Worcestershire NHS
Acute Hospitals NHS Trust

There will be a meeting of the **Worcestershire Acute Hospitals NHS Trust Board** on
Wednesday 7 September 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**	Deputy 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.* The Interim Chairman has added the following declaration of interest: • Spouse is a Director of BBK Ltd a company in the business of marketing for small companies including the health sector Stephen Howarth has updated his Declaration of Interests to include • Director of the Worcester Golf and Country Club		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **6 July 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 6 September 2016.*		
8	**Chairman's Update Report** *For information*	Interim Chairman	**Enc C1**
9	**Chief Executive's Report** *For assurance*	Interim Chief Executive	**Enc C2**

STRATEGY **Board Assurance Framework 2665, 2904, 3140**			
10.1	**Future of Acute Hospital Services in Worcestershire** *For assurance*	Interim CEO	**Enc D1**
10.2	**Trust Management Group** *For assurance*	Interim CEO	**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	**Patient Care Improvement Plan** *For approval*	Director of Planning and Development	**Enc E2**
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*	Deputy CNO	**Enc F2**
FINANCE AND PERFORMANCE **Board Assurance Framework 2888, 2668, 3193**			
13.1	**Finance and Performance Committee** *For assurance*	Committee Chair	**Enc G1**
13.2	**Integrated Performance Report** *For assurance*	Director of Planning and Development	**Enc G2**
13.3	**Financial Performance Report** *For assurance*	Interim Director of Finance	**Enc G3**
GOVERNANCE AND COMMITTEE REPORTS			
14.1	**Health and Safety Annual Report** *For approval*	Interim Chief Operating Officer	**Enc H1**
14.2	**Infection Control Annual Report** *For approval*	Deputy CNO	**Enc H2**
14.3	**Register of seals** *For assurance*	Company Secretary	**Enc H3**
15	**Any Other Business**		
	Date of Next Meeting The next public Trust Board meeting will be held on **Wednesday, 5 October 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 7 JULY AT 12:00 NOON

Present:

Interim Chairman of the Trust:	John Burbeck	
Board members: (voting)	Rob Cooper	Interim Director of Finance
	Stephen Howarth	Non-Executive Director
	Rab McEwan	Interim Chief Operating Officer
	Bryan McGinity	Non-Executive Director
	Andrew Short	Acting Chief Medical Officer
	Andrew Sleigh	Non-Executive Director
	Jan Stevens	Interim Chief Nursing Officer
	Chris Tidman	Interim Chief Executive
Board members: (non-voting)	Denise Harnin	Director of HR & Organisational Development
	Sarah Smith	Director of Planning and Development
	Lisa Thomson	Director of Communications
	Lynne Todd	Board Advisor
	Bill Tunnicliffe	Associate Non-Executive Director
In attendance:	Kimara Sharpe	Company Secretary (minutes)
	Paul Crawford	Patient Representative
	Robin Snead	LiA lead *(minute number 65/16 only)*
Public Gallery:	Press	0
	Public	3
Apologies:	Stewart Messer	Chief Operating Officer
	Alan Harrison	Non-Executive Director
	Marie-Noelle Orzel	Improvement Director

64/16 **WELCOME**

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

65/16 **LISTENING INTO ACTION**

Mrs Thomson introduced Mr Snead, the Project Manager for Listening into Action (LiA). Mr Snead outlined the philosophy behind the LiA process which was a fundamental shift in the way staff work across the Trust. The process empowers staff, giving them the authority to act and make changes within their area of work and beyond.

He outlined the ten work streams which covered all three sites and were from a range of areas. The work streams are set to run over a 20 week period and then other work streams will be taken forward.

Big Conversations have been held on all three sites which invited staff to tell their frustrations and then look at ways in which they can resolve their issues. Feedback has been almost entirely positive. Mr Snead then showed a video made by staff who had attended the events.

There have been a number of actions that have already been made for example in respect of chairs, fridges, food selection and IT. There will be more Big Conversations, particularly with volunteers and patients.

Mr Howarth asked how the initial 10 work streams were chosen. Mr Tidman stated that he had made the final choice from a number put forward by the members of the LiA steering group.

In response to Mr McGinity, Mr Snead stated that there were about 150 who had attended the Big Conversations. The aim was however, to ensure all staff were empowered and that the way of working would be throughout the whole trust. Mr Tidman agreed with Mrs Todd that a number of the work streams contributed to the current challenges faced by the Trust.

Ms Stevens reflected on the work undertaken at Barts. She stated that the effect of LiA would take a few months to be realised and was extremely powerful.

Mr Burbeck thanked Mr Snead for his presentation and looked forward to seeing progress over the next few months.

Resolved: that
The Board

- Noted the content of the story

66/16 **ANY OTHER BUSINESS**
No other items of business were raised.

