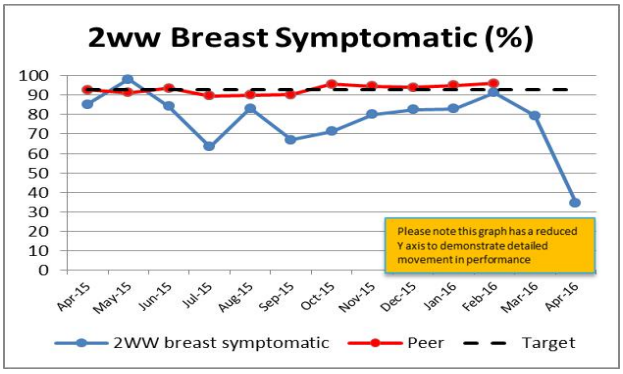
2ww referral volumes for 2ww breast symptomatic in 2015/16 have remained broadly the same compared to the last financial year; however, the Directorate has had a reduction in capacity following the loss of two GP practitioners who were undertaking 2ww clinics at the WRH. The Directorate has been covering this shortfall in capacity with waiting list initiative clinics. As a result a significant proportion of clinics are set up ad-hoc and patients are contacted at short notice to be offered appointments. Consequently a significant number of patients decline the offer to attend within the 14 day target; a smaller proportion of declined appointments are due to patient choice (holidays and other commitments). Following the Trust change in policy in relation to Waiting List Initiatives, the Directorate had reduced capacity in March which in turn translated into a backlog of patients over 2 weeks who had to be seen in April. Consequently there has been a significant deterioration in performance in April 2016 compared to March 2016 (34.50% versus 79.4%). Current year - end performance is RAG rated amber due to the underperformance in April and predicted underperformance in May 2016.

Corrective Actions

The Directorate is exploring other ways of increasing capacity; a registrar post is out for locum cover. The Directorate is working on a recovery plan in collaboration with Breast Radiology to ensure maximum utilisation of all available capacity.

Risks to Delivery

This indicator has reputational risk for the organisation and also links to the 62 day cancer standard as it is the first stage in the 62 day referral to treatment pathway. The implication of not delivering this target will be a significant detrimental impact on the 62 day standard. Historically the risk was being mitigated with ad-hoc additional capacity; detailed demand and capacity modelling is being undertaken to provide sustainable services and to mitigate the risk long term.



SRO:COO	Current Reporting Month: Apr 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	93%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	34.5%	↓	Forecast next reported month	
Last reported month performance	79.4%	↓	Forecast month after	
YTD performance	34.5%	-	Forecast month after	
Revised date to meet the standard	Not provided		Forecast year end 16_17	

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Key Performance Indicator: Time to initial assessment (patients arriving by ambulance) (mins) – 95th percentile (inc Kidd MIU); Time to initial assessment (all patients) (mins) – 95th percentile (inc Kidd MIU)

Headlines

In April 2016 the Trust failed to reach the national 15 minute "Time to Initial Assessment" target in April 2016 (95th percentile: All patient arrivals; 34mins; Ambulance arrivals; 40 mins). However, there was a significant improvement in assessment times for both ambulance and walk – in patients and this was due broadly, to the trusts ability to sustain the availability of the Senior Initial Assessment Nurse (SIAN) in the WRH ED.

Corrective Actions

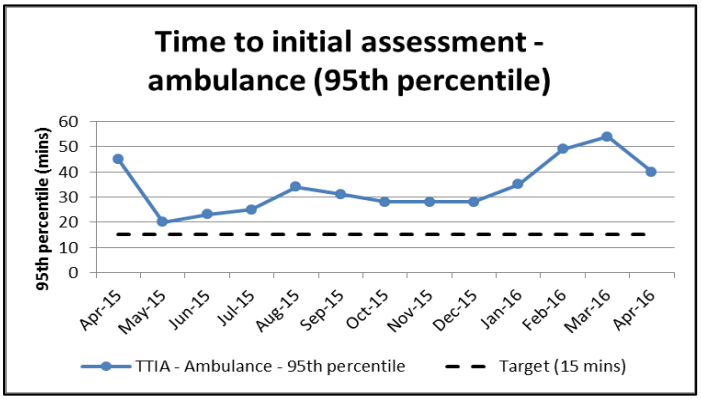
The Trust and partners in the Worcestershire health and care system are working with the Emergency Care Improvement Programme (ECIP) to address the underlying causes of poor patient flow that result in 'exit block' from the A&E department. The overcrowding issue is most acute at the WRH. Expansion of the ED at WRH is underway and on track for the first phase to open in the Autumn of 2016, offering more space to accommodate patients waiting for handover, triage and admission. Within existing resources the Trust has deployed Senior Immediate Assessment Nurses (SIANs) to take the handover of patients from the Ambulance Trust and provide initial assessment of all patients attending ED. The planned role out for this role to maintain the improvement in performance is as follows:-

May - Implementation of SIAN nurse at WRH 5 days per week.
July - Implementation of SIAN nurse at AGH 5 days per week.
September - Full 7 day implementation of SIAN nurse at WRH
November - Full 7 day implementation of SIAN nurse at AGH

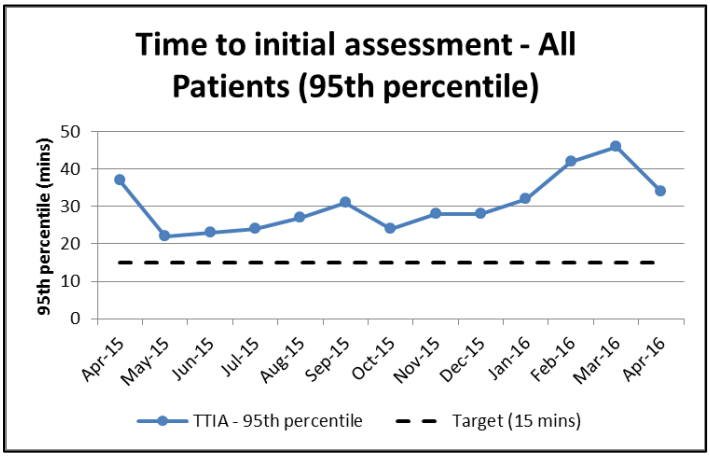
inpatient flow is also being addressed by the rollout of Best Practice Ward Rounds and the SAFER care bundle. 3 wards have commenced this on the WRH site already with a further 3 wards now live on the AGH site. This is rollout is detailed in the PCIP plan.

Risks to Delivery

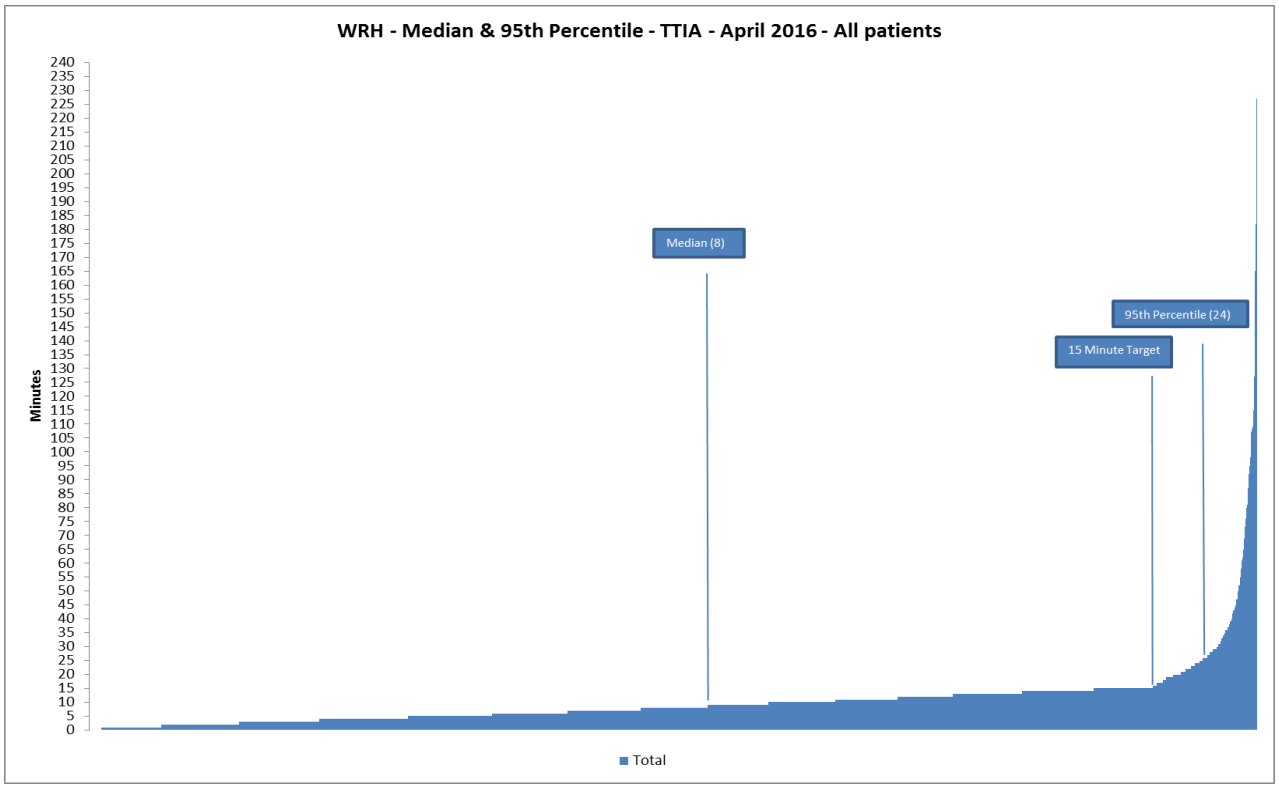
The major risk to delivery remains the very high levels of bed occupancy at the Trust and the need to ensure that patient flow is optimised

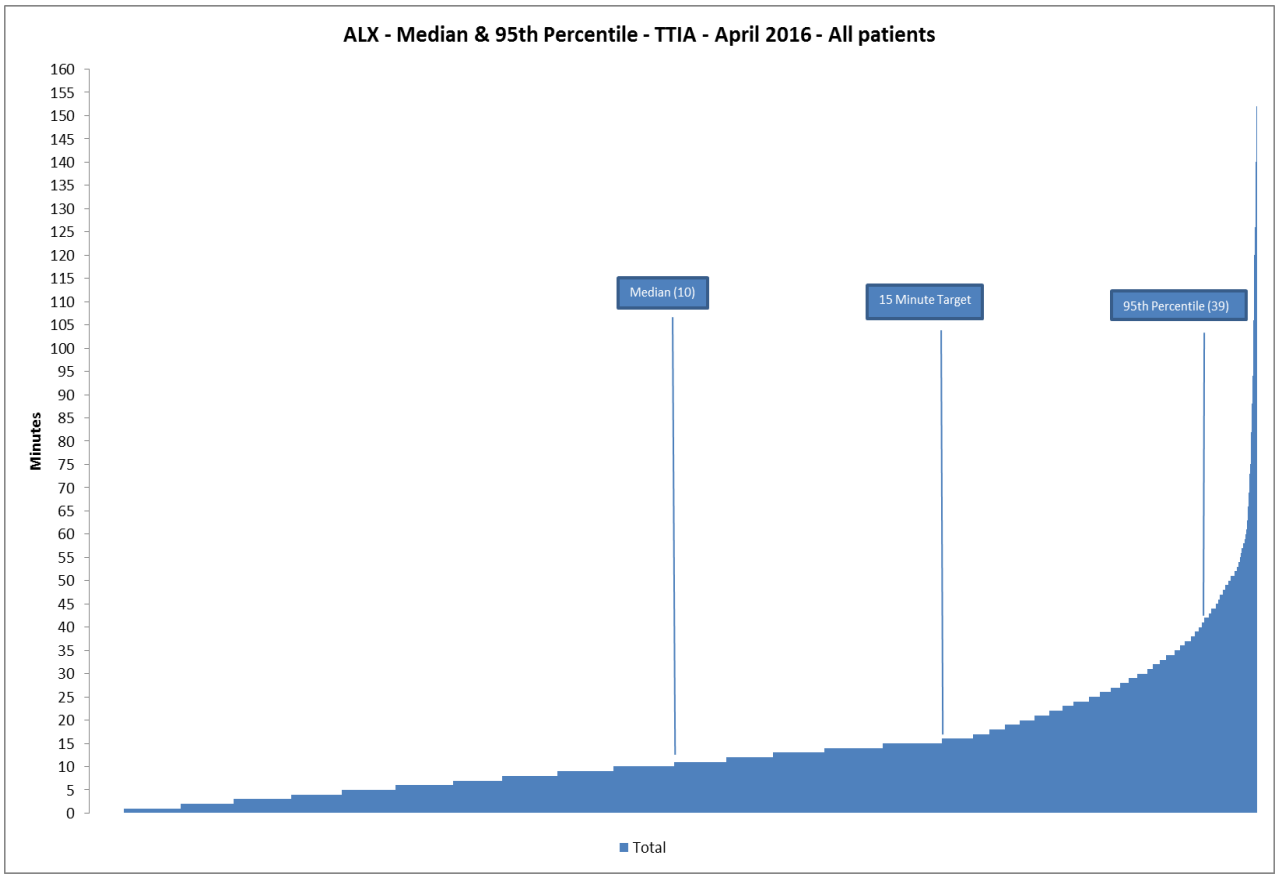


SRO:COO	Current Reporting Month: Apr 2016			
	Performance TTIA	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<=15	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	40	↓	Forecast next reported month	
Last reported month performance	54	↑	Forecast month after	
YTD performance	40	-	Forecast month after	
Revised date to meet the standard	July 2016		Forecast year end 16_17	



SRO:COO	Current Reporting Month: Apr 2016			
	Performance TTIA	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<=15	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	34	↓	Forecast next reported month	
Last reported month performance	46	↑	Forecast month after	
YTD performance	34	-	Forecast month after	
Revised date to meet the standard	July 2016		Forecast year end 16_17	


WRH - Median & 95th Percentile - TTIA - April 2016 - All patients
Minutes
Median (8)
95th Percentile (24)
15 Minute Target
Total


ALX - Median & 95th Percentile - TTIA - April 2016 - All patients
Minutes
Median (10)
15 Minute Target
95th Percentile (39)
Total

Key Performance Indicator: Ambulance Handover within 15 minutes (%) – WMAS data (CAE7.0); Ambulance Handover within 30 minutes (%) – WMAS data (CAE8.0); Ambulance Handover within 60 minutes– WMAS data (CAE9.0)

Headlines

In April 2016, there was an improvement in Ambulance handover times for 15, 30 and 60 minute performance standards. 15 minute performance improved from 37.7% in March 2016 to 54.0% in April 2016; 30 minute performance significantly improved from 81.7% in March 2016 to 91.7% in April 2016. Ambulances waiting over 60minutes to handover significantly improved from 68 in March 2016 to 31 in April 2016. The majority of breaches of the 15 minute standard were during periods of surge in ambulance attendance. We continued to experience 'exit block' from ED throughout April, particularly at WRH, and performance on ambulance handover times was impaired by the consequent over-crowding in ED.

Corrective Actions

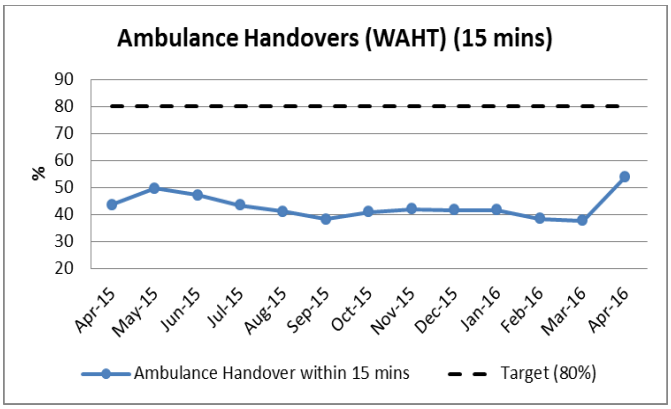
Within existing resources the Trust has deployed Senior Immediate Assessment Nurses (SIANs) to take the handover of patients from the Ambulance Trust and provide Initial Assessment of all patients attending ED. These nurses are deployed at times of peak demand in ED. The significant improvement of these performance standards is due to the emergency department's ability to maintain the SIAN nursing role on the WRH site. There is a role out plan in place to embed this role across both acute hospital sites on a 7 day per week basis.

May - Implementation of SIAN nurse at WRH 5 days per week.
July - Implementation of SIAN nurse at AGH 5 days per week.
September - Full 7 day implementation of SIAN nurse at WRH
November - Full 7 day implementation of SIAN nurse at AGH

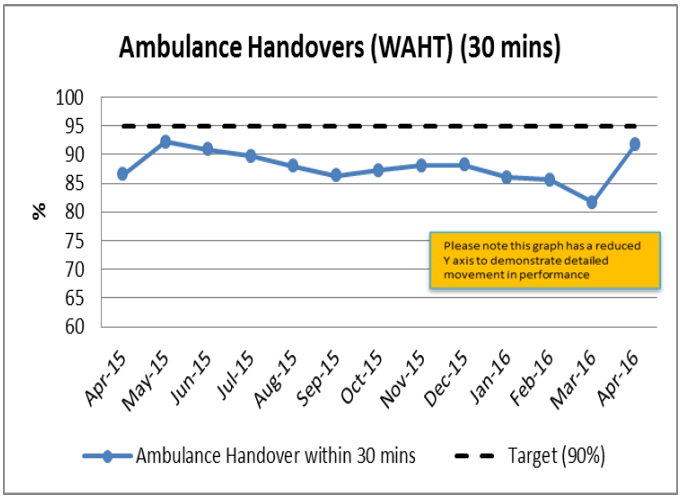
An expansion of the ED at WRH is underway and on track for the first phase to open in the Autumn of 2016, offering more space to accommodate patients waiting for handover, triage and admission.

Risks to Delivery

The major risk to delivery remains 'exit block' from the very high levels of bed occupancy at the Trust and the need to ensure that patient flow is optimised. Further risk to delivery of this standard is the availability and recruitment of appropriate staff to maintain the SIAN nurses within their roles in both Acute Hospital Emergency Departments.



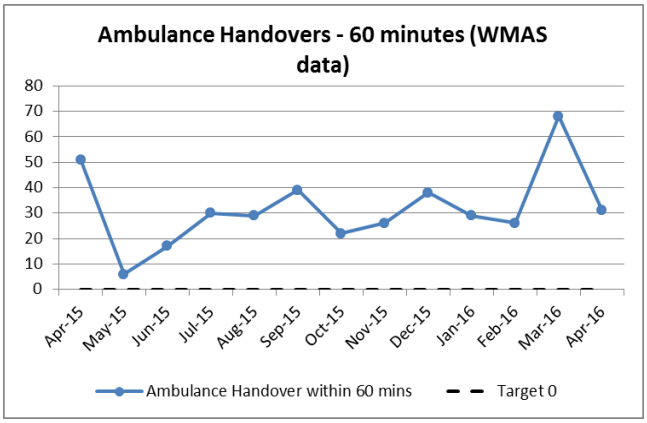
SRO:COO	Current Reporting Month: Apr 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	>80%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	54.0%	↑	Forecast next reported month	
Last reported month performance	37.7%	↓	Forecast month after	
YTD performance	54.0%	-	Forecast month after	
Revised date to meet the standard	October 2016		Forecast year end 16_17	



SRO:COO	Current Reporting Month: Apr 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	>95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	91.7%	↑	Forecast next reported month	
Last reported month performance	81.7%	↓	Forecast month after	
YTD performance	91.7%	-	Forecast month after	
Revised date to meet the standard	June 2016		Forecast year end 16_17	

SRO:COO	Current Reporting Month: Mar 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	31	↓	Forecast next reported month	
Last reported month performance	68	↑	Forecast month after	
YTD performance	-	-	Forecast month after	

Revised date to meet the standard	Not yet agreed	Forecast year end 16_17	



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

Headlines

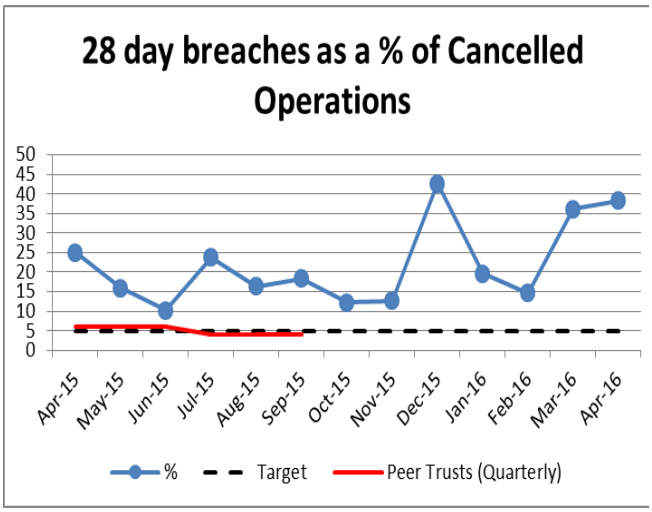
This indicator measures performance in terms of rebooking patients within 28 days of a cancelled operation and in April 2016 is at 38.03% against target of 5%. The decision to cancel operations for non-clinical reasons is taken by the Divisional Director for Surgery or Chief Operating Officer at the point the team is confident that all options have been explored. Due to on - going high levels of bed occupancy, the number of procedures cancelled on the day of surgery, due to a lack of surgical beds (timely) remains a challenge.

Corrective Actions

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

Risks to Delivery

The key risk of not delivering against this target is a delay in a patient's treatment plan which could change the clinical presentation. This is in addition to poor patient experience as patients wait longer to be treated. This indicator also has a reputational risk for the organisation and is linked to the access targets (RTT and Cancer), resulting in higher financial penalties. In recent months the risk was being mitigated with ad-hoc additional capacity whilst longer term specialty by specialty demand and capacity modelling was being undertaken.