67/16 **DECLARATIONS OF INTERESTS**
There were no additional declarations of interest

68/16 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 8 JUNE 2016**
Resolved: that

- The Minutes of the public meeting held on 8 June 2016 be confirmed as a correct record and be signed.

68/16/1 **MATTERS ARISING/ACTION SCHEDULE**
The Company Secretary confirmed that all the actions had been completed or not yet due.

69/16 **QUESTIONS FROM MEMBERS OF THE PUBLIC**
Mr David Trigger asked the following question:
Does the Trust intend to make any changes to the clinics and services that the Trust presently provides at the Evesham Community Hospital? If so, could the Board please give information about any planned changes and the timetable for their implementation?

Mr McEwan confirmed that there were no plans to change the services at Evesham. He was keen to ensure that the facilities were optimised and was working with the Health and Care Trust. There were opportunities to improve efficiency and utilisation of theatres and ultimately ensure more productivity.

70/16 **Interim Chairman's Report**

Mr Burbeck spoke to his report which had been previously circulated as enclosure C1. He explained that the Chairman's Action was taken after consulting with the Vice Chair, Chief Executive and Director of Finance and he asked for the Board to endorse the decision make to accept the revised control total.

Mr Howarth was pleased to see the new fines regime.

Mr Burbeck went onto report that he had met with the leaders in the County and has been able to reassure them about the Trust's financial situation and the plans for recovering the performance. There was evidence of good personal relationships between staff of the organisations.

Finally Mr Burbeck reminded board members that the AGM would be held after the Long Service Awards on 29 September at Chateau Impney, Droitwich.

Resolved: that
The Board

- Endorsed the Chairman's Action taken on 16 June

71/16 **Interim Chief Executive's Report**

Mr Tidman stated that he had instigated the agreed emergency changes to in patient paediatric service at the Alexandra Hospital. These would transfer to Worcestershire Royal in early September. He has briefed staff and stakeholders. He recognised that there was a need to focus on the communications strategy over the coming weeks and he described the actions in place. The main message was that the vast majority of children would continue to be seen at the Alexandra Hospital.

He then outlined the plans for the Alexandra Hospital. He was fully committed to ensure that the site was utilised fully and described the services which were planned to move there in the next few weeks which included county wide breast surgery and same day oncology service. Elective orthopaedic surgery had already moved to the site.

Mr Tidman then turned to the remainder of his report. He was delighted with the impact on social media that the Trust was making and he was pleased that there were plans to increase its presence.

He highlighted that Mr Tarum Sharma was presenting at the King's Fund Digital Health and Care Congress about the work he has undertaken in ophthalmology which was about using technology to ensure patients are informed.

Finally he outlined the work undertaken during the ECIP intensive support week. He confirmed that he was working with staff across the county to ensure alignment with the work being undertaken. The Patient Flow Centre would be transferred to the Trust in the next four weeks.

Mr Sleigh emphasised the necessity to ensure that there was a clear communication message in relation to the paediatric services. This was agreed. Mrs Todd added that there needed to be creative solutions to communicating with current and future parents.

Mr Howarth asked about the capacity on site at Worcestershire Royal. Mr Tidman explained that the paediatric beds were ring fenced and the modelling showed that

there was sufficient capacity on the site. A paediatric assessment unit will be developed to try to discharge as many children home on the same day as possible. Dr Short stated that the majority of ill children were acutely ill and the families of those children which have open access due to chronic conditions have been written to by the Trust.

Resolved: that
The Board,

- Received the assurance within the report.

72/16 **STRATEGY**

72/16/1 **Future of Acute Hospital Services in Worcestershire**

Mr Tidman spoke to the previously circulated report from the West Midlands Clinical Senate. The concerns raised in the visit in 2015 had been addressed and the Senate was impressed with the work that had been undertaken. He was keen to progress to public consultation in the Autumn as the delay has meant that emergency changes have had to be put in place. He thanked all the clinicians who have developed the proposals.

Mr McGinity pointed out that there were a number of issues raised within the report that needed to be addressed by the Trust. Mr Tidman committed to bring back the Trust's response to the next Board meeting.

Mr Howarth reported that the patient and public and stakeholder committee have requested clinical input at the consultation meetings. Mr Tidman confirmed that this was in hand.

Mr Burbeck thanked all the staff who have been involved in the process and looked forward to the next steps.

Resolved: that
The Board:-

- Noted the Clinical Senate report

73/16 **QUALITY AND PATIENT SAFETY**

73/16/1 **Quality Governance Committee**

The Chair of the Committee, Dr Bill Tunnicliffe presented the report from the Quality Governance Committee (Enclosure D1). He thanked Ms Stevens for leading an informative discussion on safety and improvement. He explained that an umbrella campaign was being put in place to cover all aspects of safety and quality. He recognised that the Trust needed to develop resources to undertake improvement and he was pleased with the plan to develop a virtual faculty in this area.

He then reported that the Committee received an extensive report on patient and carer engagement and highlighted the 1400 hours of unpaid volunteering the Trust benefitted from in 2015/16. Work to increase the response rates for the Friends and Family test was underway.

The Committee had discussed avoidable mortality at some length. There was evidence of some progress but there was more to undertake. There needed to be a step change in the management of sepsis and he was disappointed in the lack of progress with time to theatre for fractured neck of femur.

He recommended the Annual Report for Safeguarding to the Board and was pleased with the developments in the service.

The deep dive report was from Specialised Clinical Services. The number of open incidents had reduced. He stated that the pathology department had received accreditation.

The Quality Account had received a qualified audit for VTE. This was the second year running and he was disappointed that lessons had not been learnt. A quarterly report had been requested to ensure progress.

Mr Sleigh expressed his frustration that the Trust was not learning from issues. This had been picked up by the CQC.

Ms Stevens stated that she was working with Dr Short on a smarter way to deal with investigations and the associated learning. She outlined the initial thoughts which included a weekly clinically led meeting and a monthly meeting with a wider staff group. She continued to work with Oxford to implement best practice.

Dr Short gave an example of a junior doctor giving ideas about how to ensure wider learning from Serious Incident investigations.

Mr McGinity asked what assurance the Board could have that the complaints response times would improve. Ms Stevens confirmed that she was presenting a revised process to QGC at its next meeting. The process would ensure improvement.

Mr McGinity asked why the lack of theatre space was one reason for the poor performance in respect of the time to theatre for fractured neck of femur, given that theatre utilisation was less than 70%. Mr McEwan confirmed that an underutilised trauma theatre was removed from the Worcestershire Royal Hospital site. Work has now taken place to ensure better utilisation and the theatre is about to be reprovided. This will address lack of capacity on the WRH site. However there continue to be challenges with weekend provision on the Alexandra Hospital site. Mr Tidman stated that lack of theatre space was not the only cause of the issues as the month after the closure of the underutilised theatre, the Trust recorded its best month's performance in this metric. He continued to work with staff to ensure that all the challenges were addressed to achieve sustainable change.

Resolved: that
The Board

- Received assurance on the management of the Patient and Carer Experience Committee
- Noted the summarised annual report into the management of complaints and the actions currently being taken
- Thanked the Patient and Public Involvement Forum for their work
- Noted the assurance received in the management of people who have had their appointments delayed
- Noted the deep dive report into SCS division
- Noted the report into VTE assessment
- Noted the report

73/16/2 **Patient Care Improvement Plan**

Ms Smith presented the report. She acknowledged that more work needed to be undertaken in relation to the information presented to the Board. She stated that there was progress being made and she was confident that with the investment if resources in senior project management support, these changes would become evident to the

Board.

Mr Burbeck complimented her on the report. He asked about the progress with HDU improvement. Dr Short, the Executive Lead, confirmed the actions being undertaken to ensure safety within the HDUs.

In response to Mr McGinity, Ms Stevens confirmed that the divisions were being given support to ensure that their governance teams were fit for purpose.

Mr Sleigh expressed disappointment that only 26% of patients were discharged by midday on the SAFER bundle pilot wards. Mr McEwan stated that the trust wide target was 33%. Significant improvement had been made with board rounds and the categorising of 'red' and 'green' days. He explained the challenges with data collection (patients moved the discharge lounge were still shown as being on the ward) and he was confident that better use of IT would capture this. He stated that a number of discharges would continue to take place after 12 noon for example when community capacity was required. The target of 33% was agreed with ECIP.

Resolved: that
The Board

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

74/16 WORKFORCE

74/16/1 **Workforce Assurance Group**

Mr Burbeck, Chair of the WAG presented the report (enclosure F1). He reported that the Committee had received the final draft of the OD strategy which would be presented to the Board in September. The turnover deep dive did not provide assurance on the causes of the increase and further work is being undertaken.

Mr Howarth commented that staff appeared to be returning to the Trust after leaving. Mrs Harnin agreed and said that this was particularly within maternity. She added that most staff groups were static with their turnover, there was some areas which had high turnover such as radiology. She also confirmed that the 'approval to recruit' process was being revised.

Resolved: that
The Board

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

74/16/2 **Nursing and Midwifery Workforce**

Ms J Stevens presented the report (enclosure F2). She was pleased that the new Lead Nurse for Education and Workforce was now in post. She reported that there had been a huge response to the recruitment to the nursing associate role. A recent development was for the role to be developed across the STP footprint. Extra funding has been secured for the foundation degree at Worcester University for fast track training to commence in September. A return to practice programme is taking place.

Mr Tidman confirmed that positive publicity was being undertaken to support the drive to improve recruitment.