SRO:COO	Current Reporting Month: Apr 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<5%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	38.3%	↑	Forecast next reported month	
Last reported month performance	36.1%	↑	Forecast month after	
YTD performance	38.3%	-	Forecast month after	
Revised date to meet the standard	Aug 2016		Forecast year end 16_17	

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

Headlines

The achievement of the diagnostic 6 week target has been difficult due to the Trust-wide change in policy on ad hoc waiting list activity from mid-February which impacted radiology and endoscopy, Easter Bank Holiday and a continued increase in referrals, particularly from in-patients which is impinging on out-patient capacity. In addition the loss of key agency radiologists (above national agency price cap) has limited capacity.

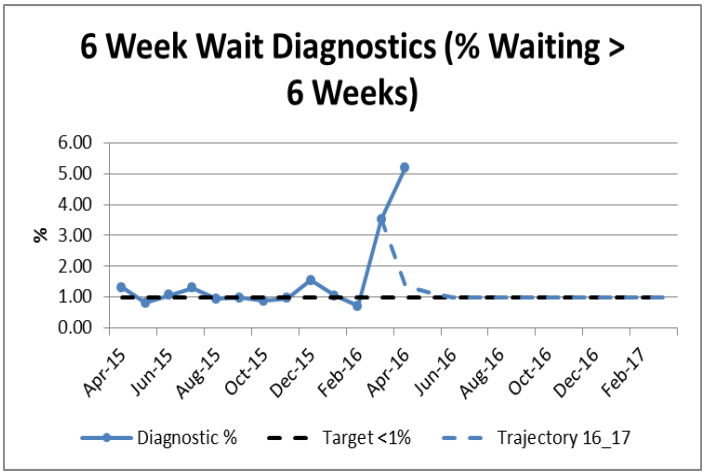
Corrective Actions

The Directorate has secured independent sector capacity, but this is minimal and is unlikely to have any significant impact on monthly achievement. The radiology directorate are continuing to attempt to obtain locum radiologists below capped rate (unsuccessful so far) while continuing with recruitment, for substantive posts. A demand and capacity exercise has been completed for endoscopy and radiology to inform the substantive staffing model for endoscopy and radiology.

Risks

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

Additional risks noted in Radiology are the recent resignation of 2 Consultants, which will impact during summer period. Recruitment process has been commenced immediately but without approval for interim locums, there will be a significant drop in ability to maintain services and reporting levels.



SRO:COO	Current Reporting Month: Apr 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<1.0%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	5.20%	↑	Forecast next reported month	
Last reported month performance	3.52%	↑	Forecast month after	
YTD performance	5.20%	-	Forecast month after	
Revised date to meet the standard	TBC		Forecast year end	

Corrective Action Statements: Workforce

Key Performance Indicators:

- All Staff Turnover – Total (WT1.0)
- Nursing Staff Turnover – Qualified (Total) (WT1.3)
- Nursing Staff Turnover – Unqualified (Total) (WT1.4)
- Sickness Absence Rate Monthly (Total %) (WSA1.0)
- Appraisals (Total) (WAPP1.2, WAPP2.2 and WAPP3.2)
- % of eligible staff completed Mandatory and Statutory training (WSMT10.2)
- Consultant and SAS Doctor Job Planning (additional information)

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

Key Performance Indicator: All Staff Turnover – (Total) (WT1.0)

We reported last month a 2.55% increase in overall Trust turnover (all staff) during the 12 month period March 2015 to March 2016. Active steps to counteract this increase in turnover have been taken throughout the year as part of the OD and Engagement Strategy.

Overall turnover for the 12 months up to 30th April 2016 is 13.01% which is the highest turnover rate that we have had in the past 8 years. Our turnover has previously tended to be in the region of 9 – 10%. In March 2016, the trust had the third highest turnover when compared with five neighbouring trusts. The average turnover of the trusts surveyed was 12.47%; 0.50% lower than the WAHT's March position (12.97%). In the preceding 12 months, turnover progressed from below the average of the neighbouring Trusts over the period April 2015 to September 2015 to exceeding the average from October 2015 onwards.

Year	2009	2010	2011	2012	2013	2014	2015	2016
Turnover %	9.04	8.19	8.45	9.21	9.13	10.33	10.25	13.01

Turnover of permanent staff by division in the 12 month period up to 30th April 2016 is:

Division	Turnover May 2015 – 30 April 2016	Turnover May 2014 – April 2015	Difference
Medicine	15.54%	10.87%	4.67%
Asset Management and IT	14.75%	8.55%	6.20%
Corporate	14.38%	17.28%	-2.90%
Women and Childrens	13.89%	9.45%	4.44%
Surgery	11.96%	8.55%	3.41%
Specialised Clinical Services	10.38%	9.04%	1.34%
GRAND TOTAL	13.01%	10.25%	2.77%

Corrective Actions

An analysis of the turnover has identified that the 9 departments with the highest number of permanent staff leaving in the 12 month period up to 30th April 2016 are:

STARTERS AND LEAVERS (NOT INCLUDING FIXED TERM CONTRACTS)			
Department	Site	Starters (WTE)	Leavers (WTE)
A&E Nursing	WRH	26.23	22.64
Maternity Team 1	WRH	21.87	15.17
MAU	AGH	12.23	13.89
Theatres	WRH	9.19	13.01
Physiotherapy	Countywide	20.41	12.89
A&E Nursing	AGH	5.43	12.84
Midwifery	AGH	1.65	12.03
Radiology	WRH	10.30	11.03
Domestics	AGH	8.68	10.64
GRAND TOTAL		568.15 WTE	602.76 WTE

The top 5 reasons for permanent staff leaving the Trust in the 12 month period up to 30th April 2016 were:

- Retirement 134.82 wte
- Work Life Balance 99.67 wte
- Relocation 90.23 wte
- Better Reward Package 48.45 wte
- Other not known 46.80 wte
- Promotion 43.76 wte

An action plan is monitored through the Nursing and Midwifery Workforce Assurance Group and the Trust Workforce Assurance Group for approval. The following actions have been agreed and implemented:

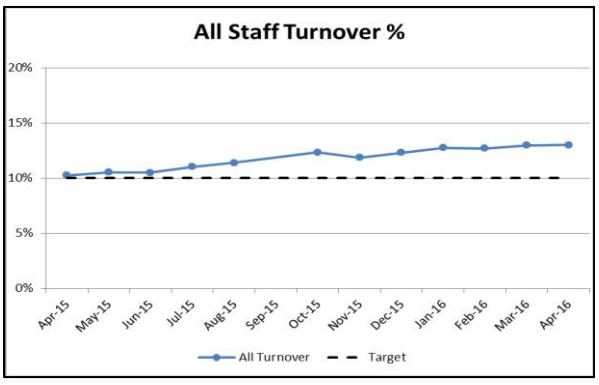
- A range of recruitment initiatives and careers fairs are planned for Nurses and HCA's.
- Recruitment plan for Physicians Associates
- Recruitment plan for ward administrator role and ward housekeeper role.
- Internal transfer process implemented for qualified nurses.
- 40 places commissioned with University of Worcester Band 4 Associate Nurse programme to commence in September 2016.

Future actions include:

- Introduction of various initiatives under the HR and OD plan to improve culture and staff engagement within the Trust including Chat-Back pulse surveys, LiA (Listening into Action), Staff Engagement Group and Health at Work plan (to meet national CQUIN).

Risks to Delivery

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



SRO: DoHR/COO	Current Reporting Month: Apr 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<10%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	13.0%	⇨	Forecast next reported month	
Last reported month performance	13.0%	⇧	Forecast month after-	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard			Forecast year end 16_17	

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

Headlines

The nursing turnover figure for April 2016 has increased from 14.2% to 14.3% (against the target of 10%). The target of 10% turnover was last met in April 2015. A benchmarking exercise with 4 other Trusts in the West Midlands shows WAHT is above the average qualified nursing turnover of 11.5% .Qualified nurse recruitment continues to be a national challenge and the Trust is currently unable to recruit sufficient qualified nurses to fill current vacancies. The finance establishment figures for qualified nurses for April 2016 show over 200 qualified nurse vacancies.

Corrective Actions

A number of actions continue to be monitored through the Nursing and Midwifery Workforce Assurance Group and then into the Trust Workforce Assurance Group for approval. The following actions have been achieved:

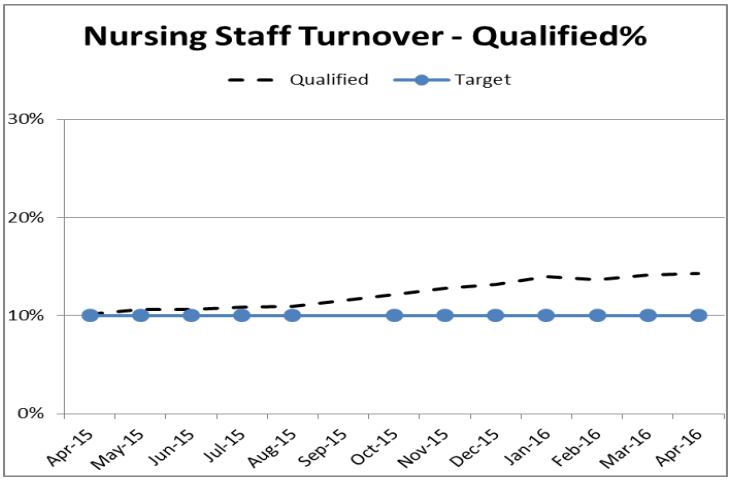
- Tracking and follow up system for University of Worcester graduates presented to NWAG monthly as percentage offers accepted requires improvement.
- 'Golden Hello' recruitment incentive for qualified nurses implemented in theatres
- Retention payment implemented for qualified nurses in theatres.
- Band 5 Assessment Centre test in process of review being revised with Worcester University, Professional Development and Pharmacy.
- Analysis of exit interviews to identify reasons for nursing leavers with 12 months or less continuous service. Evidence indicates work/life balance as primary issue.
- Review of mentoring ratio of mentor to student undertaken to increase student number intake from next intake.
- 40 places commissioned with University of Worcester Band 4 Associate Nurse programme to commence in September 2016.

Future actions are:

- 'What's in it For Me?' event planned in June 2016 to encourage internal applicants to Band 4 Assistant Practitioner role on the 1st and 6th June 2016.
- Development of a campaign to encourage qualified nurses and AHP's to return to practise.
- Review of exit interview process to ensure all leavers are provided with the opportunity to participate in the process.
- Local Recruitment Event at Alexandra Hospital 21st May 2016 to target Worcester University graduates
- Attending Stafford University Recruitment Event 27th May 2016 to target qualified nurses.

Risks to Delivery

The target for qualified nurse turnover has not been met for the last 12 months. The Trust has been unable to attract sufficient qualified nurses to fill current vacancies and there are high levels of vacancies across all the divisions. There are 103 qualified nurses due to graduate from Worcester University in August 2016 however this is insufficient to fill current vacancy levels. If we do not attract and retain qualified nursing staff we will be unable to ensure safe and adequate staffing levels. We also will need to rely on agency and bank staff which will affect patient experience, quality and financial position. High turnover impacts on staff morale and health and wellbeing so is a high priority for the Trust.



SRO: DoHR/ COO	Current Reporting Month: Apr 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	10%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	14.3%	↑	Forecast next reported month -13%	
Last reported month performance	14.2%	↑	Forecast month after	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard	**FY 17/18**		Forecast year end 16_17	

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

Headlines

The unqualified nursing turnover figure for April 2016 has slightly increased to 14%. Leavers between May 2015 and April 2016 are a mix of less experienced staff (less than 2 years experience) at 47% and more experienced members of staff (more than 2 years experience) at 53%. Medicine Division is a hotspot for HCA leavers . The Trust continues to attract a high number of applicants for HCA vacancies and extended Assessment Centres following the May recruitment event are planned to fill vacancies. Analysis of the reasons for leaving indicate the top reasons are work-life balance and relocation.

Corrective Actions

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

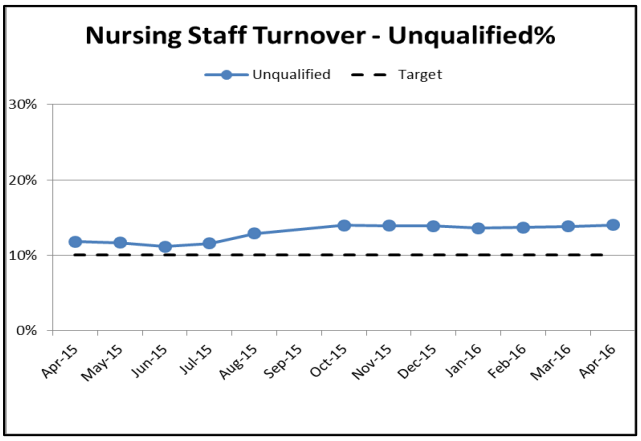
- Continue to provide 6 -day care certificate course for all new unqualified nursing staff.
- Automatic offer of posts to all HCA apprentices on completion of apprenticeship.
- Commissioned Band 4 programme with UW to offer to existing Band 3 HCA's career progression opportunities to improve retention.
- Working with NHSP to develop a Clinical Support Worker Development Programme

Future actions are:

- Analysis of exit interviews to identify reasons for nursing leavers with 12 months or less continuous service.
- Use the Band 4 development programme to improve retention by attracting applicants who want to pursue a career in nursing.
- Recruitment event at Alexandra Hospital 21st May 2016 and attendance at Recruitment Event at the Kingfisher Centre 13th May 2016
- Implementation of Chat-Back local pulse survey with quick feedback of results to enable early intervention in hotspot areas.
- Extended assessment centres following May recruitment event to fill vacancies.
- Increase recruitment of number of Clinical Apprenticeships .

Risks to Delivery

Healthcare assistants are key to providing high quality care. If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels. We also will need to rely on agency and bank staff which will affect patient experience, quality and financial position. Healthcare assistant vacancies receive high number of applications and extended assistant centres will be used to target vacancies. The Band 4 role will be promoted to retain experienced staff. High turnover impacts on staff morale and health and wellbeing so is a high priority for the Trust.



SRO: DoHR/COO	Current Reporting Month: Apr 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	10%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	14.0%	↑	Forecast next reported month	
Last reported month performance	13.8%	↑	Forecast month after	
YTD performance	-	-	Forecast month	
Revised date to meet the standard	**FY 17/18**		Forecast year end 16_17	

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

Headlines

The Trust sickness absence 'in-month' for April is 4.06% which shows a small decrease on last month (4.17%) and is the lowest 'in month' figure reported for 12 months; we remain above the Trust target of 3.5% but comparable with other NHS Trusts. The 12 month cumulative figure is 4.36% an increase of 0.02% on the March 2016 cumulative figure. Long-term sickness has remained consistent at on or around 2.8% over the last 12 months. Short-term sickness remains consistently under Trust target.

There has been a shift again this month; previously problem areas have been Asset Management and IT and TACO which continues to show decreases month on month. TACO is now 4.40% which is significant as they were averaging 7%. All other areas, with the exception of surgery, equally show decreases. Medicine Division have shown significant improvements and are the first Clinical Division to achieve 3.46% and get below Trust target of 3.5%.

Top 3 reasons for sickness absence remain consistent:

- Anxiety and stress (1443 days lost in April, a further increase on March)
- Colds and Flu (768 days lost in April compared to 1,038 days lost in March)
- Back problems (947 days lost in April compared to 1,075 days lost in March).

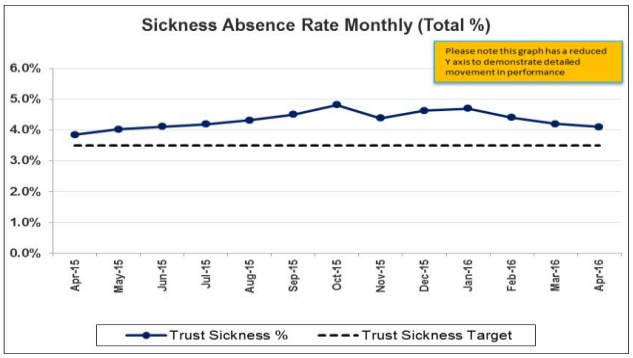
Corrective Actions

A benchmarking review has taken place and, from those Trusts who responded, this Trust is one of the lowest in terms of their sickness absence. Most Trusts seem to remain consistently between 4 and 5%.
Long-term sickness is being managed, although there have been some significant health issues for a number of staff on long term sickness who are being well supported. Of the 149 cases, 70 have been off less than 2 months, 55 less than 6 months and 22 less than 12 months. We have 2 cases over 12 months but these will be drawn to appropriate conclusion within the next month. The HR Team continue with the following actions in support of the operational teams:

- Monthly meetings with matrons/ward/line managers to review action plans for long term and episodic absences, prioritise hot spot areas, ensure referrals to self-care workshop are being made and referrals to OH are being made in a timely manner.
- Absence levels are reported monthly at Divisional Board Meetings and hot spot areas highlighted
- Future actions are to review attendance at the Being Absence Minded workshop to ensure that all staff who manage absence have attended recently.

Risks to Delivery

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



SRO: DoHR/COO	Current Reporting Month: Apr 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	=<3.5%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	4.06%	↓	Forecast next reported month	
Last reported month performance	4.17%	↓	Forecast month after	
YTD performance	4.06%	-	Forecast month after	
Revised date to meet the standard			Forecast year end 16_17	

Key Performance Indicator: Trust Appraisals (Total) (WAPP1.2, WAPP2.2 and WAPP3.2)

Headlines

Medical Staff:
The appraisal rate for all medical staff at 30th April is 80.2% which is a 2.2% decline against the March figure of 82.2%. The Trust target of 85% has still to be achieved which equates to 15 appraisals required to achieve this target.

April Breakdown by Staff Group:

- Consultants - 83.7%, a slight decrease from the March figure of 84.6% (211 out of 252).
- SAS/Career Grade - 66.7%, a decrease from the March figure of 73.9% (44 out of 66). Targeted support is being provided to SAS/Career Grade doctors including a dedicated appraisal workshop arranged for June.

The four divisions are currently below the 85% target and fall within the range of 76.2 – 83.6%.

Non-Medical staff (all staff groups except Medical & Dental)
The appraisal rate for all non-medical staff is 79.9% against a target of 85%. Non-medical appraisal shows an in month improvement of 3.7%. The two Divisions with marked improvement are Corporate and Surgery.

Corrective Actions

Medical Staff Appraisal
Current corrective actions:

- Appraiser network group meetings scheduled for July and December 2016.
- Clinical Lead for Appraisal and Revalidation – Quality Assurance role being reviewed by the Interim CMO to assess preferred recruitment process.
- Monthly RAG rated appraisal reports issued to Divisional Management Teams and action plans requested.
- Expired appraisals escalated to the Interim CMO for follow up with appropriate divisions.

Non-Medical Appraisal (all staff groups except Medical & Dental)
Current corrective actions:

- All employees who have not received an appraisal in the last 12 months have received a letter reminding them of the importance of their appraisal.
- Development of an electronic appraisal form which can be submitted directly to ESR for monitoring .
- Learning and Development Lead for appraisal meeting with low compliance heads of departments to assist with planning of appraisals.
- Appraisal documentation streamlined.

Risks to Delivery
Staff are expected to have received a formal appraisal every year so that they are aware of their performance. Where staff do not have an appraisal they do not have the opportunity to receive feedback and to give feedback to their manager and do not have the opportunity to agree appropriate development opportunities.

SRO:DoHR	Current Reporting Month: April 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	85%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	80.2% Medical, 79.9% Non-medical, 83.7% Consultant		Forecast next reported month Medical – 84% Non-Medical – 83%	
Last reported month performance	82.4% Medical, 76.2% Non-medical, 84.6% Consultant		Forecast month after Medical – 85% Non-Medical 85%	
YTD performance	83.6% medical, 77.9% non – medical. 86.2% Consultant	-	Forecast month after	
Revised date to meet the standard			Forecast year end 16_17	

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

Headlines

The Trust mandatory training performance as at April 2016 is 87.8% which shows a 1% increase since March 2016 against an agreed revised 90% target and a 5.8% increase since April 2015. There are now 10 mandatory training topics, currently 3 topics have met the 90% target, 6 further topics have made significant progress and compliance percentages range from 82% to 88% and therefore are on trajectory to achieve the 90% target by May 2016. The remaining topic is Equality and Diversity at 52% this is low due to a change in the frequency this training is required which has changed from once only to every 3 years. Analysis of the data continues to show that in identifying the clinical/non-clinical split in mandatory training rates, clinical staff are 87% compliance in all areas and 90% and above in safeguarding and infection prevention / hand hygiene and manual handling.

Corrective Actions

For Equality and Diversity training the corrective actions implemented are:

- Provision of additional training sessions and weekends and evenings.
- Alternative methods of training delivery.
- Written assessments to replace e-learning for staff that have limited IT contact

In addition for all topics the following has been implemented:

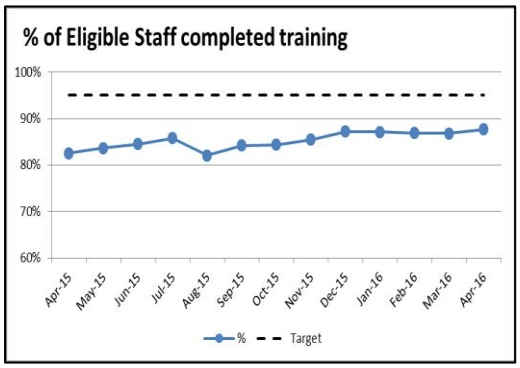
- Mobile phone text reminder service implemented.
- Updating of Mandatory training pages on intranet with easy access from Intranet Home page.
- Competencies attached to each job role on ESR to enable easier access to correct e-learning programme.