In response to Mr McGinity, Ms Stevens confirmed that as a career choice, nursing was very popular. Health Education England were considering how to promote other NHS careers.

Resolved that
The Board received assurance in relation to

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

74/16/3 **Medical Workforce**

Dr Short presented the quarterly report, enclosure F3. He explained that the report had been previously considered by the Workforce Assurance Group. There had been a significant reduction in medical vacancies and he stated that he was impressed with the quality of consultants wanting to work in Worcestershire. He stated that the Trust was now waiting for national guidance in respect of the implementation of the junior doctor contract following the rejection in the national ballot.

He was pleased that appraisal rates were improving and was in discussion with HR colleagues about ensuring a more transparent process for job planning which would include anonymised publication on the intranet.

Mr Sleigh asked whether there was a tool to aid job planning. Mrs Harnin confirmed that there was, but it is cumbersome to use. She confirmed that work was being undertaken to improve the process.

Resolved that
The Board

- Noted the content of the report and assurances that current key priorities are being progressed to support the management of the Medical Workforce

74/16/4 **Medical revalidation**

Dr Short presented the annual report, enclosure F4. He stated that the position was improving. He was working with HR to recruit a lead for appraisal which would support the process and increase rates.

Resolved that
The Board

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

75/16 **FINANCE AND PERFORMANCE**

75/16/1 **Finance and Performance Committee Report**

Mr Sleigh, Committee Chair, presented the report from the Finance and Performance Committee held on 1 July 2016 (enclosure G1). The Trust was on target for the year end agreed position. He stressed the importance of meeting in year targets. The Committee has requested Ms Smith to review the quality impact analysis process in the light of the savings needed to meet the year end position.

Ms Smith confirmed that the QIA review was underway. She was keen to ensure that QIAs were being undertaken consistently across all programmes of work. Ms Stevens confirmed that she and Dr Short reviewed all the QIAs and she welcomed the work that Ms Smith was undertaking. She emphasised the necessity for training to undertake a QIA.

Resolved that:-
The Board

- Noted the YTD deficit remains close to plan, but with underlying reduction variances in both income and expenditure.
- Noted the need to define the remaining £6M of savings.
- Noted the challenges remaining to achieving key clinical targets and the need for focus needed through the organisation to meet planned trajectories before the end of Q2.

75/16/2 **Integrated Performance Report**

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

She stated that the Trust was significantly challenged in meeting the cancer, RTT, EAS and diagnostics targets. During April and May there had been a planned dip in performance to clear the backlog of patients waiting. She acknowledged that patients were waiting longer than was acceptable. She assured members that a recovery plan was in place and this needed to be sustainable going forwards.

She then invited Mr McEwan to present information in relation to the Emergency Access Standard (EAS). Mr McEwan stated that the Trust has planned that from July the target of 92% for the four hour wait would be met in order for STP funding to be released.

The performance was generally better at the Alexandra Hospital than Worcestershire Royal. Weekly attendance at WRH was up by 9.5% in May. There are challenges with patients being admitted as there is high bed occupancy, consistently above 100%. The acuity of patients tends to be high and increasing with frail elderly patients with many comorbidities increasing – an increase of 20% at WRH in the number of over 75 year olds and a 19% increase at AH in a two year period. There had been a 16% rise in ambulance conveyances in May.

Mr McEwan was pleased to report that despite these pressures, the initial assessment and handover had improved significantly.

He then went onto outline the actions in place to address the change in demand. The new modular build at the ED at WRH will be opened in August and the whole new area including an ambulatory care centre will be operational from September. He explained the benefits of such an area.

He went onto explain that pathway 1 was being reviewed to ensure speedy discharge and he described the work of the OPAL team.

Finally, he stated that June performance was closer to the national average and he was confident that with the support being given into community care, July performance

would improve again.

Mrs Todd thanked Mr McEwan for his comprehensive report. She asked whether the Trust was aware of why there had been an increase in attendances in May. Mr McEwan confirmed that this had happened country-wide. A recent audit undertaken with ambulance colleagues confirmed that 60% of patients who had been bought in by ambulance could have been managed within the community. He was firmly of the belief that many patients could have attended another service.

Mr Tidman echoed Mr McEwan's view and confirmed that following a presentation by ECIP to health partners he was working with the health economy to provide better information about the alternative options available for patients, including the use of MIUs. There had been an acceptance that it was a health economy challenge, not just one for the Acute Trust. One idea that he was pursuing was the provision of contemporaneous information in the EDs about waiting time in MIUs.

Mrs Todd expressed her disappointment with the theatre utilisation figures. Mr McEwan agreed that the figures presented were disappointing. He stated that the presentation at the Finance and Performance Committee by PWC had been encouraging and he outlined the actions being undertaken. He expected to see an improvement in the following month's figures.

Mr Tidman was confident that with better medical engagement and a resultant change in practice would significantly impact on patient flow. Dr Short was meeting with all consultants that afternoon.

In response to a comment from Mr Sleigh, it was agreed to give the Finance and Performance Committee an update on data quality.

Resolved that the Board

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

75/16/3 **Financial Performance Report**

The Interim Director of Finance, Mr Cooper, presented the financial performance report (Enclosure H2) and highlighted the main points. He referred to the income and expenditure position which showed £18,000 away from plan for month 2. Month 3 analysis will include a detailed stock take of budgets and a full year forecast.

Mr Cooper then outlined the risks associated with the financial performance. Income was in large part within the Trust's control. There was a gap of £5.8m in relation to the cost improvement programme and he expressed concern that more impetus was required to deliver the target. Significant elements of the target were related to medical agency spend and the work being undertaken by PWC. However there was a need for an action plan in relation to medical agency as the projection was to increase spend in the next few months. Finally Mr Cooper referred to the additional £3.7m required as a result of the revised control total. He confirmed that this would not be passed onto divisions and stated that with the revised system in respect of fines and theatre utilisation, he was confident that this could be met.

Finally, Mr Cooper emphasised the necessity to meet Month 3 control total to ensure that the Trust received the STP funding.

In response to Mr McGinity, Mr Cooper confirmed that next month's financial performance report would state the revised control total.

Dr Short asked what assumptions had been made in respect of waiting list initiatives (WLI). Mr Cooper confirmed that the assumption was the activity was the same as the previous year. Dr Short stated that this would be challenging within the current job plans. Mr Tidman stated that the use of WLI had become normalised to cope with the additional referrals. The Trust had to be clear what the capacity gap was and what extra staff and productivity would be needed to match the demand.

Mr Tidman requested further analysis in relation to the surge in admissions and ambulance conveyances and the 3% reduction in income as shown on page 14.

Resolved that:-
The Board noted that:-

- The Trust is broadly in line with plan at Month 2.
- Income is below plan due to activity being under plan.
- The Trust is required to deliver an additional £3.7m savings to achieve the revised control total.
- The Trust has received a high volume of data queries from Commissioners and a number of contractual notices are expected imminently.

76/16 **GOVERNANCE**

76/16/1 **Board Assurance Framework and Corporate Risk Register (BAF & CRR)**

Ms Stevens presented the report. She asked for comments on its content. Ms Smith requested a review of the corporate risk relating to emergency surgery at Alexandra Hospital and Mr McEwan agreed to action this.

Mrs Todd stated that there were three dates which were showing as 'red' on the report.

Mr Tidman complimented the tracking report.

Resolved that:-
The Board:

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

76/16/2 **Organ Donation Annual Report**

Dr Short presented the annual report. He stated that the systems in place to identify potential donors were robust. Link nurses were being put in place in ED and ITU to maintain the systems with the lead nurse on secondment to Birmingham.

Resolved that:-
The Board

- Supported the training of link nurses in the accident and emergency departments and intensive care units to promote organ donation.
- Supported the work of the organ donation committee both within WAHT and outside in the community.

76/16/3 **Safeguarding Annual Report**

Ms Stevens presented the Annual Report. It had been previously considered in depth by QGC. She outlined the significant work being undertaken by the new lead for safeguarding and highlighted the updated risks. She was confident that this area of work was under control.

In response to Mr McGinity, Mr McEwan confirmed that the issue of mental health support for patients in ED was being discussed at the urgent care programme board. There was active dialogue with the Health and Care Trust.

Resolved that:-
The Board

- Noted the work of the Safeguarding team and the annual report

DATE OF NEXT MEETING

The next Trust Board meeting will be held on Wednesday 7 September at 09:30 in the Kidderminster Education Centre, Kidderminster Hospital and Treatment Centre, Kidderminster.

The meeting closed at 14:42 hours.

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

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT 7 SEPTEMBER 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
7-7-16	FOAHSW	72/16/1	Present Trust's response to the clinical senate report to the next board meeting	CT	Sept 2016		On agenda	
7-7-16	WAG	74/16/1	OD strategy to be presented to TB in September	DH	Sept 2016		Deferred. For discussion with the Chairman for way forward	
7-7-16	BAF	76/16/1	Review CRR in relation to emergency surgery	RM	Sept 2016	Oct 2016		
9-9-15	CEO report	116/15	Baseline assessment and audit for seven days services	RM	Mar 2016	May 2016 June 2016 July 2016	Executive Team developing a proposal on 7-day services for discussion at the May Board meeting. The Interim COO agreed to circulate the baseline audit undertaken which set out the services already being provided 7 days a week. May update: Baseline audit undertaken. Benchmarked data available mid-May. Report to TB in June with benchmarked data.	

							Benchmarked data not available. Deferred to July. To be presented to QGC – July. Deferred to August QGC. Verbal report at QGC. Item closed.	