Future Actions include:

- Networking continues with all 27 Trusts engaged in the West Midlands Mandatory Training Streamlining Project to develop new ideas and agree transferable training records between Trusts to improve compliance.
- Further work on competencies now linking to training completed work to be completed by May 2016.

Risks to Delivery

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



SRO: DoHR/COO	Current Reporting Month: Apr 2016			
	Perform-ance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	>90%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	87.8%	↑	Forecast next reported month	
Last reported month performance	86.8%	↑	Forecast month after-	
YTD performance	87.8%	-	Forecast month after	
Revised date to meet the standard	**June 2016**		Forecast year end 16_17	

Additional Information:

Key Performance Indicator Name: Consultant and SAS Doctor Job Planning (additional information)

Headlines

As at 16th May 2016, the Consultant and SAS workforce with a current job plan has improved to 75% compared to the April figure of 68%.

The number of current job plans now total:

- Consultants - 204 out of 267 (77%)
- SAS Doctors - 25 out of 43 (58%)

Divisions have between 9 and 19 job plans outstanding, although a significant number of these reviews have been undertaken and a weekly progress report is provided by divisions including completed job plans for validation.

Corrective Actions

- Monthly Divisional RAG rated reports and weekly exception reports to identify areas of non-compliance with action plans provided by HR.
- Escalation to CMO in respect of red rag rated job plan outstanding for divisions/specialties.
- Meetings with Clinical Directors/Leads and Managers to support, guide and interpret the Trust's Job Planning policy
  Analysis of diary exercise data is performed by HR to support job planning review meetings.

Future corrective actions:

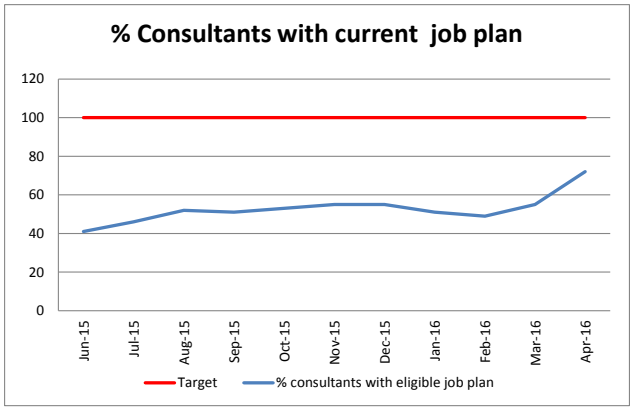
- The key area for additional support remains SAS doctors. Additional training and support is being arranged jointly between the SAS and consultant lead to ensure the SAS doctors are fully informed on the policy and procedure to complete their job plan review.
- A more detailed 12 month trajectory plan by Division and Specialty has been developed and will be issued to divisions for agreement and will be used to forward plan future job plan reviews

Risks to Delivery

If job plans are not reviewed and validated annually there is no provision to assess individual and specialty activity affecting capacity planning and service delivery. The Trust may also be liable for individual claims for additional remunerated programmed activities which cannot be substantiated if there has been no robust process.

The table below demonstrates percentage movements for the month of May 2016 in comparison to April 2016.

	16/05/2016 compared to 18/04/2016				
	Division				TRUST TOTAL
	Specialised Clinical Services	Medicine	Surgery	W&C	
% Consultants with current job plan	↑ 6% to 79%	↑ 4% to 75%	↑ 6% to 76%	↑ 5% to 77%	↑ 5% to 77%
% SAS Doctors with current job plan	↑ 11% to 53%	↔ 14%	↑ 8% to 85%	↑ 55% to 75%	↑ 13% to 58%
% eligible doctors with current job plan	↑ 7% to 76%	↑ 4% to 68%	↑ 7% to 78%	↑ 11% to 77%	↑ 7% to 75%



SRO: DoHR/COO	Current Reporting Month: May 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	100%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	75%	↑	Forecast next reported month	
Last reported month performance	68%	↑	Forecast month after-	
YTD performance	75%	↑	Forecast month after	
Revised date to meet the standard	June 2016		Forecast year end 16_17	100%

Corrective Action Statements:

Quality and Safety

Key Performance Indicator Names;

- Mortality – HSMR monthly and rolling 12 months (HED tool) (QPS9.8)
- Mortality - SHMI monthly and rolling 12 months (inc. Deaths 30 days post discharge) (QPS9.1)
- The total number of Serious Incidents open longer than 60 day (QPS3.1)
- Falls resulting in serious harm (QPS6.6)
- Safety Thermometer (QPS10.1)
- % of approved risks overdue for review (QR1.0) and % of approved with overdue actions (QR1.2)
- Hip Fractures – Time to Theatre within 36 hours – all patients (QEF3.1)
- VTE Risk Assessment (QPS11.1)

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

Key Performance Indicator: HSMR monthly (QPS9.8) and rolling 12 months (HED tool) (QPS9.81)

Headlines

The HSMR result for the month of February is 107. The HSMR value for the rolling 12 months to February 2016 (the most recent period for which data is available) is 105, the comparable peer group figure is 99. There is month on month variability. To identify a sustained trend the rolling 12 month figures are used. There does appear to be an improvement trend from the peak in the May '14 – April '15 period.

Data from the latest 3 months should be viewed with caution as it is based on an incomplete dataset due to patients admitted during these months still having active management. The impact of data refresh is to increase the HSMR value as long stay patients tend to have a higher overall mortality but not a higher predicted mortality.

Corrective Actions

The Trust has embarked on 4 work streams to identify and address avoidable lapses in care that would be expected to impact on avoidable mortality as part of the overall Trust Improvement Programme.

Stream 1: Routine review of the care of patients dying whilst an in-patient, with in - depth review when issues are identified at primary screening such that root cause is identified and actions put in place to reduce the risk of recurrence.

Stream 2: Reduction in avoidable cardiac arrests, with a specific focus on re-launching the Trust's approach to responding to the deteriorating patient, using the nationally accredited track and trigger tool.

Stream 3: Ensuring patients with sepsis are identified and treated within an hour of presentation, a single screening tool that drives timely interventions and on-going management is on trial in both ED's

Steam 4: Ensuring all patients presenting with a fractured neck of femur receive rapid treatment specifically surgery within 36 hours of presentation – work is underway to identify ring fenced ward and theatre capacity together with enhanced perioperative care

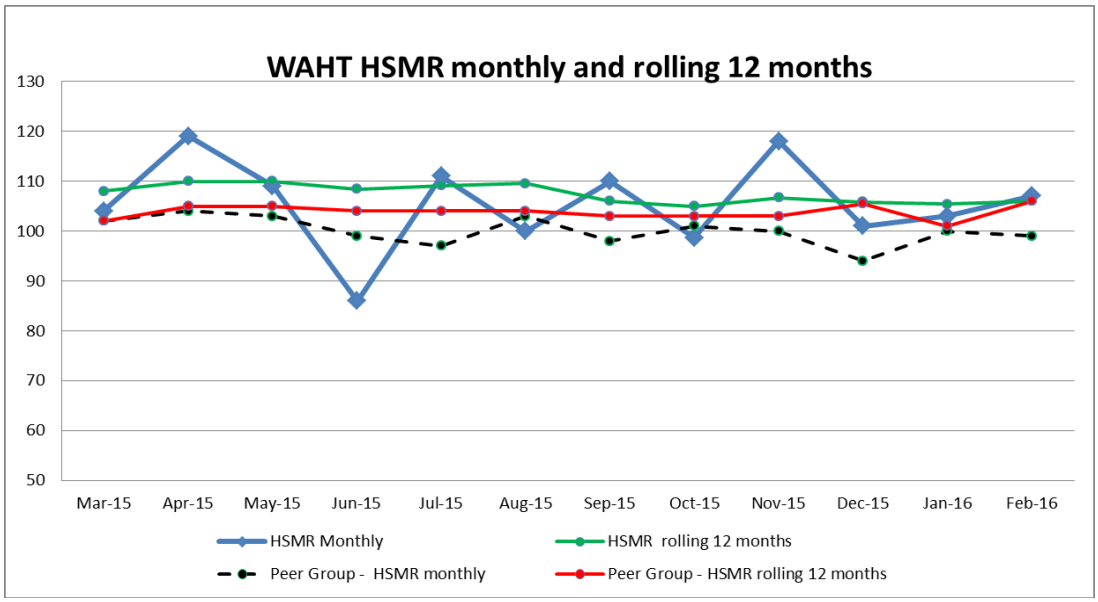
The requirement to undertake Deep Dive Reviews in heat map identified diagnostic groups indicating adverse trends has been discussed by CMO and relevant DMDs. Divisional governance processes/ meetings are to be refocused.

Risks to Delivery

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

This graph and chart relate to the rolling 12 months (QPS9.81)

SRO:CMO	Current Reporting Month: Feb 2016			
	Performance – rolling 12 months	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	<100	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	106	↑	Forecast next reported month	
Last reported month performance	105	↓	Forecast month after	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard	Not provided		Forecast year end	



Key Performance Indicator: SHMI – inc. deaths 30 days post discharge – monthly (QPS9.0) and rolling 12 months (QPS9.1)

Headlines

The Trust's SHMI value for the month of January 2016 was 111. The SHMI value for the 12 month rolling period to January 2016 (latest 12 month period for which data is available) is 109. The 12 month rolling figures demonstrated in the chart below show a plateauing in value rather than any sustained reduction.

Corrective Actions

The Trust has embarked on 4 work streams to identify and address avoidable lapses in care that would be expected to impact on avoidable mortality as part of the overall Trust Improvement Programme.

Stream 1: Routine review of the care of patients dying whilst an in-patient, with in - depth review when issues are identified at primary screening such that root cause is identified and actions put in place to reduce the risk of recurrence.

Stream 2: Reduction in avoidable cardiac arrests, with a specific focus on re-launching the Trust's approach to responding to the deteriorating patient, using the nationally accredited track and trigger tool.

Stream 3: Ensuring patients with sepsis are identified and treated within an hour of presentation, a single screening tool that drives timely interventions and on-going management is on trial in both ED's

Steam 4: Ensuring all patients presenting with a fractured neck of femur receive rapid treatment specifically surgery within 36 hours of presentation – work is underway to identify ring fenced ward and theatre capacity together with enhanced perioperative care

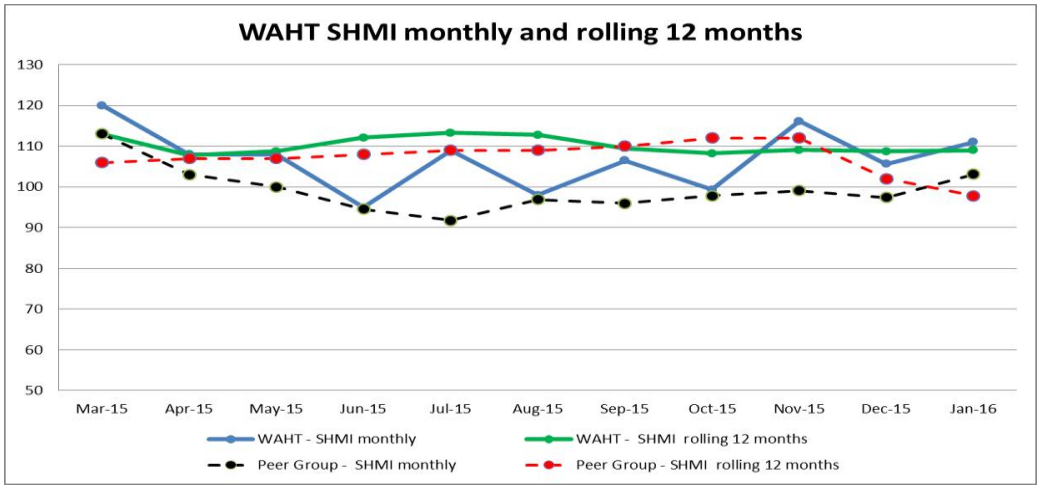
The SHMI incorporates deaths occurring within 30 days of discharge and work continues to establish mortality reviews for patients dying within 7 days of discharge in a non-hospice environment and review of the pre-admission care of t ose dying within 24 hours of admission. These initiatives should identify any avoidable factors compromising the quality of care delivered to these groups of patients and thus facilitate improvement.

Risks to Delivery

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

This graph and chart relate to the rolling 12 months (QPS9.1)

SRO:CMO	Current Reporting Month: Jan 2016			
	Performance – rolling 12 months	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	TBC	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	109	⇨	Forecast next reported month	
Last reported month performance	109	⇨	Forecast month after	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard	Not provided		Forecast year end	



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

Headlines

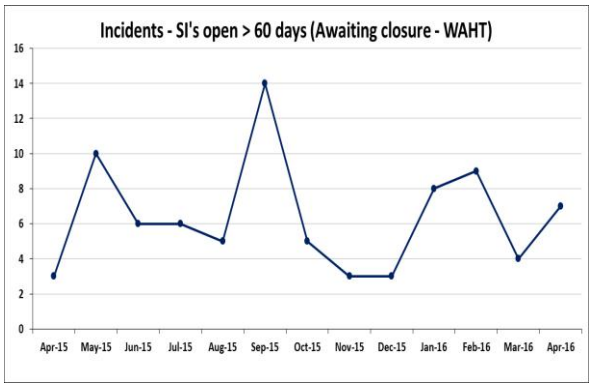
7 SI investigations were open beyond 60 days at the end of April, an increase of 3 compared to March 2016. There was 1 in the Surgical Division, 2 from the Specialised Clinical Services Division and 4 from Medicine. There are a total of 37 open SI investigations. The clock has been stopped for 2. There were 5 new SIs reported in April and 66 SIs that have been open for longer than 20 days.

Corrective Actions

The weekly Trust Operational Governance Meeting, which reviews new significant incidents, progress with investigations and SI reports, is being reviewed to improve both the initial incident review and the approval process. Enabling actions to deliver capability in all the Divisions to review and sign off investigation reports are being considered as part of the review which will include learning from processes used at Oxford University Hospitals FT. Training and workshops for support teams will be delivered to address skills and knowledge gaps. Divisional review meetings continue to monitor progress of SI investigations and share any immediate learning within their area of responsibility.

Risks to Delivery

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



SRO:CNO	Current Reporting Month: Apr 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	7	↑	Forecast next reported month	Not provided
Last reported month performance	4	↓	Forecast month after	Not provided
YTD performance	-	-	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided

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

Headlines

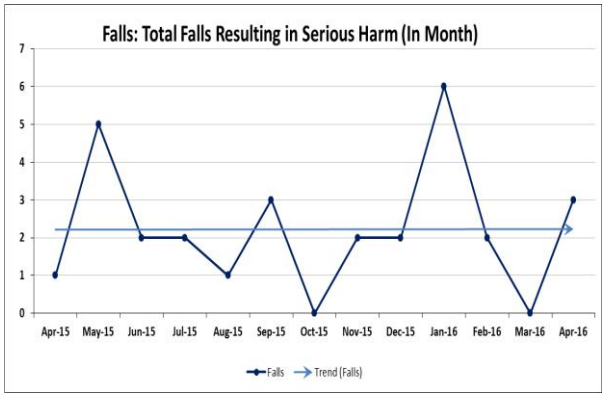
There were 3 serious harm falls reported in April 2016. The injuries sustained were a right fractured neck of femur (Silver unit); a right fractured humerus (Avon 2) and a fractured skull (Avon 3). There was one patient who was medically fit for discharge. The falls were all unwitnessed.

Corrective Actions

There are on-going falls prevention and reduction training strategies in place. Following our Royal College of Physicians Falls and Frailty audit, it is planned that we change our assessment documentation and care plan in May. This will be done in conjunction with our Falls Champion events already planned in May. There are specific actions from each of these SI falls and in particular the fall on Silver Unit requires more in-depth discussion and analysis.

Risks to Delivery

We need to be mindful that length of stay and mortality are increased by serious harm falls. This also directly affects the patient safety and experience. We will be looking at whether a patient is medically fit for discharge when they sustained the fall.



SRO:CNO	Current Reporting Month: Apr 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	3	↑	Forecast next reported month	
Last reported month performance	2	↓	Forecast month after	N/A
YTD performance	2	-	Forecast month after	N/A
Revised date to meet the standard	Not applicable		Forecast year end	

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

Headlines

In April there were 8 patients that were not screened in High Risk Wards. This resulted in performance being below the 95% target at 94.5%. This is the first month where the performance has been below the target since October 2015.

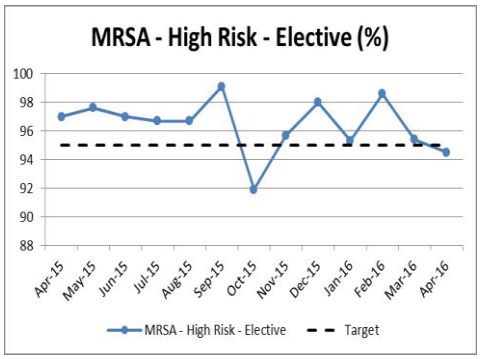
Corrective Actions

Further work is being undertaken to review and refine MRSA screening figures, which for April will include:

- A review of the status of elective Hereford patients. This is relevant where MRSA screening is undertaken at Hereford, as WAHT will be showing an admission with no linked MRSA screen, hence lowering the compliance. A remedy will therefore need to be agreed.
- A look at MAU and Severn Unit short stay patients. These areas have numerous 'ward attenders' e.g. post-surgery, who may be registered as an admission. This means again there are admissions that are not linked to an MRSA screen, hence also lowering the overall compliance rate.
- A look at contracts for NHS waiting list patients having their surgery at a private hospital (namely Spire and Droitwich). If these patients have their screen at WAHT, but not their surgery, the screen won't be linked to an admission and this will affect screening figures. We may need to have a separate tally for these patients or find a way to include them in our figures.
- A fresh look at inclusions and exclusions to the MRSA screening policy, including for pain clinics and chemotherapy day case.
- Extending the revised approach when agreed to non - elective high risk areas.
- A review and update of the MRSA screening policy to be published in Q1 2016-17.

Risks

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



SRO: CNO	Current Reporting Month: Apr 2016		
	Elective – High Risk	**Plan/ Forecast**	**Status/ RAG**
Target	>95%	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	94.5%	Forecast next reported month	
Last reported month performance	95.4%	Forecast month after	
YTD performance	94.5%	Forecast month after	
Revised date to meet the standard		Forecast year end	

Key Performance Indicator: Safety Thermometer (QPS10.1)

Headlines

The target score set for harm free care is 95%. The Trust's overall harm free care score for April 2016 was 90.97% against a national benchmark for acute trusts of 93.55%. The Trust has achieved a score of 95% for 2 months out of the last 12 rolling months. Overall performance in the last 4 months has been between 90.97% and 94.8%. The main reason for not achieving 95% has been the scores for all pressure ulcers and the presence of catheters and urinary tract infections. The total number of pressure ulcers was 5.96% and the number of new pressure ulcers was 0.99%. The number of falls and new VTE's had also increased slightly to 0.74% for both. There was also an increase in the number of reported catheters and urinary tract infections which was 1.99%. All of these had increased from the previous month of March's figure. The new harm free score was 97.52%.

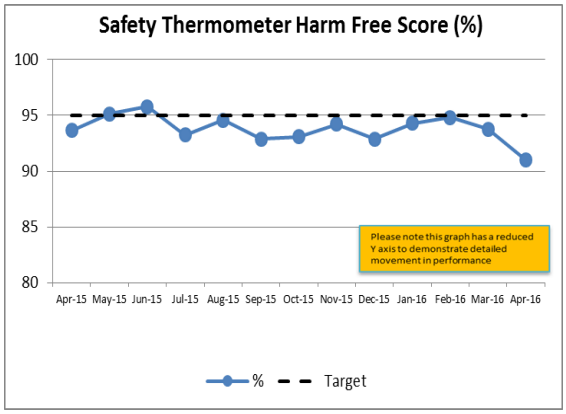
Corrective Actions

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

Risks to Delivery

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

Due to the fact that the NHS Safety thermometer tool picks up the prevalence of harm that has occurred outside of the Acute Trust setting it is not possible for us to give any assurance that we will be able to meet the 95% target. The use of New harm free score may be a better key indicator for harm within the Acute Trust.



SRO:CNO	Current Reporting Month: Apr 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	90.97%	↓	Forecast next reported month	
Last reported month performance	93.77%	↓	Forecast month after	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard	Not provided		Forecast year end	

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

Headlines

Reasons an action is not completed on time include:

- Unrealistic timeframe set or inadequate planning
- Cancelled meetings, or risk register not added to agenda
- Staff not held accountable for overdue actions

Overall this month, the trust met target for QR1.0 but not QR1.2.
Women and Children have achieved a significant improvement in performance this month.

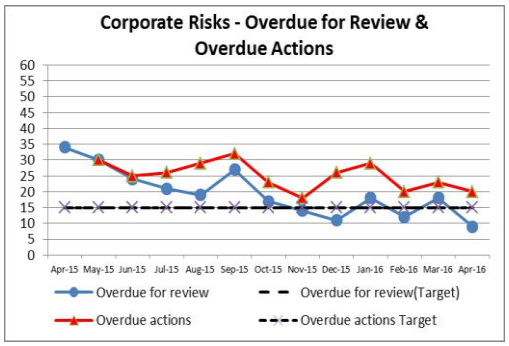
Corrective Actions

The Trust Risk Officer is liaising with the Divisional Quality Leads and the relevant DMT's where performance is a concern. It has been noted that despite these efforts, if the chair or attendees do not challenge overdue dates, performance will not improve.
Divisional Management Teams have been provided with a guide to the risk reporting process to ensure robust review of risks within governance meetings. This will be appended to the Trust Risk Strategy which is being updated in pathway format.
Risk training continues. Ward risk registers will be implemented alongside Ward Performance Dashboard in phase three, which is now scheduled for May 2016. The format has been designed and development is underway.