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7 September 2016 **Enc C1**

Report to Trust Board

Title	**Revised Governance Structure**
Sponsoring Director	**John Burbeck** **Interim Chair**
Author	**Kimara Sharpe** **Company Secretary** **Sally Batley, Clinical Governance**
Action Required	Trust Board is requested to: • Approve the disbanding of the Strategy and Transformation Committee • Approve the Disbanding of the Workforce Assurance Group • Approve the clarification of roles of meetings and the revised Governance Structure
Previously considered by	EMT Board development QGC WAG

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	The CQC identified challenges within the governance structure of the Trust which meant that there was not a clear line of sight from ward to board.
Glossary	

Key Messages

The proposed new governance structure is to show clear and strengthened lines of accountability and responsibility throughout Worcestershire Acute Hospitals NHS Trust.

Date of meeting: 7 September 2016 **Enc C1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 7 SEPTEMBER 2016

1. Situation

The CQC in its report, November 2015, recommended that the Trust improve its clinical governance arrangements to ensure clearer ward to board reporting. The Trust has taken the opportunity to review its board level governance structure which is presented.

2. Background

Good governance means

- Focusing on the organisation's purpose and on outcomes for citizens and service users.
- Performing effectively in clearly defined functions and roles.
- Promoting values for the whole organisation and demonstrating the values of good governance through behaviour.
- Taking informed, transparent decisions and identifying and managing risk.
- Developing the capacity and capability of the organisation to be effective.
- Engaging stakeholders and making accountability real

In order to support improved governance, changes are proposed to clarify the roles of committees and their structures. The attached definitions and structure supports strengthened ward to board reporting for quality, and expands the role of the Trust Management Group which it is proposed is accountable to the Trust Board. This will result in better decision making at operational level and improved assurance at Board and subcommittees.

3. Assessment

3.1 Key risks

The revised governance structure (attached) aims to show a clear framework from strategy to delivery. The new structure fosters the right level of oversight and scrutiny and ensures assurance and escalation is managed and delivered at the appropriate levels within the organisation. The clinical governance structure also limits the key risk of the overlap of meeting agendas and discussions which has been experienced in the past.

It is proposed to disband the Workforce Assurance Group (WAG) and replace it with an Operational Group, accountable to the Trust Management Group because the agenda for WAG has been increasingly operational with the risk that Board members review operational rather than strategic issues. The TMG needs to ensure a tight grip on the workforce agenda and this proposal makes that easier.

The Strategy and Transformation Committee is proposed to be disbanded as the role has been superseded by the STP process. A Task and Finish group will be set up as required, with NED input for the development of the Trust's strategic plan.

3.2 Titles of meetings

It is proposed that clear demarcations of responsibilities are defined within the titles of meetings.

Trust Board – All Non-Executive Directors, Executives and interested stakeholders are in attendance to develop vision and strategy, constructively challenge options to make the best decisions, ensure good leadership to realise the organisational strategy, ensure probity, agree the organisations appetite for risk and receive subcommittee assurance updates that the organisation is delivering quality services within appropriated public funds. The Trust Board decides what decisions it takes itself and what it delegates to Trust management and sub committees to make on its behalf. Subcommittees of the Board should be few in number and have formally agreed delegation through terms of reference.

Sub Committees – Chaired by a Non-Executive Director, with other NEDs and Executives in quorum. These subcommittees agree strategic plans, work is commissioned through the organisation, advisors or key partners for delivery of the strategy. Subcommittees constructively challenge that actions are going to deliver the agreed outcome, receives assurance updates and escalation where it is unable to be managed within agreed groups/task and finish/meetings.

Group – Chaired by Executive Lead/Medical Director gives management top tier oversight and scrutiny, strategic and operational steer. This will agree operational plans, received escalation and assurance and reports for Board subcommittees (except TMG which it is suggested is accountable to the Trust Board).

Expert Forum – Chaired by Senior Responsible Officer/Clinical Lead. Clinical and managerial experts assemble to professional debate and agree what work plan needs to be delivered through the organisation to ensure our services are aligned to current good practice and statutory responsibilities around their specialist interest area. The divisional representatives take this into their divisions to become part of their divisional delivery plans over the next year.

Meetings – Where the operational level work plans get developed, actioned, measured, updated and evidence of completion and sustainability is sought. Lessons are disseminated to the wider workforce so that improvements in practice and behaviour can be made. Assurance reports are built up from here and fed into the next layer of governance structure, so that the ward/area voice is heard all the way up to Board.

Task and Finish – These are commissioned throughout the governance structure where short life groups take on delegated tasks or to seek advice. These can be one off or a series of meetings with a clear task to deliver that has been commissioned by one of the above governance assemblies. The aim of this group is to deliver to the commissioned task within the agreed timeline and report back delivery as specified in the original brief.

3.3 Next steps

If approved, the next steps are to develop the appropriate terms of reference for the expert forums.

3.5 Evaluation

Currently all Board subcommittees are subject to an annual evaluation. This will continue. This will also be put into place for groups and expert forums.

4 Recommendation

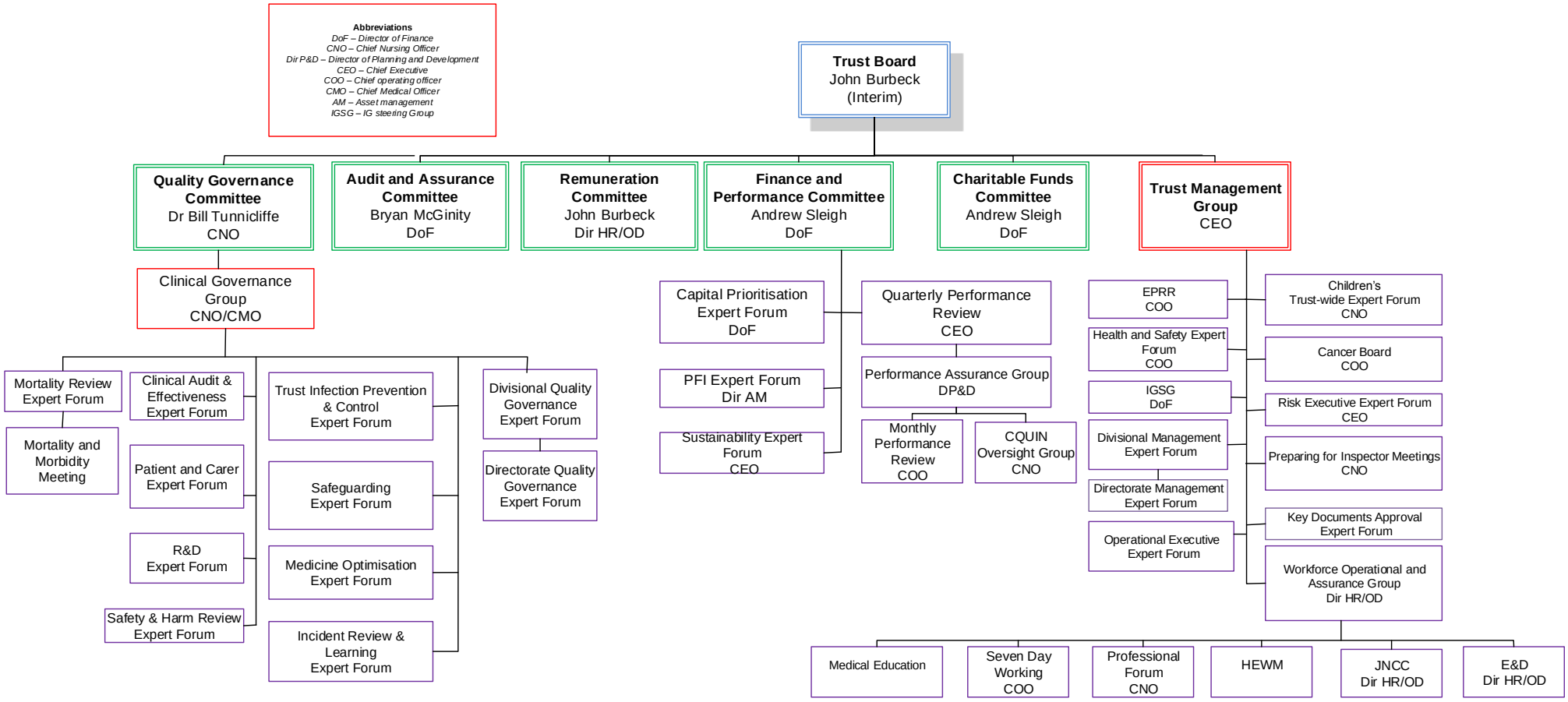
Trust Board is requested to:

- Approve the disbanding of the Strategy and Transformation Committee
- Approve the Disbanding of the Workforce Assurance Group
- Approve the clarification of roles of meetings and the revised Governance Structure

John Burbeck
Interim Chairman

Date of meeting: **7 September 2016** **Enc C1**

Revised governance structure



Title of report	Revised Governance Structure
Name of director	John Burbeck

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7 September 2016 **Enc C2**

Report to Trust Board

Title	**Interim Chief Executive's Report**
Sponsoring Director	**Chris Tidman, Interim Chief Executive**
Author	**Kimara Sharpe, Company Secretary**
Action Required	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 (√)

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

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

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: 7 September 2016 **Enc C2**

WORCESTERSHIRE ACUTE HOSPITAL NHS TRUST

REPORT TO PUBLIC TRUST BOARD – 7 SEPTEMBER 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 Emergency centralisation of inpatient paediatric services

Operational protocols and plans have now been agreed for the temporary emergency transfer of inpatient paediatric services from the Alexandra Hospital to the Worcestershire Royal Hospital, which takes effect from today. These changes have been necessary in order to maintain safe medical staffing rotas. Communication of these changes has been made through a number of channels, and will continue for the foreseeable future. I should like to thank all the clinical and managerial staff from within the Trust as well as partner organisations who are working hard to manage an effective and safe transfer. It is worth stressing that children's outpatient services are unaffected and most children will continue to be seen at the Alexandra A & E, with only the sickest children requiring potential hospital admission needing to be seen at Worcestershire Royal.