Risks to Delivery

The following could all impact on the delivery of the target:

- Divisions and Corporate services not giving sufficient time or attention to overdue risks & actions.
- Cancelled meetings or risk register not added to agenda/papers.
- Risk owners not sufficiently engaged or state they do not have time to update the risk.



SRO:CNO	Current Reporting Month: Apr 2016			
	Overdue for review	Overdue actions	Plan/ Forecast	Status/ RAG Overdue Actions
Target	<15%	-<15%	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	9%	20%	Forecast next reported month	
Last reported month performance	18%	23%	Forecast month after	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard	Q2 2016/17		Forecast year end	

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

Please note that the target for 2016_17 has been reduced from 90% to 85%
The national average for 2014 was 72%.

Headlines

April 2016 Performance:-

Worcester Royal Hospital	Apr-16
Total NOF admissions	44
Achieved 36hrs	23
% Achieved	52%

Alexandra Hospital	Apr-16
Total NOF admissions	25
Achieved 36hrs	15
% Achieved	60%

The challenge this month was theatre capacity at the WRH Site - 14 of the 44 patients (32%) did not get to theatre on time at WRH due to lack of theatre capacity both during the week and at the weekend. At the AGH site the main issues are imaging and referrals to specialist centres for malignancies.

Worcester Royal Hospital	55%	66%	48%	52%
	Jan-16	**Feb-16**	**Mar-16**	**Apr-16**
Total NOF admissions	40	29	40	44
Achieved 36hrs	22	20	19	23
Unfit	4	2	9	5
Weekend Theatre Capacity	3	3	6	4
Theatre Capacity	7	2	2	10
Required THR	1	0	0	0
Non operative treatment	2	2	3	0
BH capacity	0	0	0	0
In non-surgical bed	0	0	0	1
Requires further imaging	1	0	1	1
Total	40	29	40	44

Corrective Actions

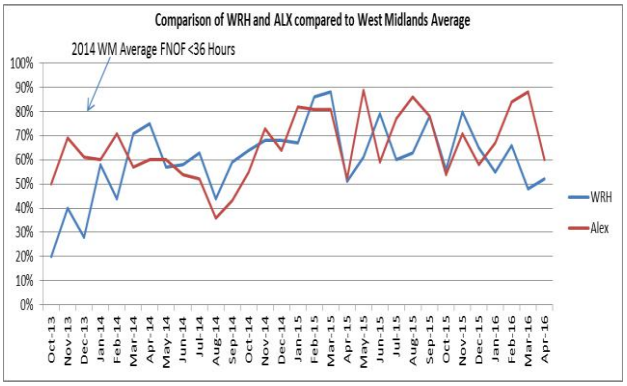
1) Prioritisation of #NoF cases to be done first on the PM Trauma Theatre Sessions; this to be driven by the Trauma Nurse Practitioners & Clinical Teams.
2) Hip Fracture Escalation Policy disseminated to the T&O Clinical Teams to support the following:- - #NOFs first on the list; other cases to be prioritised - Hip Fracture Escalation Policy to be enforced - delaying fracture care needs to be challenged - 36 hour breach time to be added onto Bluespier (support required from IT to implement – on going).
3) Trauma Nurse Practitioners & Clinical Teams are reviewing and escalating daily trauma issues.
4) Trauma Nurse Practitioners submit a daily #NOF Report on the achievement of the 36 hour target; report submitted to the COO & Surgical Division.

5) #NoF performance reviewed and discussed at the Monthly T&O Directorate Meetings; this will be a monthly standard agenda item for discussion.
6) Business Case to be submitted for additional weekend Trauma Theatre Sessions for both The Alexandra & Worcester Sites. The document "Case for Change – Weekend Trauma Sessions" was resubmitted on the 3 March 2016. Business Case to be submitted May 2016.

Risks to Delivery

Weekday Theatre 3 & Theatre 4 - PM Sessions are required to support #NOF performance.
Currently no dedicated weekend Trauma Theatre Sessions at the Alexandra Site and only weekend AM dedicated Theatre Sessions at the Worcester Site.
There appears to be a significant number of patients being prescribed new generation anticoagulants, which is delaying surgery as we cannot reverse these in the same way as Warfarin. Guidance is required from haematology and anaesthetics on this matter as more and more patients seem to be switching from Warfarin to e.g. Apixaban for AF in the community.
Require dedicated Orthogeriatric cover.

SRO:COO	Current Reporting Month: Apr 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	85%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	55%	↓	Forecast next reported month	
Last reported month performance	63%	↓	Forecast month after	
YTD performance	55%	-	Forecast month after	
Revised date to meet the standard	Not provided		Forecast year end	



Key Performance Indicator: VTE Risk Assessment (QPS11.1)

Headlines

Previously the Trust had achieved the target (until November 2015) however performance declined to below 95% in subsequent months, stabilising above 93%. April 2016's performance of 93.8% demonstrates an improvement on March's reported performance of 93.5%. A group of clinicians, governance and information team representatives continue to assess and address the recent deterioration in performance. The group's review of data quality included:

- Identified that varying processes being used by different Ward Clerks to record VTE assessments.
- There is a lack central management structure for Ward Clerks creating difficulties in achieving a consistent approach.
- Identified concerns relating to the reporting of VTE, currently being sourced from two systems, OASIS and Bluespier.

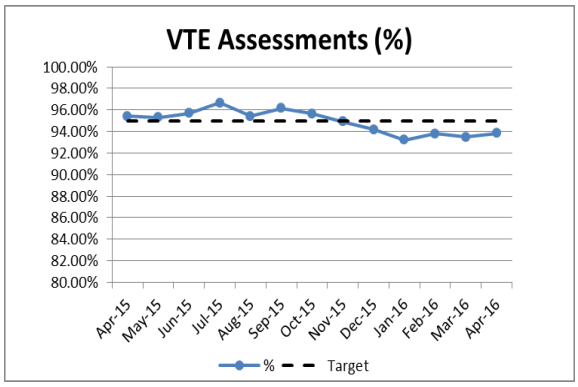
Corrective Actions

The corrective actions reported in the previous months are on-going.
Actions agreed:

- To review best practice ward rounds and draft a procedure document for review by the group for subsequent discussion with Matrons/ Divisional Lead Nurses for implementation
- Trust's VTE assessment policy to be updated to include agreed changes to support improvement
- Current agreed exclusion criteria to be reviewed and changed to align with agreed clinical practices
- Information Department agreed to produce separate reports from the two systems for comparison and further investigation.

Risks to Delivery

Not performing VTE assessments prevents the provision of appropriate therapeutic interventions which reduce an individual's risk of developing a VTE with the possibility of subsequent morbidity or mortality. Not recording VTE assessments, which have been completed appropriately, results in avoidable adverse reporting. Failing to achieve this KPI will result in a contract query with CCG.



SRO:CNO	Current Reporting Month: Mar 2016			
	Perform-ance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	>95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	93.8%	↑	Forecast next reported month	
Last reported month performance	93.5%	↓	Forecast month after	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard	**TBA**		Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Corrective Action Statements:

Finance

Key Performance Indicator Names;

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

PLEASE REFER TO THE DETAIL INCLUDED IN THE MONTH 01 FINANCIAL PERFORMANCE REPORT

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

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: April 2016

Patient Safety

Area	Indicator Type	Indicator		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-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)	3	10	6	6	5	14	5	3	3	8	9	4	7	-	-	Local	0	-	>0	CMO	
	National	QPS4.1	Never Events	0	0	0	0	0	0	0	1	1	0	0	0	0	0	2	National	0	-	>0	CMO	
	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	1	5	2	2	1	3	0	2	2	6	2	0	3	3	26	Local	<=1	-	>=2	CNO	
	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	2	0	2	0	0	3	2	0	1	0	0	2	1	1	12	Contractual	0	1 - 3	>=4	CNO	
	Contractual	QPS7.7	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 4 Avoidable (Monthly)	0	0	0	1	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	108	109	112	113	113	110	108	109	109	109				-	-	National	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months*	114	113	109	109	109	106	105	107	106	105	106			-	-	National	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.21	% Primary Mortality Reviews completed			51%	14%	24%	18%	42%	69%	64%	66%	57%	41%	40%	40%		Local - Q1 target	60		<60	DPS	
	National	QPS.9.22	% Secondary Mortality Reviews completed			0%	0%	0%	0%	14%	0%	7%	0%	0%	0%	0%	0%		Local - Q1 target	20		<20	DPS	
Safety Thermometer	National	QPS10.1	Safety Thermometer - Harm Free Care Score	93.63%	95.12%	95.78%	93.25%	94.57%	92.86%	93.09%	94.20%	92.86%	94.28%	94.82%	93.77%	90.97%	-	-	National	>=95%	90% - 94%	<90%	CMO	
VTE	National	QPS11.1	VTE Risk Assessment	95.41%	95.31%	95.71%	96.67%	95.43%	96.17%	95.65%	94.91%	94.19%	93.20%	93.86%	93.58%	93.82%	93.82%	95.00%	National	>=95%	94% - 94.9%	<94%	CMO	
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	3	3	3	2	4	2	3	0	2	2	3	2	2	2	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	0	1	0	0	0	1	National	0	-	>0	CNO	
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective - NEW**	97.00%	97.58%	97.01%	96.65%	96.68%	99.14%	91.86%	95.70%	97.97%	95.31%	98.61%	95.40%	94.50%	-	-	National	>=95	-	<95%	CNO	
	Contractual	QPS12.15	MSSA Cases (Trust Attributable)	0	3	0	3	2	3	1	0	1	1	2	3	1	1	19	Local	-	-	-	CNO	

Patient Experience

Area	Indicator Type	Indicator		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-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)	41	37	53	59	47	50	54	68	36	63	57	64	57	57	629	-	-	-	-	CNO	
	Local	QEX1.3	Complaints - Number per 10,000 Bed Days (YTD)	16.65	15.87	17.70	19.09	19.31	19.58	19.91	21.08	20.29	20.52	20.84	21.29	24.90	24.90	21.29	-	-	-	-	CNO	
	Local	QEX1.14	Complaints - % of Category 2 complaints responded within 25 days (WAHT)	66.0%	59.0%	53.0%	53.0%	64.0%	86.0%	81.0%	62.0%	77.0%	81.0%	61.0%	55.0%			67.0%	Local	>=90	80-90%	<79%	CNO	
Friends & Family****	National	QEX2.1	Friends & Family - A&E (Score)	73.5	77.2	72.5	68.0	66.2	61.9	69.6	76.6	70.7	72.4	61.6	63.2	70.2	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	83.2	76.0	National	>=71	67-<71	<67	CNO	
	National	QEX2.7	Friends & Family - Maternity (Score)	88.4	84.5	80.7	87.4	86.4	88.5	86.0	82.5	84.9	86.7	78.2	76.1	85.88	85.9	84.2	National	>=71	67-<71	<67	CNO	
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	0	1	0	1	0	0	0	0	0	0	0	0	0	0	2	National	0	-	>0	CNO	

Effectiveness of Care

Area	Indicator Type	Indicator		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-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%	0.5%	0.4%	0.4%	0.4%	0.5%	0.3%	0.5%	0.3%	0.4%	0.5%	0.3%	0.3%	0.4%	-	-	-	-	CMO	
EDS	Local	QCQ1.2	Completion of Electronic Discharge Summaries	73.7%	75.8%	77.7%	77.2%	74.5%	75.6%	79.7%	79.1%	78.1%	74.0%	45.7%	48.0%	40.9%			-	-	-	-		
Hip Fracture	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	51.3%	70.4%	70.0%	68.0%	71.0%	78.0%	56.0%	76.0%	61.8%	59.0%	76.0%	63.1%	55.0%	55.0%	66.0%	National	>=90%	-	<90%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Treatment Pts	69.0%	79.2%	84.0%	76.0%	75.0%	88.0%	63.0%	87.0%	76.0%	68.0%	80.0%	75.9%	63.0%	63.0%	75.9%	National	>=90%	-	<90%	CMO	

Risk Register Activity

Area	Indicator Type	Indicator		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-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	34.0%	30.0%	24.0%	21.0%	19.0%	27.0%	17.0%	14.0%	11.0%	18.0%	12.0%	18.0%	9.0%	9.0%	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%	20.0%	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.

** 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.

* **Complaints and Compliments are reported one month in arrears

****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.

*****QR metrics - data reported for April was extracted on 01/04 and may be reported as March month commencing figures.

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

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: April 2016

Area	Indicator Type		Indicator	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Waits	Local	PW4.0	Backlog > 18 weeks (Admitted)	3715	3628	3119	2952	3008	3122	2997	3134	2764	2770	3083	4202	4,483	4,483	4,202	Local	-	-	-	COO	
	Local	PW4.1	Backlog > 18 weeks (Day Case + Elective Inpatients)	1425	1468	1373	1348	1193	1186	1172	1303	1256	1310	1537	1940	1,993	1,993	1,940	Local	-	-	-	COO	
	National	PW1.1.3	6 Week Wait Diagnostics (Proportion of waiting list)	1.31%	0.81%	1.06%	1.30%	0.95%	0.98%	0.87%	0.97%	1.55%	1.05%	0.71%	3.52%	5.20%	5.20%	1.28%	National	<1%	-	>1%	COO	
	National	CW3.0	RTT - Incomplete 92% in 18 Weeks	87.33%	87.68%	89.07%	90.25%	89.42%	88.81%	89.00%	92.05%	92.05%	92.04%	91.50%	89.20%	88.90%	88.90%	89.20%	National	>=92%	-	<92%	COO	
	Local	CW4.1	Over 52 week waiters who have been treated in month - NEW	1	1	1	3	0	0	1	0	0	0	0	0			7	Local	0	-	>0	COO	
Theatres	Local	PT2.1	Booking Efficiency - ALX	74.00%	72.00%	72.00%	73.00%	70.00%	71.00%	70.00%	72.00%	71.00%	71.00%	77.00%	75.00%			-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT2.2	Booking Efficiency - WRH	92.00%	84.00%	81.00%	86.00%	82.00%	81.00%	82.00%	84.00%	77.00%	82.00%	77.00%	85.00%			-	Local				COO	
	Local	PT2.3	Booking Efficiency - KGH	72.00%	70.00%	67.00%	67.00%	74.00%	68.00%	69.00%	70.00%	70.00%	68.00%	71.00%	71.00%			-	Local				COO	
	Local	PT1.1	Utilisation - ALX	70.00%	66.00%	69.00%	70.00%	69.00%	71.00%	68.00%	70.00%	70.00%	70.00%	72.00%	70.00%			-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT1.2	Utilisation - WRH	75.00%	75.00%	73.00%	74.00%	74.00%	76.00%	72.00%	73.00%	70.00%	72.00%	70.00%	72.00%			-	Local				COO	
	Local	PT1.3	Utilisation - KGH	68.00%	66.00%	63.00%	65.00%	71.00%	67.00%	68.00%	68.00%	66.00%	65.00%	68.00%	68.00%			-	Local				COO	
A & E	National	CAE1.1	4 Hour Waits (%) - Trust	83.99%	86.71%	85.46%	85.61%	86.43%	85.00%	88.21%	88.83%	86.97%	81.37%	78.70%	78.77%	80.60%	80.60%	85.30%	National	>=95%	-	<95%	COO	
	National	CAE1.1a	4 Hour Waits (%) - Trust inc. MIU - from September 14	86.89%	88.59%	88.21%	88.35%	88.83%	87.64%	90.25%	90.66%	89.07%	84.30%	82.40%	82.30%	84.40%	84.40%	87.90%	National	>=95%	-	<95%	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile ^ (inc Kidd MIU)	45	20	23	25	34	31	28	28	28	35	49	54	40	40	-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment (All Patients) (Mins) - 95th Percentile ^ (inc Kidd MIU)	37	22	23	24	27	31	24	28	28	32	42	46	34	34	-	National	<=15mins	-	>15mins	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	43.66%	49.65%	47.14%	43.50%	41.16%	38.20%	41.09%	42.04%	41.58%	41.74%	38.40%	37.74%	54.00%	54.00%	43.43%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	86.47%	92.16%	90.85%	89.69%	87.99%	86.34%	87.23%	88.10%	88.18%	86.02%	85.58%	81.65%	91.70%	91.70%	88.62%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes - WMAS data	51	6	17	30	29	39	22	26	38	29	26	68	31	31	381	Local	0		>0	COO	
Cancer**	National	CCAN5.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	80.73%	85.12%	75.37%	78.10%	86.50%	75.10%	79.30%	79.40%	89.10%	86.30%	84.40%	75.30%	74.00%	74.00%	81.20%	National	>=85%	-	<85%	COO	
	National	CCAN7.0	62 Days: Wait For First Treatment From Consultant Upgrades: All Cancers	100.00%		60.00%	18.20%	66.70%	54.60%	66.70%	55.60%	100.00%	80.00%	100.00%	100.00%	58.33%	58.30%	70.00%	National	>=90%	-	<90%	COO	
	National	CCAN8.0	2WW: All Cancer Two Week Wait (Suspected cancer)	91.47%	90.28%	86.84%	83.10%	81.80%	81.40%	85.00%	88.30%	90.40%	84.10%	89.00%	77.30%	39.40%	39.40%	85.70%	National	>=93%	-	<93%	COO	
	National	CCAN9.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	85.28%	98.15%	84.21%	63.50%	83.10%	66.90%	71.40%	80.10%	82.60%	82.90%	91.20%	79.40%	34.50%	34.50%	80.00%	National	>=93%	-	<93%	COO	
	National	CCAN10.1	Cancer Long Waiters (104 Day +) includes suspected and diagnosed - treated in month - NEW			14	10	2	6	12	10	6	2	4	5	10			-	-	-	-	COO	
Stroke***	Local	CST1.0	80% of Patients spend 90% of time on a Stroke Ward (Final)	97.67%	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	94.29%	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	68.75%	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 ****	103%	100%	103%	100%	100%	101%	101%	102%	102%	108%	102%	102%	102%	102%	102%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX ****	93%	93%	91%	85%	91%	93%	94%	96%	94%	104%	104%	96%	91%	91%	94%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN2.3	Beds Occupied by NEL Stranded Patients (>7 days) - last week of month										65.10%	41.60%	48.40%	55.60%			Local	<=45	-	>45		
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute	57	37	48	41	39	31	59	25	34	26	33	27	36	36	457	-	-	-	-	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute	2532	2198	1146	1178	1010	778	1362	817	918	807	1,090	725	739	739	14561	-	-	-	-	COO	
	Local	PIN4.2	Bed Days Lost Due To Acute Bed No Longer Required (Days)	3,237	3,359	2,876	2,783	3,438	3,057	3,900	3,133	3,832	3,966	3,320	3,468	3,038	3,038	40,369	-	-	-	-	COO	
Elective	National	PEL3.0	28 Day Breaches as a % of Cancellations*****	25.0%	15.9%	10.2%	23.8%	16.4%	18.4%	12.3%	12.7%	42.6%	19.7%	14.6%	36.1%	38.33%	38.33%	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			TBC	-	-	-	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	0	0	0	0	0	0	1	1	1	1	0	0	0.00	0.00%	4	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	5.3	5.1	5.1	5.3	4.9	4.8	4.5	4.3	4.6	5.0	4.6	4.7	4.75	4.8	4.8	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	6.9	6.7	6.7	7.0	6.5	6.4	6.3	5.9	6.5	6.9	6.5	6.5	6.54	6.5	6.6	-	-	-	-	COO	

**Theatre Dashboard has failed due to a significant data quality issue which is waiting to be resolved by Operations*
*** Cancer _this involves small numbers that can impact the variance of the percentages substantially.*
**** Stroke data is moving from locally applied rules to national rules at the point of publishing the April data had not been signed off.*
*****Bed occupancy data source is Bed State Report.*
*****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: April 2016

Area	Indicator Type	Indicator		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-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)	59	32	50	32	221	130	52	67	42	67	106	49	57		906	Local	-	-	-	DoHR
Turnover	Local	WT1.0	Staff Turnover WTE %	10.2%	10.5%	10.5%	11.0%	11.4%	11.6%	12.3%	11.9%	12.3%	12.8%	12.7%	13.0%	13.0%		12.97%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.3	Nursing Staff Turnover - Qualified	10.1%	10.7%	10.7%	10.9%	10.9%	11.2%	12.1%	12.8%	13.2%	14.0%	13.7%	14.2%	14.3%		14.2%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.4	Nursing Staff Turnover - Unqualified	11.8%	11.6%	11.1%	11.6%	12.9%	13.2%	14.0%	13.9%	13.9%	13.6%	13.7%	13.8%	14.0%		13.8%	Local	9-10%	<>9-10%	-	DoHR
Sickness & Absence	Local	WSA1.0	Sickness Absence Rate Monthly (Total %)	3.84%	4.02%	4.10%	4.19%	4.31%	4.50%	4.82%	4.38%	4.62%	4.70%	4.38%	4.17%	4.06%		4.17%	Local	<= 3.50%	>=3.51% & <=3.99%	>= 4.00%	DoHR
Temporary Staffing	Local	WTS1.0	Agency Staff - Medics (WTE) Indicative	148.0	157.6	158.1	165.8	173.0	176.0	176.7	170.7	163.4	159.4	154.8	158.7	126.6		158.7	Local	<=85	85.1-100	>100	DCE
Induction	Contractual	WIN1.3	% of eligible staff attended Induction	85.1%	89.7%	95.5%	89.2%	92.1%	93.5%	73.8%	87.3%	94.6%	100.0%	73.4%	87.0%	100.0%	100.0%	88.2%	Contractual	>= 90%	80 - 89%	< 80%	DoHR
Statutory and Mandatory Training*	Contractual	WSMT10.2	% Of Eligible Staff completed Training	82.6%	83.7%	84.5%	85.8%	82.1%	84.2%	84.4%	85.5%	87.2%	87.1%	86.9%	86.8%	87.7%	87.7%	85.1%	Contractual	>= 90%	60.1-89.9%	<=60%	DoHR
Appraisals	Contractual	WAPP1.2	% Of Eligible non-medical Staff Completed Appraisal	78.9%	79.6%	80.4%	82.7%	77.0%	75.2%	74.4%	74.5%	78.2%	78.3%	76.2%	79.9%	81.1%	81.1%	77.9%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP2.2	% Of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	85.6%	83.6%	83.8%	86.4%	85.1%	84.1%	84.0%	82.7%	81.6%	81.4%	83.0%	82.4%	80.2%	80.2%	83.6%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP3.2	% Of Eligible Consultants Who Have Had An Appraisal	89.7%	89.1%	90.0%	88.3%	87.2%	85.5%	85.3%	85.3%	82.0%	83.5%	85.2%	84.6%	83.7%	83.7%	86.2%	Contractual	>= 85%	71 - 84%	< 71%	DoHR

**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: April 2016

Area	Indicator Type	Indicator		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kite mark
																				On Target	Of Concern	Action Required		
Scheduled Bookings	National	MSB1.1	Women Booked Before 12 + 6 Weeks	88.6%	85.6%	88.0%	89.0%	87.7%	89.0%	88.5%	93.3%	92.0%	88.5%	88.6%	91.3%	85.9%		89.2%	National	>=90%	-	<90%	CNO	
Deliveries	Contractual	MDEL1.0	Deliveries	465	511	519	507	472	484	496	484	439	447	462	496	441		5782	Contractual	<=465	466 - 516	>516	CNO	
Births	Contractual	MBIR1.0	Total Births	471	521	532	515	478	490	504	492	447	454	470	502	449		5876	Contractual	<=480	481 - 531	>532	CNO	
Normal Vag. Deliveries	Contractual	MNVD1.0	Maintain Normal Vaginal Delivery Rate	62.5%	57.5%	56.6%	57.7%	62.7%	63.7%	56.9%	56.8%	56.7%	57.3%	60.6%	63.3%	56.0%		59.3%	Contractual	>63%	63% - 60%	<60%	CNO	
C- Section	Contractual	MCS1.0	Total Caesareans	25.8%	28.2%	33.7%	32.6%	28.1%	26.6%	31.3%	32.6%	30.5%	29.8%	28.6%	27.6%	32.7%		29.6%	Contractual	<27%	27% - 30%	>30%	CNO	
	Contractual	MCS1.1	Elective Caesareans	12.8%	9.3%	12.8%	12.3%	10.0%	11.0%	15.0%	13.6%	13.2%	11.6%	13.0%	11.7%	13.8%		12.2%	Contractual	<=11.2%		>11.2%	CNO	
	Contractual	MCS1.2	Emergency Caesareans	13.0%	18.8%	20.8%	20.3%	18.1%	15.6%	16.3%	19.0%	17.3%	18.1%	15.6%	15.9%	18.8%		17.4%	Contractual	<=15.2%		>15.2%	CNO	
Outcome Indicators	National	MOI1.0	Breast Feeding Initiation Rates	70.2%	71.1%	72.5%	73.0%	72.0%	74.6%	73.0%	68.6%	69.7%	70.1%	71.1%	70.6%	71.7%		71.4%	National	> 74%	70% - 74%	< 70%	CNO	
	Contractual	MOI3.0	Midwife Led Care %	23.7%	21.0%	22.0%	21.1%	20.5%	23.9%	20.1%	20.9%	19.4%	18.3%	22.5%	22.4%	19.5%		21.3%	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

Date of meeting: 8 June 2016 **Enc G4**

Report to Trust Board (in public)

Title	**Financial Performance – Month 1 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	• Formulate plans to deliver the contracted levels of activity whilst striking a balance between additional activity session costs and fines. • CIP Plans for the full £24.3m target need to be formulated and implemented urgently to coincide with the ramp up of the target over the coming months.
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.

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.

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, P**ayment 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

- The Trust has delivered a Month 1 deficit of £4.84m, broadly in line with the £4.76m planned deficit.
- The high levels of emergency demand and reduced additional activity sessions have impacted income across the elective, day case and outpatient points of delivery. The expenditure variance to some extent reflects the lower than planned activity levels and reduced expenditure associated with additional activity sessions. The consequential impact on the key performance metrics has resulted in high levels of anticipated fines.
- Against a target of £1.7m the Trust delivered £1m of savings. However, the variance from plan is benefitting by £0.5m from the back phased CIP with only £1.5m of the £24.3m target in Month 1.
- Agency expenditure continues to fall and has dipped below £2m per month for the first time since March 2015. Agency cap breaches are expected to reduce over the coming months as further savings schemes take effect.
- The Trust held a balance of £13.1m at the end of April, an increase on the year-end balance of £10.9m. The Trust currently has cash support secured until July 2016 with a commitment from NHSI to provide cash support to cover the planned deficit.

Title of report	Financial Performance – Month 1 2016/17
Name of director	Rob Cooper

Report to Trust Board

Worcestershire NHS
Acute Hospitals NHS Trust

Finance Report
Month 1

Rob Cooper

Interim Director of Finance

27th May 2016

Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

Position Overview

The Trust recorded a deficit of £4.84m in April. This is broadly in line with the planned deficit of £4.76m. The position was driven by significant under achievement against the income target which was offset by the largely related underspends on Pay and Non-Pay. In reviewing the variances from plan below it is important to recognise that £0.5m of growth has been factored into both income and expenditure plans.

£'000	Var	Variance Analysis	Pages
Patient Care Revenue	(1,662)	Anticipated fines £0.9m adverse, Inpatient income £1.1m adverse, Outpatient income £0.2m adverse and Other Contract income £0.5m favourable. Initial estimates indicate that the Junior Drs strike reduced income by £0.4m. Note that across income PODs £0.5m of growth was factored into plans which has not materialised.	11-15
Pay	1,167	As noted above, the budgeted growth did not materialise (£0.4m favourable variance). Across Nursing and Medics £0.3m of the variance was due to a reduction in additional activity sessions. A further £0.3m is due to vacancies across STT and non clinical staff groups.	6-9
Non Pay	427	NP delivered positive variances across most areas due to the impact of low activity levels, contingencies and comparatively low CIP targets.	6
Total of key variances	**(68)**		
Other	(19)		
Total variance from plan	**(87)**		

Key Messages

- The high levels of emergency demand and reduced additional activity sessions have impacted income across the elective, day case and outpatient points of delivery. The expenditure variance to some extent reflects the lower than planned activity levels and reduced expenditure associated with additional activity sessions.
- The consequential impact on the key performance metrics has resulted in high levels of anticipated fines.
- £0.5m of the income underperformance and expenditure underspend is related to growth built into plans that has not materialised. Hence, the there is no impact on the bottom line.
- The variance from plan is benefitting by £0.5m from the back phased CIP with only £1.5m of the £24.3m target in Month 1 (page 16). Plans need to be formulated and implemented urgently to coincide with the ramp up of the target over the coming months.

Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

Income – The anticipated fines (page 13) and the activity under performance (page 12) are partly related to emergency pressures (page 15) and partly resulting from the reduced levels of additional activity sessions (page 8). The underperformance is mostly concentrated in T&O, General Surgery and Gastroenterology which together account for £1m. This was offset by a positive variance against Other Contract Income of £0.4m due to CCG QIPP non delivery; these were expected to commence from the beginning of the financial year within the plan. Daycase and outpatient activity is expected to recover to planned levels during May. However, emergency activity is above April levels and well above planned levels with the inevitable impact on elective activity exacerbated by continuing low levels of additional activity sessions. In addition, initial estimates are that strike action by Junior Doctors reduced income by £0.4m.

Pay – As expected, expenditure has reduced by £0.6m compared to March (page 6) reflecting the impact of the £10m full year reduction and the reduced levels of additional activity sessions (page 8). Pay under spent by £1.2m across all staffing groups and was driven by the benefit of £0.4m growth funding and the impact of reduced additional activity sessions worth £0.3m. The balance was generated by vacancies in STT and Non Clinical staff not covered by agency staff (£0.2m and £0.1m respectively).

Agency expenditure and cap breaches – Agency expenditure continues to fall and has dipped below £2m per month for the first time since March 2015. Despite the reduction in agency expenditure the breaches remain at around 600 per week due to a further reduction of the capped rates and the extension of framework breaches to all staff groups from April. Breaches are expected to reduce over the coming months as further savings schemes take effect. The Trust's agency ceiling of £22.9.m appears achievable when taking into consideration the anticipated delivery of in-year savings. (Page 9).

Non Pay – The non pay expenditure (page 6) is in line with lower than planned activity levels including lower than anticipated levels of outsourcing.

Cash - The Trust held a balance of £13.1m at the end of April, an increase on the year-end balance of £10.9m. 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 the remaining balance of £11.3m will provide the Trust with cash support until July 2016.

CIP - Against a target of £1.7m the Trust delivered £1m of savings. £0.1m of the shortfall is related to the delays in the Silver Ward move which was enacted in mid May. The remaining £0.6m gap reflects the lack of identified schemes. Current performance must be viewed against a phasing profile that significantly increases the target savings required as the year progresses. By the end of April, the Trust had identified plans of £17.2m; the saving target for the year is £24.3m. (Page 16).

Financial Risks & Forecast - At the end of month 1, alongside performance against savings targets, a failure to deliver contracted income and fines represent the largest risk to the Trust's financial position. We will also need to manage additional cost pressures such as increases in clinical vacancies and service developments such as OPAL.

Worcestershire NHS
Acute Hospitals NHS Trust

Appendices

Trustwide Position

Worcestershire NHS
Acute Hospitals NHS Trust

Table 1

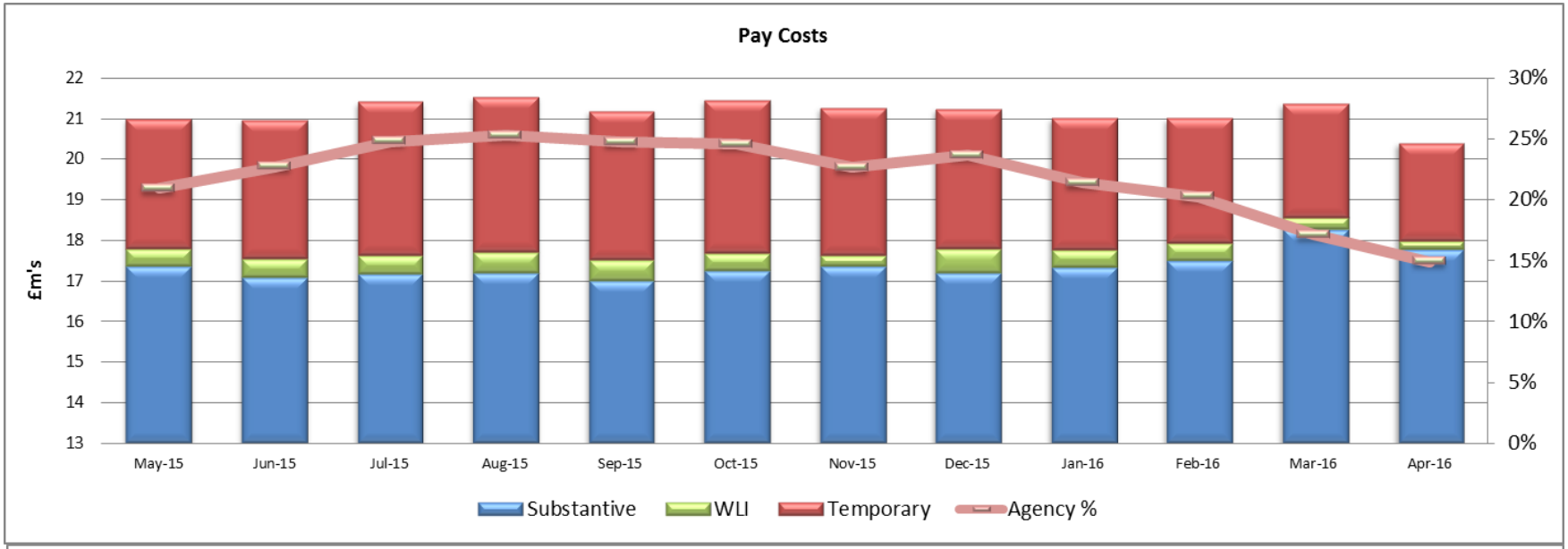
April 16 (Month 1)

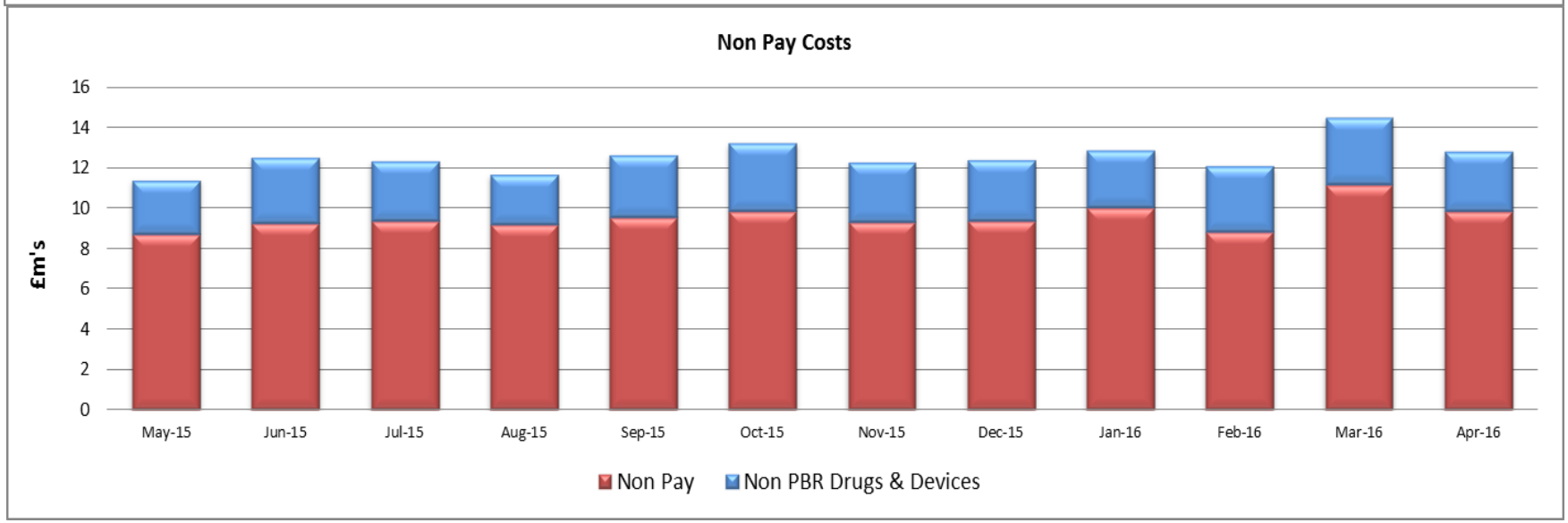
Income & Expenditure	Current Month			Full Year
	Plan	Actual	Var	Plan
	£000s	£000s	£000s	£000s
Operating Revenue & Income				
Patient Care Revenue	27,093	25,431	(1,662)	317,661
Other Operating Income	2,038	2,073	35	24,918
Non PBR Drugs & Devices	2,933	2,933	0	41,319
Total Operating Revenue	**32,064**	**30,437**	**(1,627)**	**383,898**
Operating Expenses				
Pay	(21,573)	(20,406)	1,167	(256,356)
Non Pay	(10,311)	(9,884)	427	(113,592)
Impairment impact				
Non PBR Drugs & Devices	(2,933)	(2,933)	0	(41,319)
Total Operating Expenses	**(34,817)**	**(33,222)**	**1,594**	**(411,267)**
EBITDA *	**(2,753)**	**(2,785)**	**(32)**	**(27,369)**
EBITDA %	-8.6%	-9.1%		-7.1%
Depreciation	(832)	(832)	0	(9,982)
Net Interest, Dividends & Gain/(Loss) on asset disposal	(1,177)	(1,232)	(55)	(14,123)
Reported Total Surplus / (Deficit)	**(4,762)**	**(4,849)**	**(87)**	**(51,474)**
Less Impact of Donated Asset Accounting	6	6	0	72
Less Impact of Impairments	0	0	0	0
Surplus / (Deficit) against Control Total	**(4,756)**	**(4,843)**	**(87)**	**(51,402)**
Surplus / (Deficit) %	-14.8%	-15.9%		-13.4%

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

Pay & Non Pay

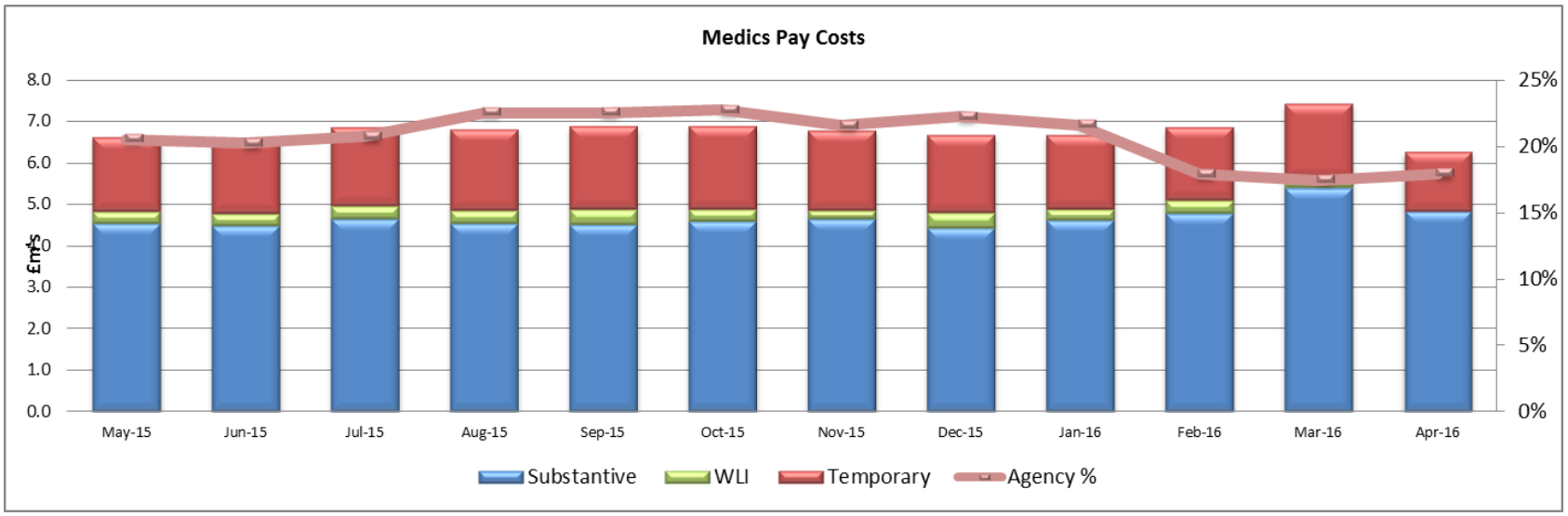
Worcestershire NHS
Acute Hospitals NHS Trust



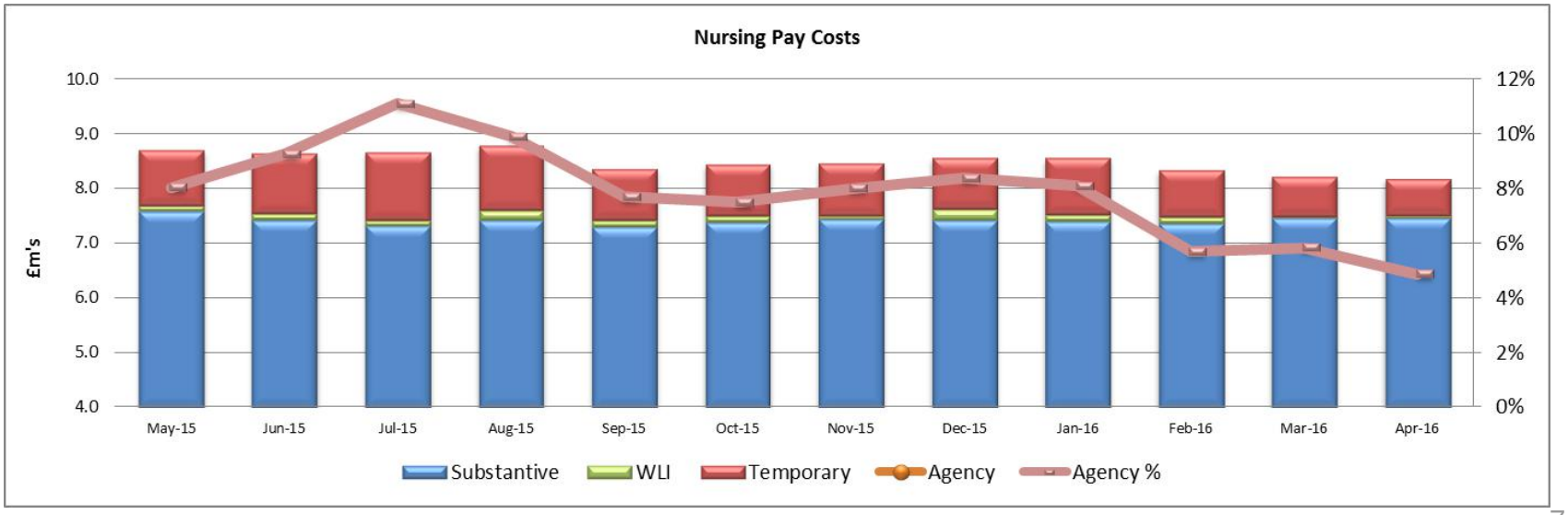


Medics & Nursing Pay

Worcestershire NHS
Acute Hospitals NHS Trust

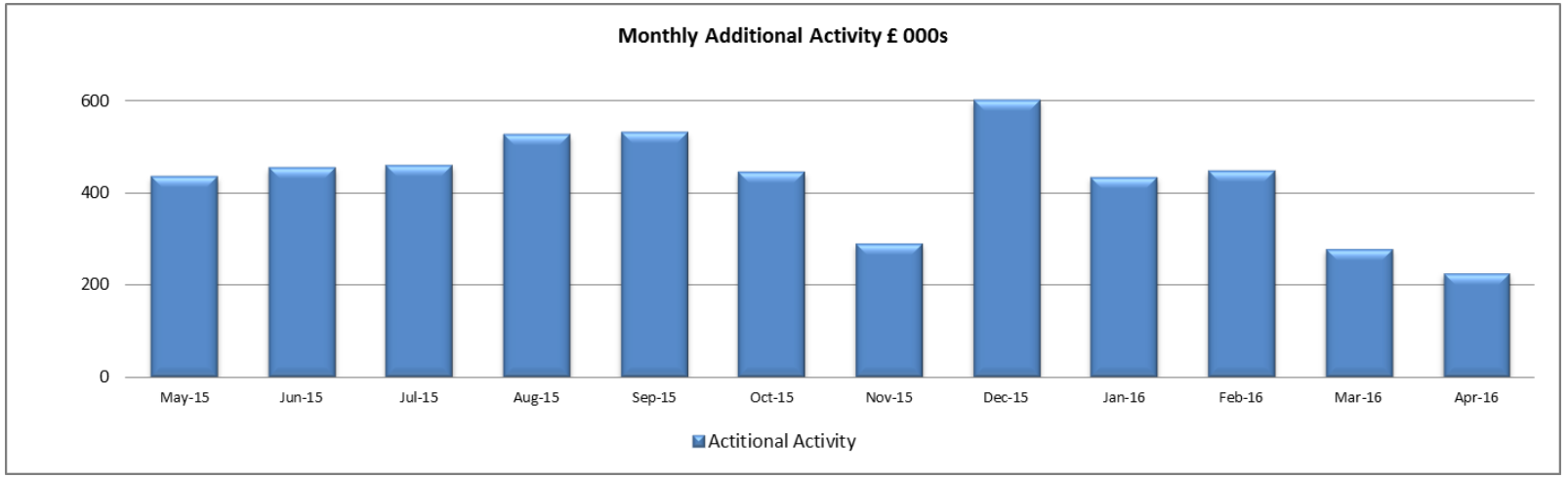


Note. Month 4 contained a YTD change from a net position to a gross position for Consultants sub-contracted to other Trusts.



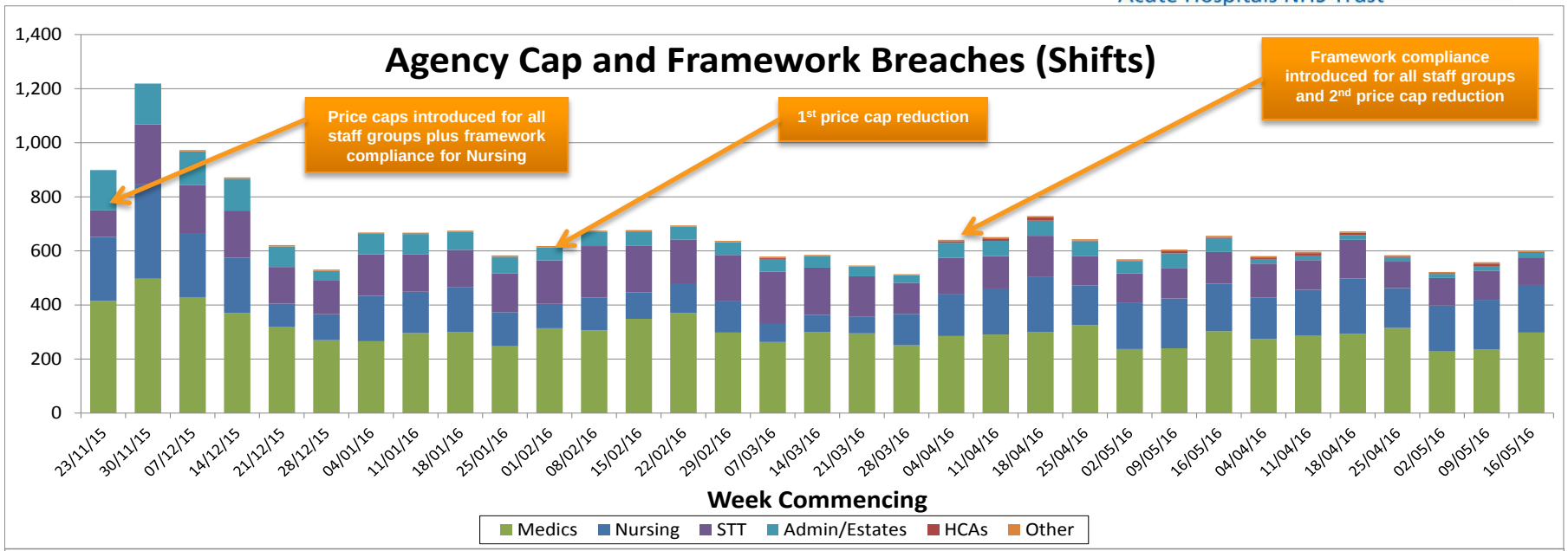
Additional Activity Sessions

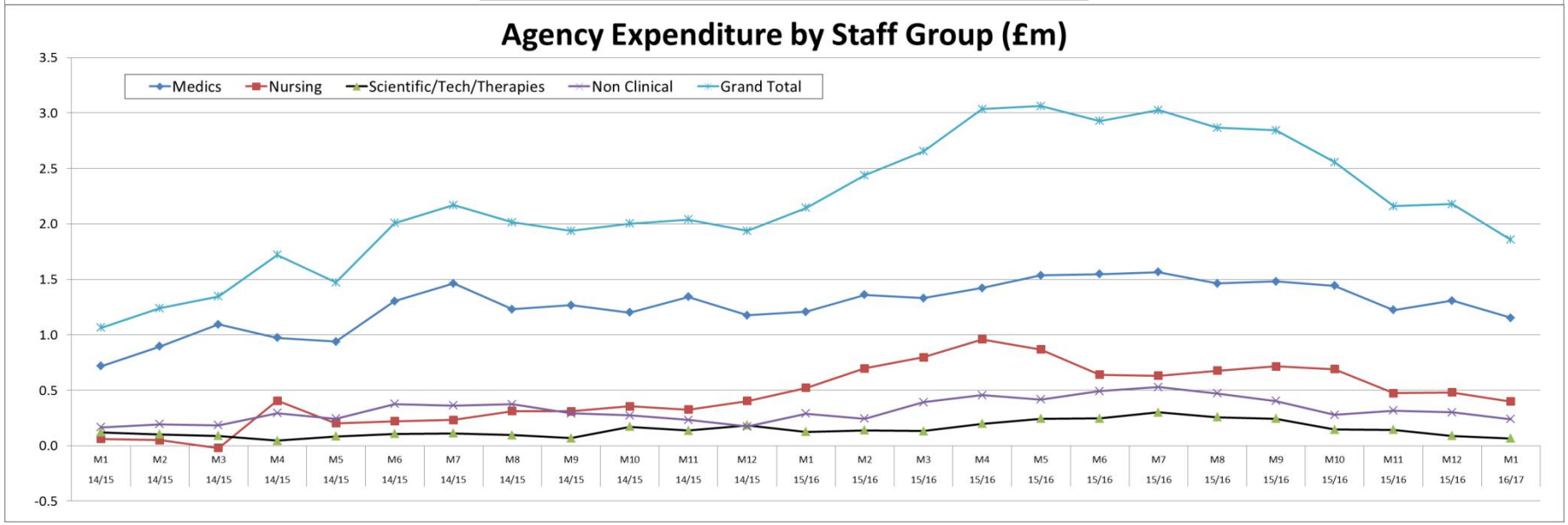
Worcestershire NHS
Acute Hospitals NHS Trust



Agency Breaches and Expenditure

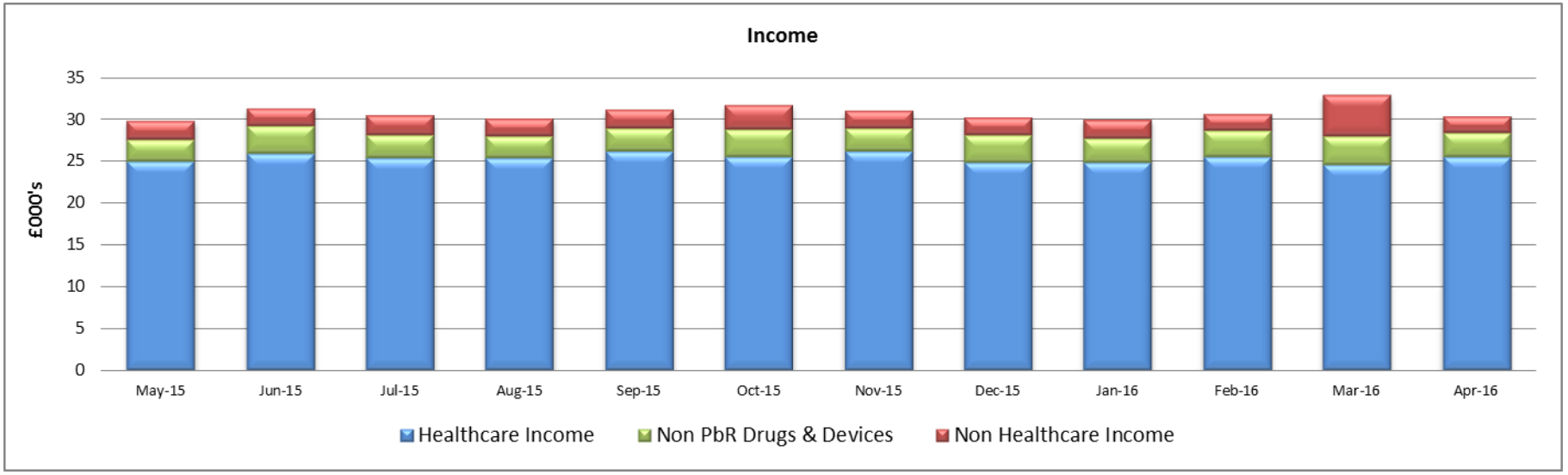
Worcestershire NHS
Acute Hospitals NHS Trust





Income

Worcestershire NHS
Acute Hospitals NHS Trust



Income

Worcestershire NHS
Acute Hospitals NHS Trust

	In Month				Full Year	
	Plan	Actual	Var	%	Initial Plan	Current Plan
	£'000	£'000	£'000	£'000	£'000	£'000
Elective	2,266	1,885	(381)	(17%)	27,293	27,293
Daycase	2,902	2,560	(342)	(12%)	35,063	35,063
Non Elective - Emerg	7,431	7,120	(311)	(4%)	88,795	88,795
Non Elective - Other	137	98	(40)	(29%)	1,610	1,610
Total Inpatients	**12,737**	**11,663**	**(1,074)**	**(8%)**	**152,760**	**152,760**
Outpatients New	1,645	1,459	(187)	(11%)	19,953	19,953
Outpatients F Up	1,573	1,526	(47)	(3%)	19,312	19,312
Outpatients Procedure	687	732	45	7%	8,525	8,525
Total Outpatients	**3,906**	**3,717**	**(189)**	**(5%)**	**47,790**	**47,790**
ED Attendances	1,326	1,328	2	%	16,645	16,645
Community MIU	172	178	6	4%	2,155	2,155
Total ED/MIU	**1,497**	**1,506**	**8**	**1%**	**18,800**	**18,800**
Maternity - Delivery	1,166	987	(179)	(15%)	13,267	13,267
Maternity - Non Delivery	4	0	(4)	(100%)	47	47
Maternity - Outpatient	2	2	0	20%	19	19
Maternity Ante Natal	750	849	100	13%	8,625	8,625
Maternity Post Natal	123	113	(10)	(8%)	1,598	1,598
Total Maternity	**2,045**	**1,951**	**(94)**	**(5%)**	**23,555**	**23,555**
Paed - Daycase/Elective	21	23	2	11%	250	250
Paed - Non Elective	422	421	(1)	(%)	5,527	5,527
Paed - Outpatient	216	240	24	11%	2,645	2,645
Paed - BPT, Drugs, CQUIN	123	110	(13)	(11%)	1,501	1,502
Paed - Neonatal Cot Days	354	396	41	12%	4,250	4,250
Total Paediatrics	**1,137**	**1,190**	**53**	**5%**	**14,174**	**14,175**
Chemotherapy Delivery	**325**	**315**	**(10)**	**(3%)**	**3,828**	**3,828**
Drugs PBR Excluded	1,758	1,758	0	%	25,700	25,951
Critical Care ITU/HDU	854	725	(128)	(15%)	10,242	10,242
Other Contract Income	4,539	5,034	495	11%	55,663	55,618
Total Other Contract Income	**7,151**	**7,518**	**367**	**5%**	**91,605**	**91,811**
Non Elective - Emerg Threshold	0	0	0		0	0
Financial Sanctions	0	(891)	(891)		0	0
Contractual Risk	(135)	0	135		(1,624)	(1,624)
Total Contractual Deductions	**(135)**	**(891)**	**(756)**	**559%**	**(1,624)**	**(1,624)**
Non Contract Income	578	609	31	5%	7,970	7,883
Phasing Adj	787	787	0	%	0	0
	30,026	**28,364**	**(1,663)**	**(6%)**	**358,859**	**358,980**

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

Activity

Worcestershire NHS
Acute Hospitals NHS Trust

	In Month				Full Year	
	Plan	Actual	Var	%	Initial Plan	Current Plan
Elective	813	669	(144)	(18%)	9,679	9,679
Daycase	4,413	3,933	(480)	(11%)	64,901	53,771
Non Elective - Emerg	3,512	3,396	(116)	(3%)	42,403	42,403
Non Elective - Other	49	43	(6)	(12%)	575	575
Total Inpatients	**8,788**	**8,041**	**(747)**	**(8%)**	**117,559**	**106,429**
Outpatients New	11,549	10,288	(1,261)	(11%)	138,738	138,738
Outpatients F Up	19,991	19,516	(475)	(2%)	243,400	243,400
Outpatients Procedure	3,952	4,097	145	4%	48,800	48,800
Total Outpatients	**35,492**	**33,901**	**(1,591)**	**(4%)**	**430,939**	**430,939**
ED Attendances	12,166	12,140	(26)	(%)	152,768	152,768
Community MIU	2,910	3,016	106	4%	36,539	36,539
Total ED/MIU	**15,076**	**15,156**	**80**	**1%**	**189,307**	**189,307**
Maternity - Delivery	513	436	(77)	(15%)	5,845	5,845
Maternity - Non Delivery	199	180	(19)	(10%)	2,312	2,312
Maternity - Outpatient	3,588	3,548	(40)	(1%)	44,112	44,112
Maternity Ante Natal	521	584	63	12%	5,989	5,989
Maternity Post Natal	448	408	(40)	(9%)	5,802	5,802
Total Maternity	**5,269**	**5,156**	**(113)**	**(2%)**	**64,061**	**64,061**
Paed - Daycase/Elective	32	39	7	21%	415	415
Paed - Non Elective	551	513	(38)	(7%)	7,220	7,220
Paed - Outpatient	1,336	1,445	109	8%	16,080	16,080
Paed - BPT, Drugs, CQUIN	0	0	0		270	0
Paed - Neonatal Cot Days	735	784	49	7%	8,816	8,816
Total Paediatrics	**2,654**	**2,781**	**127**	**5%**	**32,801**	**32,531**
Chemotherapy Delivery	**791**	**917**	**126**	**16%**	**11,130**	**11,130**
Drugs PBR Excluded	0	0				
Critical Care ITU/HDU	806	733	(73)	(9%)	9,673	9,673
Other Contract Income	0	0				
Total Other Contract Income	**806**	**733**	**(73)**	**(9%)**	**9,673**	**9,673**
Non Contract Income						
Phasing Adj						

Estimated Fines (subject to validation)

Worcestershire NHS
Acute Hospitals NHS Trust

£'000	Apr-15	YTD Total
Fines & Penalties		
RTT (Incomplete)	(419)	**(419)**
A&E Waits	(180)	**(180)**
Ambulance Handover	(86)	**(86)**
Cancer Waits	(207)	**(207)**
6 week Diagnostics	0	**0**
RTT 52 weeks	0	**0**
12 Hour Trolley Waits	0	**0**
MRSA, Cancelled Ops, Never Events	0	**0**
Total Fines & Penalties	**(891)**	**(891)**
Worc MRET	0	**0**
Associate MRET	0	**0**
Total Other	**0**	**0**

The table shows that RTT fines are continuing. Dermatology, Oral Surgery, T&O and Thoracic (Resp) Med are the Specialties contributing the majority.

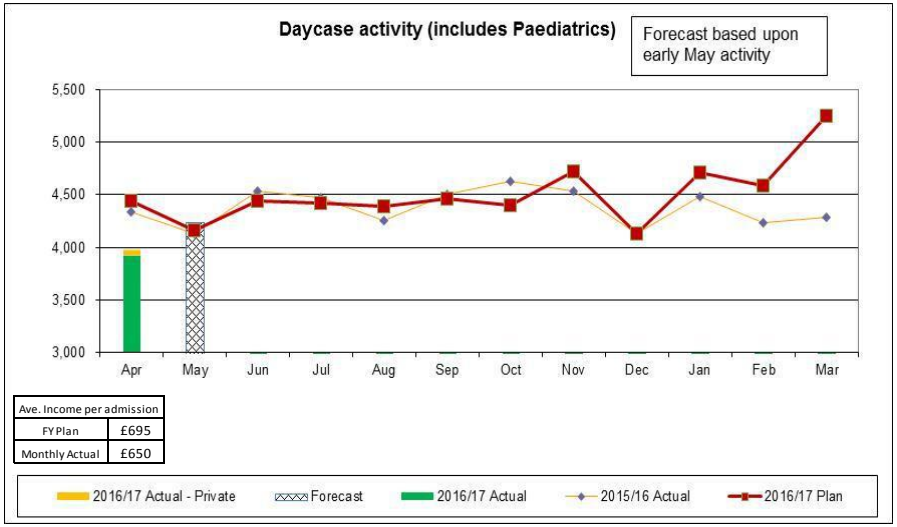
A&E waits are at same level as end of 2015/16 which had seen growth in the final quarter

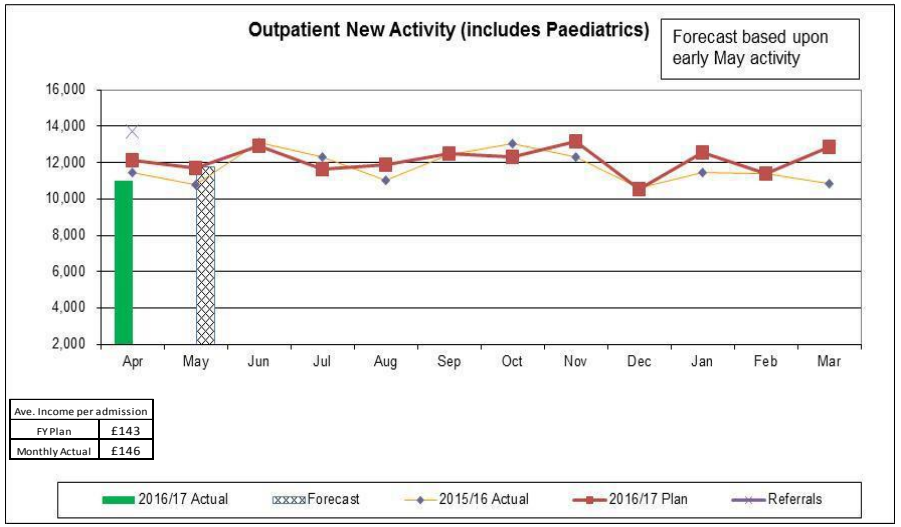
Ambulance are lowest level since June 2015.

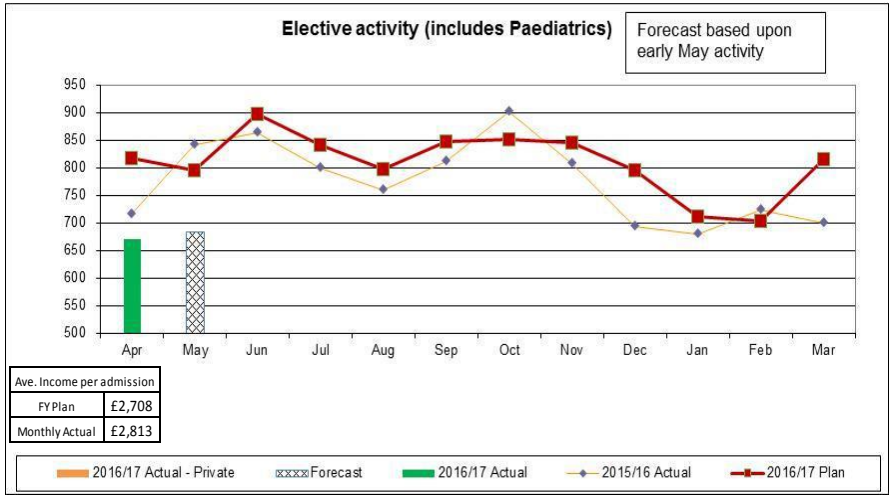
Cancer waits have increased dramatically. The highest monthly value last year was £55k. These are early draft and are being checked by the team.

Elective, Day Cases & Outpatients New

Worcestershire NHS
Acute Hospitals NHS Trust



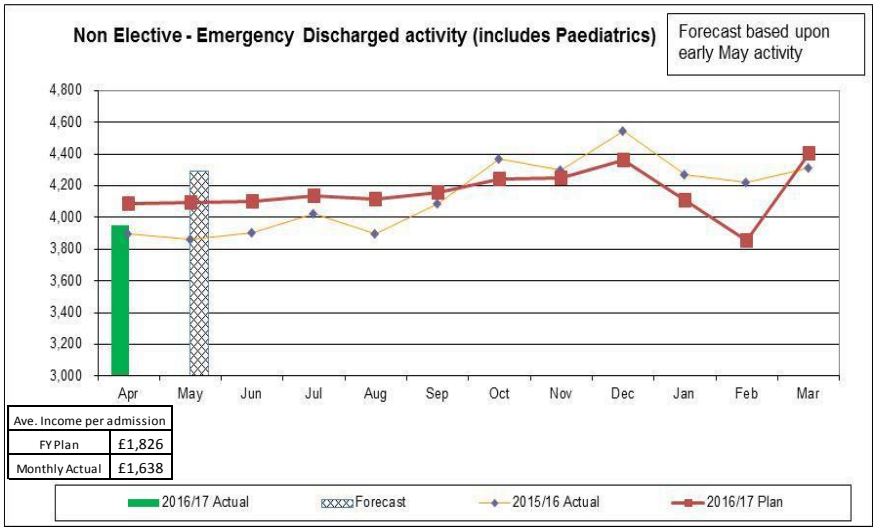


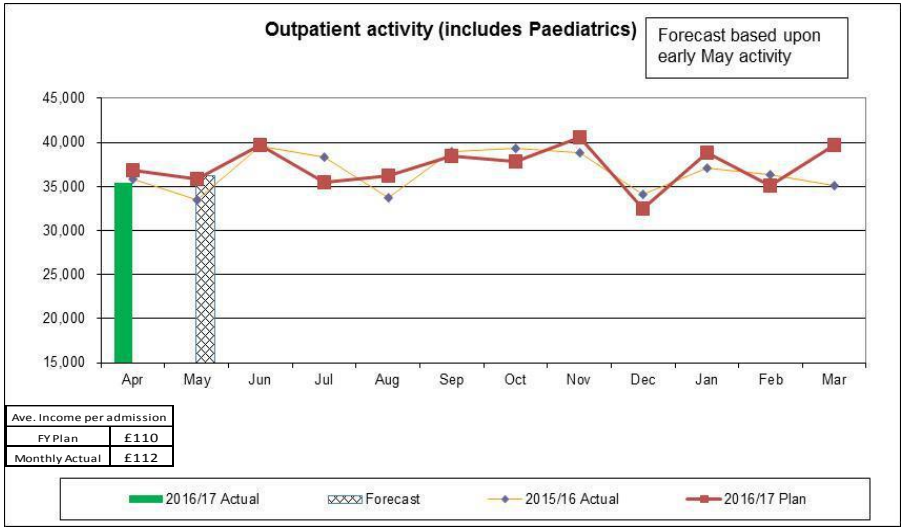


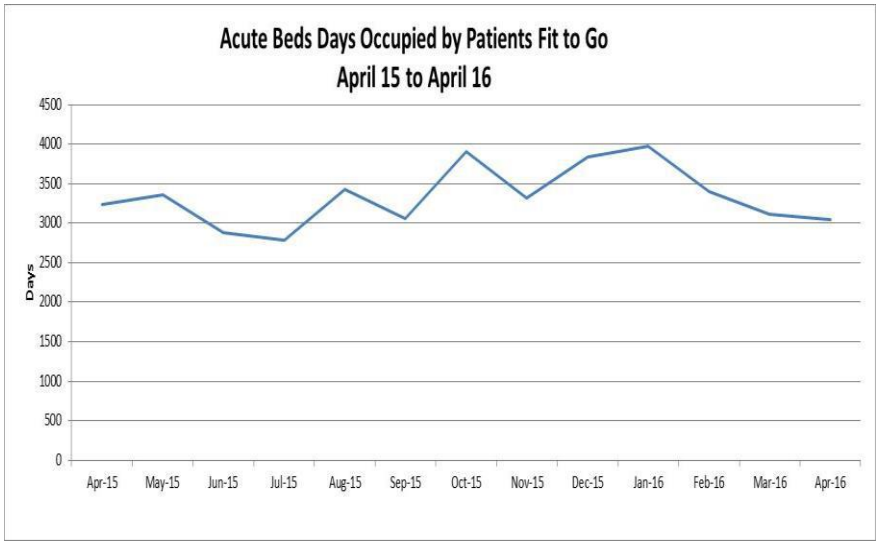
Activity performed within Trust and sent Private				
	Daycase		Elective IP	
	Trust	Private	Trust	Private
Apr	3,923	50	670	0
May	0	0	0	0
Jun	0	0	0	0
Jul	0	0	0	0
Aug	0	0	0	0
Sep	0	0	0	0
Oct	0	0	0	0
Nov	0	0	0	0
Dec	0	0	0	0
Jan	0	0	0	0
Feb	0	0	0	0
Mar	0	0	0	0
YTD	3923	50	670	0

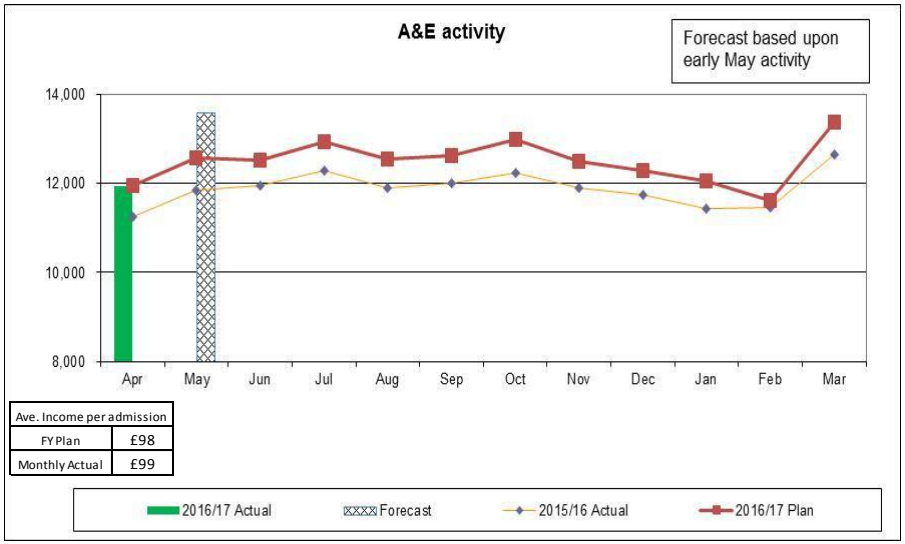
Outpatients, Non Elective and A&E

Worcestershire NHS
Acute Hospitals NHS Trust



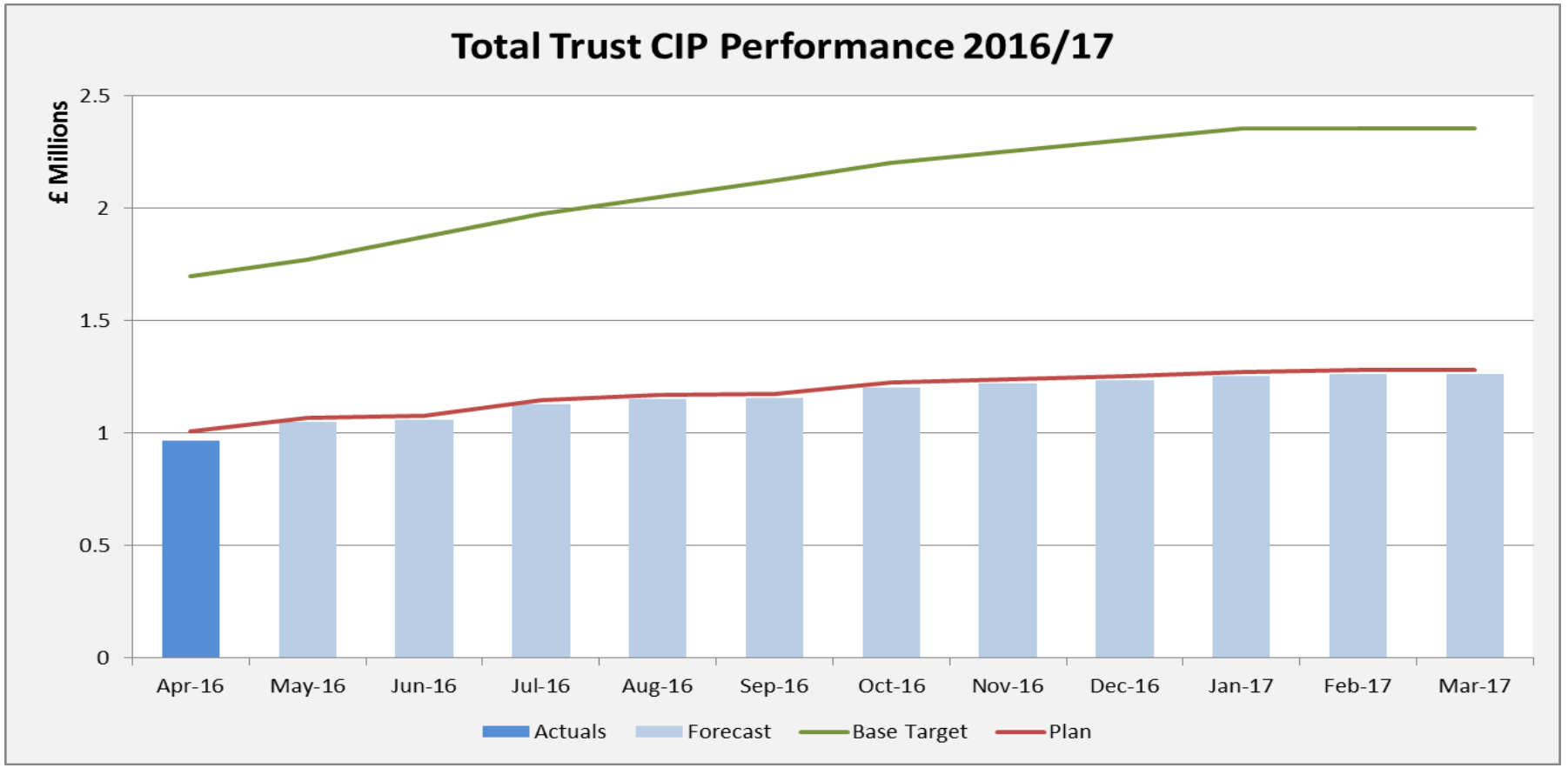






CIP – Target £24.3m

Worcestershire NHS
Acute Hospitals NHS Trust



Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8th June 2016 **Enc. G5**

Report to Trust Board (in public)

Title	**Sustainable Development Plan (2016 Update)**
Sponsoring Director	**Chris Tidman, Interim CEO** **James Longmore, Asset Management & ICT**
Author	**Ray Cochrane, Head of Estates**
Action Required	The Board is requested to support 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.
Previously considered by	**Not applicable**

Priorities (√)

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

Related Board Assurance	2665 - If we do not achieve wider service redesign in a timely way we

Framework Entries	will have inadequate numbers of clinical staff to deliver quality care 3140 - If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected
Legal Implications or Regulatory requirements	This report covers Statutory issues: • Sustainability • Climate Change Levy • Energy usage
Glossary	DH – Department of Health

Key Messages

This paper highlights the Trust's current position regarding sustainable development.

Using the DH's 'Good Corporate Citizen' self-assessment tool, the Trust's current performance produced a baseline score of 32%. As a guide, NHS organisations with no board level commitment on sustainable development will typically score 25%.

This places the Trust on an improved trajectory towards full compliance though less than where we would ideally like to be. To improve matters, a Committee has been established within the Trust to further develop the Trust's sustainability objectives, targets and profile.

In broad terms, capital investment is key to being able to develop and deliver energy saving schemes and alternative sources of development capital are being identified by the Trust Estates Department.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8th June 2016 **Enc. G5**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 8th June 2016

1. Situation

Previously to 2014 the Trust did not have sustainability plans and strategies which placed the Trust at risk of financial and reputational damage through fines, failure to comply with Statute and DH Statutory and Mandatory requirements. The Trust has since corrected this position and adopted its Sustainable Development Management Plan in May 2014. The plan commits the Trust to deliver business operations in a manner that recognises its social, economic and environmental sustainability responsibilities. The following summarises the Trust's current position and where we aspire to be.

2. Background

Compliance with statutory and mandatory requirements is imperative, It is equally essential that the Trust invests in its infrastructure to ensure that energy efficient schemes are not only implemented but actively encouraged thus ensuring that county-wide buildings are improved to make them not only more sustainable, energy efficient but to ensure that control systems and the energy saving process is automated were reasonably practicable to do so. Lord Carter's recommendations are very clear about achieving savings through buildings control and management.

A significant reduction in Climate Change Levy's paid through reduced energy usage will naturally flow from such works with the Trust aspiring to have all buildings meeting BREEAM "Excellent" criteria over time.

3. Assessment

3.1 Key risks

An aging and inefficient infrastructure throughout the Trust results in a poor energy efficiency, increased energy usage, increased light pollution, wasteful practises (such as leaving lights on) and procedures that cannot (by design and purpose) be improved upon.

The PFI building has been built to an affordability model and that did not fully recognise and consider the long term impact to sustainability through a lack of sub-metering, minimum insulation, basic energy controls and a lack of an energy model rating. The building was designed and built to meet the minimum acceptable criteria required at the time to achieve financial close. To significantly improve matters will require significant capital investment.

The Trust's estate has recently been re-valued and, taking into account the construction standard of build, this exercise has resulted in an overall devaluation.

In recent years, energy improvement works have been regularly deferred to allow available capital to be spent on clinical priorities, resulting in a loss of efficiencies which grows exponentially as systems age and become obsolete.

3.2 Controls in place

The Estates and Facilities Team endeavour to keep systems functioning though

many are at end of life. There is minimal scope for improvement without significant capital investment which will allow modern equipment to be specified and installed to lower energy consumption and result in areas of high energy usage being identified and targeted for further improvements.

There are quarterly Sustainability Committee meetings though these are currently poorly attended; the format and content of these meetings has recently been changed to encourage increased participation which will have the added benefit of improving stakeholder participation.

The Trust has arranged a 'Sustainability Day' for 15th and 16th June to try encourage greater awareness and interest sustainability right across the Trust. These will take place at the Alexandra Hospital and Worcestershire Royal Hospital. Kidderminster will also have an event hosted later in the year.

We have arranged further involvement with Engie, the PFI Hard FM contractor, Engie are global specialists in energy management and it is expected that their increased involvement countywide will identify additional energy saving opportunities and provide a standardised approach to be identified and maintained.

Specialist 'Salix Funding' can allow for basic schemes to be funded and paid back through savings achieved – allowing the Trust to pay for capital improvements and gain the savings when the payback period has ended (usually 5 years) .

In partnership with the Procurement Team, we have retendered our energy contract and entered into an agreement with Laser – a public sector co-operative scheme run by Kent County Council, it is anticipated that this arrangement will result in significant energy savings over the next two years and the simpler invoicing arrangements will result in additional savings through lower energy tariffs, more efficient bill paying and efficiencies generated through a recognised managed service agreement.

The DoH Estates and Facilities Dashboard identifies that we are in the lower quartile (the best 25% of trusts) for energy purchase price, however this is offset by higher, inefficient energy usage.

3.3 Actions

The Trust's approach to sustainable development has been developed to be delivered in three distinct stages:

These stages are:

1. Getting Started (Understanding Sustainability) (Starting Phase)
   Taking Ownership, Taking Action

2. ON THE WAY (Transitional Phase)
   Expectation that sustainability is becoming the norm

3. GETTING THERE (Innovation Phase) Target 2020
   Sustainability is routine, culturally embedded and self-regulating

The Trust's actions thus far indicate that the Trust is at the "Getting started" stage:

- Coordinating officer appointed to develop and drive the Trust sustainability

objectives (March 2014)

- Board level approved sustainable development management strategy and implementation plan developed and adopted May 2015.
- Established current status with regards to sustainability utilising the Good Corporate Citizen Metrics (September 2014)
- Committee with membership from across the Trust directorates has been formalised to deliver the Trusts sustainability objectives as defined within the Trust's sustainable development management strategy and the implementation plan (SDMIP) (September 2014).
- Key actions from Sustainable Development Management Committee (SDMC) to date include:
  a) Unifying campaign name and logo for promoting sustainability within the Trust.
  b) Draft sustainable procurement strategy following a review of the Trust existing approach to procurement of goods and services by the procurement Team in support of the objective outlined in the SDMIP.
  c) Review of the approach to the procurement of energy supplies and actions to secure more cost effective energy supply contracts.
  d) Draft Sustainable Transport and Travel Strategy
  e) Draft Waste Management Strategy

Energy conservation initiatives and opportunities 2016-17 (and beyond)

- Closure of two inefficient Trust buildings planned for 2016-17 (A Block, Kidderminster; Aconbury east, WRH)
- Energy centre refurbishments - Work in progress to secure Tenders for the works. Likely to be Salix funded.
- Chiller and air handling units replacements (Alexandra Hospital design works in progress, Proposals predicts significant cost savings on running cost and avoidable costs such the hiring costs of portable air conditioning units)
- Lighting systems and lighting controls upgrade:
  (Alexandra Hospital public car park lights to receive intelligently controlled LED lamps. Similar works proposed for Kidderminster and retained estates at Worcester Newtown Road)
- Insulation works;
  Valves and pump insulation jackets installation fitted at Alexandra hospital plant room 5 and at Kidderminster Hospital plant rooms
- Physiotherapy pool cover replaced saving on pool water temperature, heat and water losses by evaporation
- Replacement glazing (Survey works proposed)
- Metering services (Sub metering strategy and automated meter reading proposed for individual buildings and major energy and water consuming plants)

3.5 Success criteria

The Good Corporate Citizen assessment tool prompts the Trust with action and initiatives to improve performance. The recommendations for overall improvement are suggested by the GCC as being:By 2012, the Trust should be "Getting there" in at least two questions in each area of the test - or achieve a minimum of 22% in each area of the results.

- By 2015, the Trust should be "Getting there" in at least four questions in

each area of the test, and "Excellent" in at least two questions in each area - or achieve a minimum of 56% in each area of the results.

- By 2020, the Trust should be "Excellent" in all areas of the test - or achieve a minimum of 78% in each work area of the GCC metrics.

"Getting there" refers to a score of 4 or more out of 9 (>44%)
"Excellent" refers to a score of 7 or more out of 9 (>78%)

4 Recommendation

The Board is requested to support 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.

James Longmore
Director Asset Management & ICT

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc H1**

Report to Trust Board (in public)

Title	**Audit and Assurance Committee report**
Sponsoring Director	**Bryan McGinity** **Chair – Audit and Assurance Committee** ***Presented by Andrew Sleigh, Vice Chair***
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Board is recommended to: • Approve the membership of the Audit Panel • Receive assurance in relation to the management of claims • Receive assurance in relation to the management of risk • Note the receipt of the Whistleblowing annual report • Note the Committee Annual Report • Note the Gift and Hospitality register for 2015/16 • 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	The Committee reviews and provides assurance on the overall management of the BAF risks.
Legal Implications or Regulatory requirements	
Glossary	

Key Messages

This is the routine report from the Audit and Assurance Committee to the Trust Board and covers the meeting held on 12 May 2016.

Title of report	Audit and Assurance Committee Report
Name of director	Bryan McGinity

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc H1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 8 JUNE 2016

1. Situation

The Audit and Assurance Committee met on 12 May 2016. This report details the business undertaken at that meeting.

2. Background

The Audit and Assurance Committee provides assurance on systems and processes in place at the Trust. It is a key assurance committee.

3. Assessment

3.1 Assessment of the working of the Workforce Assurance Group

The Committee received a paper outlining the performance of WAG. Due to unforeseen circumstances, the Committee were unable to discuss this with the chair of WAG. The Committee were assured by the contents of the paper and have requested attendance at a future meeting when the proposed changes to the terms of reference have been operational.

3.2 Claims Annual Report

The Committee were assured on the process for managing claims within the Trust. It was noted that the Trust is average for the number of claims and that the number reduced in 2015/16. The Committee also noted the concern raised that not all incidents have an investigation prior to the claim being lodged with the trust.

3.3 Data Quality

The regular data quality audit was presented. This showed that there had been a problem with staff shortages so the clinical coding audit plan has been disrupted, but the mandatory section of the IG toolkit has been completed.

There is a new chair of the Data Quality Group which will give a focus on the electronic discharge summary. The Committee raised concern about the number of outstanding discharge letters. However it was confirmed that consultants had spoken directly to GPs about the issues. The EMT will be looking to progress this.

3.4 Risk Strategy – annual review

The Committee received a report in relation to the progress of the Risk Management Strategy. Whilst assurance was gained in relation to the progress of the strategy, the Committee noted that the challenge in respect of actions identified needed to be more robust.

Title of report	Audit and Assurance Committee Report
Name of director	Bryan McGinity

It was understood that the organisational development strategy was undertaking training on roles and responsibilities which would clarify this area for staff and enhance the use and ownership of risk registers.

The committee noted that the work undertaken by the Risk Manager had placed the Trust in a good position to be able to reach 'exemplar status' for risk management.

3.5 **Whistleblowing annual report**

The Annual Report showed that one case had been considered under the whistleblowing policy for 2015/16. This concerned issues around the delivery of management change within the maternity department. The investigation showed that there was evidence of concern in the introduction of new ways of working. Work had been undertaken on team building and the issues were now resolved.

3.6 **External Audit**

The External Auditors reported that they were expecting to qualify the value for money opinion. The final accounts process was underway and the Audit and Assurance Committee would approve the accounts prior to the next Board meeting.

A referral will be made to the Secretary of State as the Trust would be reporting a year end deficit. This is a routine referral

3.7 **Internal audit**

The Head of Internal Audit Opinion was limited assurance. The Assurance Framework was robust and supported the Annual Governance Statement. The Head of Internal Audit took into account third party reports such as the CQC report when making his assessment.

The Committee received the audit into the Information Governance toolkit.

3.8 Contract Management Board update

The Committee were disappointed that the recommendations from the audit undertaken in 2015 had not been fully implemented. However it was acknowledged that relationships were better.

A full review of the recommendations was requested.

3.9 Audit Panel

The Committee have agreed that the membership of the Audit and Assurance Committee, together with the Director of Finance and Deputy Director of Finance would constitute the Audit Panel. This would

then consider the requirement to tender for external audit services.

3.10 Items received

The Committee received the following items:

- A report on ward based risk registers
- Annual Governance Statement
- Audit and Assurance Annual Report (attached as appendix 1)
- Declarations of interest for the Directors, Senior Managers and consultants
- Gifts and Hospitality register for 2015/16 (attached as appendix 2)
- Tender waivers for 2015/16

4 Recommendation

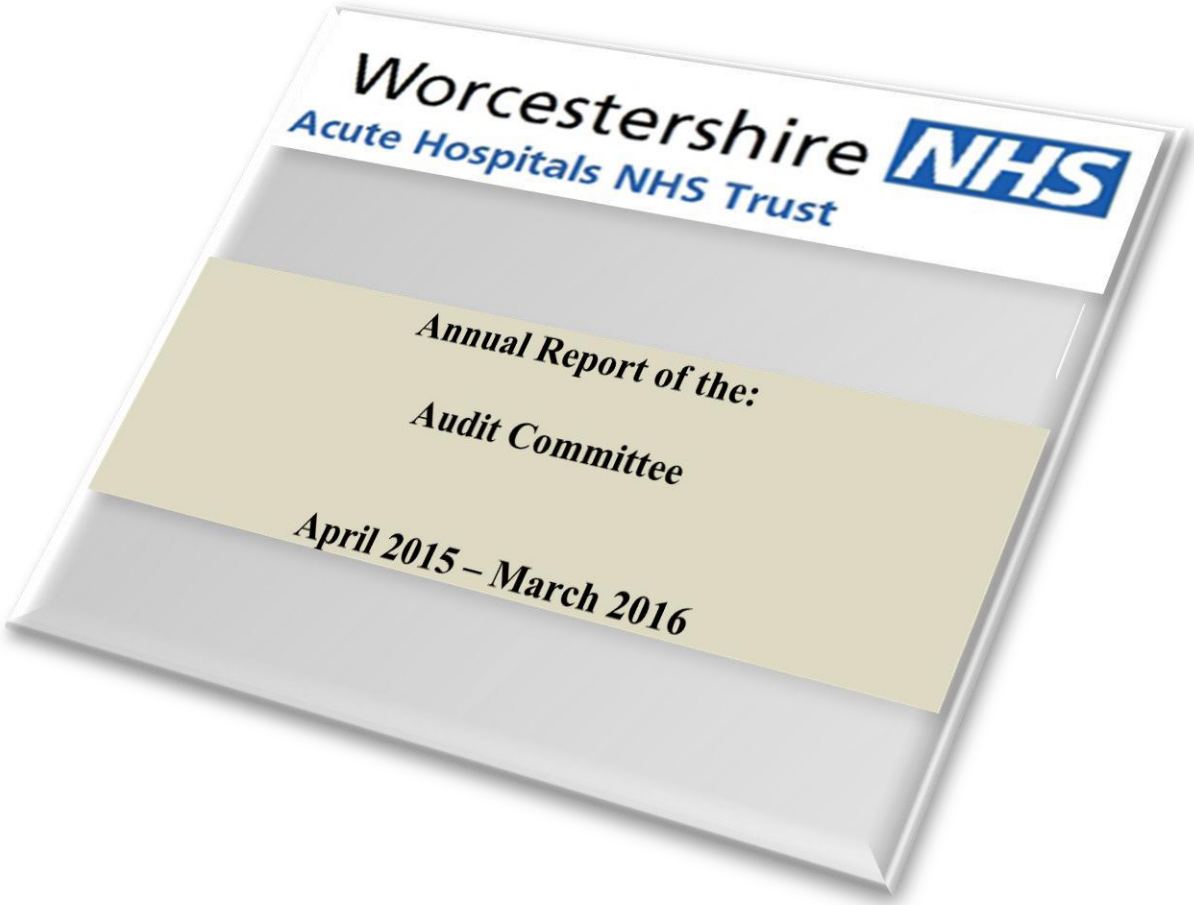
The Board is recommended to:

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

Bryan McGinity
Chair – Audit and Assurance

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc H1**



Patients | Respect | Involvement | Delivery | Efficiency

Taking pride in our healthcare services

Title of report	Audit and Assurance Committee Report
Name of director	Bryan McGinity

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc H1**

Foreword

Our mission – To provide our patients with safe, effective and personalised care delivered consistently across all sites by skilled and compassionate staff – demonstrated the Board's commitment to safety and quality, and our PRIDE values ask staff to ensure that they put patients at the centre of all they do on a daily basis.

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

The evidence in this report provides assurance to support the statements made by the Chief Executive in the Annual Governance Statement 2015/16.

Bryan McGinity
Audit Committee
Chairman

Andrew Sleigh
Audit Committee
Vice-Chairman

Stephen Howarth
Audit Committee
Member

Title of report	Audit and Assurance Committee Report
Name of director	Bryan McGinity

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc H1**

Audit Committee Annual Report

For the year 1st April 2015 - 31 March 2016

1 Introduction

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

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

2 Audit and Assurance Committee's Opinion

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

3 Information Supporting Opinion

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

3.1 Internal Audit

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

At its meeting on 17 March 2016, the Committee received the Internal Audit Progress Report for the 2015/16 financial year. Subsequently, the Trust has received the Annual Internal Audit Report for 2015/16, which incorporates a summary of all work undertaken throughout the financial year, and the Head of Internal Audit Opinion.

The Head of Internal Audit's overall opinion for 2015/16 is that only **limited** assurance can be given as weaknesses in the design and/or inconsistent application of controls put the achievement of the Trust's objectives at risk in a number of areas reviewed.

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

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

Title of report	Audit and Assurance Committee Report
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Significant Assurance

- Client end Financial Systems

Moderate assurance

- Serious Incidents
- Medical Revalidation
- RTT – Follow Up
- Discharge Planning*
- Financial Management / QIPP

Limited assurance has been achieved in the following areas:

- Complaints
- Temporary Staffing
- Waiting List Initiative Payments

With reference to the Assurance Framework, the Head of Internal Audit concluded that
It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2015/16 Annual Governance Statement. The Assurance Framework highlights a number of significant risks to the achievement of the Trust's strategic objectives, and these are monitored regularly by the Trust Board.

During the 2015/16 financial year, a number of reviews were undertaken which were predominantly testing and validation only, rather than full system reviews and assessments that key control objectives were being met. These reviews produced a number of "narrative" reports (to which management is still required to respond) but do not contain an Internal Audit opinion on the level of assurance that internal controls are being complied with.

The Audit and Assurance Committee is satisfied that management has put in place action plans to resolve all recommendations but Internal Audit will be asked to continue to rigorously monitor progress over the next year.

3.2 External Audit

The Trust's external audit is provided by Grant Thornton, who have attended all Audit and Assurance Committee meetings during the year. In May 2015 they presented their Audit Findings Report summarising the findings of their audit of the Trust's 2014/15 financial statements and their on the Value for Money Conclusion. The audit was completed and the audit opinion issued before the deadline specified by the Department of Health.

Grant Thornton issued an unqualified opinion on the Trust's 2014/15 accounts, after reporting the detailed audit findings to the Audit and Assurance Committee. However, Grant Thornton qualified their Value for Money Conclusion on an 'except for' basis due to the reported in-year deficit and planned deficit for 2015/16. This

situation also required Grant Thornton to refer the Trust's financial position to the Secretary of State under section 19 of the 1998 Audit Commission Act. They also provided a limited assurance opinion on the Trust's 2014/15 Quality Account.

The auditor's annual audit letter summarised the issues arising from their 2014/15 audit and Grant Thornton's engagement lead, Jon Roberts, presented this to the Trust's Annual General Meeting in September.

Progress and update reports have been presented to each Audit and Assurance Committee meeting during the year providing committee members with an overview of progress with the 2015/16 audit and highlighting issues in the wider Health environment. This includes briefings on Grant Thornton's national report on Health sector issues.

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

3.3 Other Assurance Providers

3.3.1 Local Counter Fraud Specialist (LCFS)

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

3.3.2 Management

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

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

4.1 Membership of the Committee

The Members of the Committee during the period of the report were as set out in the Annual Governance Statement in the Annual Report. The full disclosure of interests is on the website at http://www.worcsacute.nhs.uk/about-us/trust-board-whos-who/.

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

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet at least 4 times a year. Seven meetings took place during the period April 2015 to March 2016. The attendance register is as set out in the Annual Governance Statement in the Annual Report.

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

4.2.2 Work Programme

The Committee is satisfied that it has covered all work planned as outlined in the work programme in appendix 1.

4.2.3 Committee Assessment

The Committee was assessed by the external company Deloittes who also undertook a review of the Board, Quality Governance Committee and Finance and Performance Committee. A report of this is within the Trust Board section of the Annual Report.

4.2.4 Key Business Considered by the Committee during the year

The Committee:

a) Received assurance from the internal audit on the design and operation of the Board Assurance Framework and associated process to support the Trust's AGS.
b) Reviewed the 2014/15 Annual Accounts and Annual Report, recommending to the Board that these be approved.
c) Reviewed and approved instances where the Waiver to Tenders procedures has been applied ensuring satisfactory explanation as to why.
d) Reviewed the Internal Audit work plan for 2015/16 and has emphasised to management, its requirement to be involved in the development of the areas to be included in the programme.
e) Reviewed progress on implementation of actions agreed through audit recommendations.

5. Conclusions

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

5.1 Board Assurance Framework

The Assurance Framework has been reviewed by the Audit and Assurance Committee and full Board during the year.

5.2 Governance Arrangements

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

The Annual Governance Statement (AGS) for 2015/16 was reviewed by the Committee during May 2016.

6. Recommendation

Title of report	Audit and Assurance Committee Report
Name of director	Bryan McGinity

Given the issues identified in Section 4 and our conclusions in Section 5 we recommend that the Board approves the Audit and Assurance Committee's Annual Report 2015/2016, recognising that it provides it with further assurance to support the Annual Governance Statement (AGS)

Bryan McGinity
Audit and Assurance Committee Chairman

Title of report	Audit and Assurance Committee Report
Name of director	Bryan McGinity

Date of meeting: 8 June 2016 **Enc H1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Audit and Assurance Committee – Work plan 2016

Items	10-3-16	12-5-16	1-6-16 to receive accounts	14-7-16	15-9-15	5-11-15	20-1-16
Internal Audit Annual Report		✓					
Internal Audit Work Plan	✓						
Internal Audit Reports	✓	✓		✓	✓	✓	✓
• Waiting list initiatives (limited assurance) – Inese Robotham to attend. Carole Hewitt organised (25-1-16)	✓						
Internal Audit Progress Report	✓	✓		✓	✓	✓	✓
Annual Audit Letter and Action Plan				✓			
External Audit Annual Plan and Agreement of Audit Fees	✓						
External Audit Reports – Drafts and Final Accounts	✓	✓	✓				✓
External Audit Progress Report	✓ annual benchmarking report	✓		✓	✓	✓	✓
Audit Committee Annual Report		✓					
Trust Annual Report			✓				
Trust Annual Accounts		✓	✓				
Annual Governance Statement		✓					✓
Letter of Representation			✓				

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Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 8 June 2016 **Enc H1**

Items	10-3-16	12-5-16	1-6-16 to receive accounts	14-7-16	15-9-15	5-11-15	20-1-16
Anti Fraud Update Report	✓	✓		✓	✓	✓	✓
Anti Fraud Annual Report	✓	✓		✓			
Anti Fraud Work Plan	✓						
NHS protect report – quality review							✓
Changes to the BAF	✓				✓		✓
Audit Committee Terms of Reference - Review							✓
Audit Committee self-assessment of its own effectiveness (comprehensive assessment Year 1 – interim reviews for years 2 & 3)		✓					
Audit Committee Assessment of External Audit					✓		
Audit Committee Assessment of Internal Audit.		✓			✓		
Data Quality Audit (Rebecca Brown)		✓			✓ action plan		
Private Audit Committee meeting with External Auditors to consider the External Auditors' audit strategy.	✓				✓		
Private Audit Committee meeting Internal Auditors to review and approve Internal Audit Plan.						✓	
Review of SFIs/Standing Orders/Scheme of Delegation							✓
Declarations of interest Gifts and Hospitality		✓					
Review of Accounting Policies							
Review of Tender Waivers	✓ trend analysis	✓				✓	

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Worcestershire NHS
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Date of meeting: 8 June 2016 **Enc H1**

Items	10-3-16	12-5-16	1-6-16 to receive accounts	14-7-16	15-9-15	5-11-15	20-1-16
Review of Debts Write off	✓			✓			✓
Review of Losses & Compensation Payments	✓				✓		
Review of Clinical Negligence Claims		✓					
LSMS							✓
Whistleblowing annual report		✓					
Fees the trust pays to other organisations	✓						
CMB update		✓		✓	✓	✓	✓
QGC Chair							✓
WAG Committee Chair		✓					
Finance & Performance Committee Chair				✓			
Improvement board Chair					✓		
PWC governance action plan		✓		✓	✓	✓	✓

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

GIFTS AND HOSPITALITY REGISTER 2015-16

DATE	NAME OF COMPANY	NAME OF MEMBER OF STAFF/DIRECTORATE	GIFT/HOSPITALITY RECEIVED	APPROXIMATE VALUE	COMMENTS
01/04/2015	Fit4less Gym Daniel Chinn	Riverbank	Easter eggs	£90	
01/04/2015	NatWest Stratford Deb Hughes	Riverbank	Easter eggs	£150	
02/04/2015	Funeral Directors Philip Tomlins	Riverbank	Easter eggs	£145	
02/04/2015	Rich products Hartlebury Ian Adams	Riverbank	Easter eggs	£30	
02/04/2015	eResponse Recruitment Jenna Knight	Riverbank	Easter eggs	£35	
2/4/2015	E Response	Riverbank	20 Easter eggs	£60	
2/4/2015	Mrs Drinkwater	Riverbank	27 Easter eggs	£81	
2/4/2015	Gemma and Andrew Walmsley	Riverbank	50 mini Easter bunnies	£100	
03/04/2015	Cricketers Arms Kidderminster	Riverbank	Easter eggs	£318	
03/04/2015	Tesco Worndon	Riverbank	Easter eggs	£40	
04/04/2015	Westbury Celtic FC Natalie Wood	Riverbank	Easter eggs	£20	
04/04/2015	Nat West Droitwich Cheryl Taylor	Riverbank	Easter eggs	£10	
4/4/2015	Bramley Cottage	Riverbank	96 Easter eggs	£288	
4/4/2015	Tesco	Riverbank	13 Easter eggs	£39	
4/4/2015	Specsavers	Riverbank	28 Easter eggs	£110	

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DATE	NAME OF COMPANY	NAME OF MEMBER OF STAFF/DIRECTORATE	GIFT/HOSPITALITY RECEIVED	APPROXIMATE VALUE	COMMENTS
			4 Teddies 3 Box Chocs		
4/4/2015	Mr Groves	Riverbank	7 Easter eggs Bar choc	£24	
05/04/2015	Darcie & Tallula Eglesfield	Riverbank	Easter eggs	£150	
05/04/2015	Read recruitment	Riverbank	50 Easter eggs	£150	
16-4-15	Grateful patient	James Powell	2 concert tickets Picture	£24	Picture to be framed and hung in department
11-6-15	ACIST	Kavitasagary Karunasaagarar	Cardiac Cross-Sectional Imaging Evening Dinner	£40	
20-22 May	Stryker	Karl Bell	Conference Ireland		
24.6.2015	Grateful Patient	Sarah Birch	1940's fob watch (broken)	?	
22-24-6-15	Takeda	Dr Ian Gee	contribution towards expenses incurred attending the annual BSG meeting in London (22-24/6/15)	£500	
22-24-6-15	Takeda	Dr Thea Haldane	contribution towards expenses incurred attending the annual BSG meeting in London (22-24/6/15)	£500	
30 May	Computacentre	Chris Tidman/James Longmore	FA Cup Final VIP Corporate hospitality	£50	Meal only
	ComputaCentre	James Longmore	FA Cup semi final Corporate hospitality	£50	Meal only

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30.06.2015	Norgine	Janet Gentle & Team	Retirement Lunch	60.00	
22-09-15	Noemalife	David Whitelock	Hotel stay: Lodi Agriturismo Cascina Pezzolo	approx. 100 Euros	Visit to Noemalife HQ and to see a successful deployment of ePMA software that the trust has purchased
23/9/15			Hotel stay: Bologna Hotel Al Cappello Rosso	approx. 118 Euros	
22-09-15	Noemalife	Dan Banton	Hotel stay: Lodi Agriturismo Cascina Pezzolo	100 euros	
3-11-15	Xerox	James Longmore	Dinner @ EHI Live	£30	
		Lisa Martin	attendance at wound care conference, with associated hotel stay and meals	£800	
22-12-15	Tesco	Paediatrics	5 bags of new toys	£700	
9-12-15	Neil Smith	Riverbank	50 selection boxes	C £250	
7/7/15	HCL workforce solutions, 10 Old Bailey, London EC4M 7NG	All Sponsorship for Staff Achievement Awards 2015		£3000	
25/9/15	Planned Office Interiors Ltd1 Forge Farm Offices, Stafford Road, Aston-by-Stone, Staffordshire, ST15 0BH			£500	
25/9/15	Kainos Evolve4-6 Upper Crescent Belfast			£1500	

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	BT7 1NT				
31/7/15	University of Worcester, Hylton Road Worcester	All Sponsorship for Staff Achievement Awards 2015		£1500	
29/6/15	P2GLLP - russell@p-2-g.co.uk			£500	
25/9/15	Siemens Charles Hastings Way Worcester WR5 1DD			£500	
11/8/15	Computacenter, Hatfield Avenue Hatfield, Hertfordshire, AL10 9TW			£3000	
25/6/15	Allscripts, Battersea Studios | 80 Silverthorne Rd | London | United Kingdom SW8 3HE			£1500	
29/6/15	Cofely, WRH, Charles Hastings Way, Worcester			£1500	
25/9/15	Semperian Worcs Hospitals PLC			£3000	
20/7/15	Worcester Ambassadors 232 Malvern Road Worcester WR2 4PA			£500	
01/8/15	ISS			£3030	

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25/9/15	Welch Allyn Cublington Road Aston Abbotts HP22 4ND			£1500	
25/9/15	Hydrop ECS Wrens Court, 55 Lower Queen Street, Sutton Coldfield, West Midlands, B72 1RT			£500	
25/9/15	Chartered Management Institute CMI House Cottingham Rd Corby Northants NN17 1TT			£500	
25/9/15	NHSP;			£3000	
21/7/15	Synergy Synergy Health Derby DE24 8HE United Kingdom			£500	
25/8/15	Xerox Bridge House, Oxford Road, Uxbridge, Middlesex UB8 1HS			£3000	

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20/7/15	Dell 18 Soho Square, London, W1D 3QL UK			£1500	
20/6/15	Royal College of Nursing, 33 Beeches Road, Marlpool Gardens, Kidderminster, DY11 5HE			£500	
4/8/15	Nelson Training, 3 Drake Street, Welland, Malvern.			£500	
25/9/15	Woodrow Mercer dfleckner@woodrow.mercer.com			£500	
25/9/15	Harrold-Jones Services 75 Lifford Lane, Kings Norton , Birmingham, B30 3JH	All Sponsorship for Staff Achievement Awards 2015		£500	
25/9/15	Cisco Crescent House Towers Business Park Wilmslow Road Manchester M20 2JE			£500	
19/9/15	W L Moore Training consultant 2 Caldicott Leys,Ebrington, Gloucestershire			£100	

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11 and 12 September	Guerbet Laboratories Ltd	Dr Inderjeet Nagra	Attending a level 1 cardiac MRI course	£450	
11/12/15	Synertec	Breast screening	staff study day	£200	
		Radiotherapy Department, Oncology Centre	evening meal for a group of 30 Oncology Staff	£500	
9-11/11/15	Advancis	Lisa Martin			
4-1-6	Phillips HealthCare	Richard Johnson	Return flights to Munich for a training day o fusion US machine		
13.01.2016	Stryker UK Ltd	Karl Bell	Sponsored educational trip to Stryker HQ in Mawah New Jersey 23-26 Feb incl travel, return flights, 2 nights accommodation.	£5000-6000	Stryker Products used for knee and hip replacements for last 10yrs. Dveleopments of techniques/future development possibly available to the Trust.
16-18 Mar 2016	Hameln Pharmaceuticals, Gloucester, GL3 4AG	Richard Cattell	travel, accommodation and conference fee for the European Association of Hospital Pharmacy, Vienna	£550+euro600 conference fees	
22.03.2016	St Augustine's High School	Dana Picken	30 Easter Eggs	?£80	
23.03.2016	Jude Prosser	Dana Picken	100 Easter Eggs	?£250-300	

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23.03.2016	Lear Computing	Dana Picken	20 Easter Eggs	?£60	
24.03.2016	e.Response Industrial	Dana Picken	20 Easter Eggs	?£60	
25.03.2016	I force Limited	Dana Picken	Easter Eggs	£50	
26.03.2016	Specsavers	Dana Picken	Easter Eggs	£80	
26.03.2016	The Bramley Cottage Pub	Dana Picken	Easter Eggs	£40	

Kimara Sharpe
April 2016

Title of report	Audit and Assurance Committee
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