4 Radiology

The Trust had an unannounced CQC visit on 27 July which focussed on the backlog of plain films still to be reported by a Radiologist. To put this into context, a scan will typically be viewed by the requesting clinician as part of determining a patient's treatment plan, and the radiologist report that follows provides a more expert opinion. Although efforts had been made to reduce the number of unreported plain films (particularly Chest X Rays), the backlog had increased over recent months as a result of a gap between demand and capacity and priority being given towards reporting the more complex scans (e.g. CT/MRI). An action plan was already in place to clear the current backlog through the commissioning of additional capacity from the UK independent sector, and this recovery plan has now been strengthened. The Trust has subsequently received a section 31 notice from the CQC setting out the need for more robust governance and monitoring of this backlog and a number of additional actions have been put in place by the Executive and Divisional management teams. To provide an independent view of the Trust's approach to clearing the backlog and its broader governance arrangements for Radiology, the Trust has also commissioned an external peer review and will be seeking advice from the Royal College of Radiologists. The Quality Governance Committee approved the Trust's proposed approach to reviewing patients who may have been affected by the backlog.

5 Junior Doctor Strike – week commencing 12 September

The Trust has received notification of the five day junior doctor strike commencing on 12 September 2016. We are developing contingency plans to ensure that the impact

of the strike to patients is minimised.

6 Annual Worcestershire Palliative Care Conference

I should like to thank Alison Harrison, lead nurse for Oncology, Haematology and Palliative Care and colleagues from across Worcestershire, – including; hospices (St Richards, Primrose and Kemp) the University of Worcester, and the Health and Care Trust for organising an excellent Worcestershire Palliative Care Conference. This Annual Conference welcomed 175 delegates (the largest number to date) from around the region. The theme for this year was complex issues at End of Life and focused on patients with neurological conditions, such as MND and the issues they face, including; respiratory support and artificial feeding. Speakers included Professor David Oliver – who spoke about MND and its challenges, and Nigel Hartley, CEO of Mountbatten Hospice on the Isle of Wight. Local resident and patient, Steve Jones talked about the changes in his life with the progression of MND and the Haylo Theatre Company, gave a performance around the theme of Assisted Suicide.

7 Cream tea for volunteers

Over 220 volunteers from across sites gathered at the Chateau Impney, near Droitwich for the annual summer cream tea, celebrating the enormous amount of hours given by volunteers in our hospitals. This year, the patient experience team have recorded over 55,000 hours of volunteer service across the trust – a phenomenal achievement that highlights the range and variety of crucial roles our 600 volunteers undertake.

8 Sustainability and Transformation Plan

Additional modelling and service redesign work is continuing on developing an STP for the Hereford and Worcestershire health and social care systems. The final STP submission is due in October and whilst good progress has been made, there remains a great deal of work to do in order to produce an evidence based plan for delivering a sustainable range of safe and accessible services for the two counties. It is clear that any successful STP will need to demonstrate a more integrated and seamless system of care that begins to break down traditional organisational barriers and this will inevitably bring about a great pooling of resources and the need for a change in clinical and managerial behaviours towards the system as opposed to an organisational model.

9 Emergency Department at Worcestershire Royal Hospital (WRH)

The phase 1 expansion of the WRH ED is now complete, which is enabling a better streaming of 'minor' patients as well as the co-location of ambulatory emergency care assessment. This expansion will provide additional clinical space and will improve the ability of ED to organize its service. However, this does not take away the pressures on the ED of patients having to wait to be admitted into an inpatient ward and the weekend of 20th and 21st August proved to be particularly pressured, with a number of 12 hour trolley waits recorded. As a result, a number of additional steps are being taken by the Executive team in liaison with the Medicine Division and ECIP team to establish earlier discharges, quicker specialist assessment and improved weekend resilience. A Listening into Action Event took place on 31st August in order to take ideas from clinical staff as to what gets in the way of patient flow and these actions will be embedded into the Urgent Care PCIP and will form the basis of the

Trust's winter plan.

10 Local A&E Delivery Board (Strategic Resilience Group (SRG))

From 1st September 2016, the SRG changed to the Local A&E Delivery Board, chaired by myself. This is a national change and the agenda will be to focus on five specific work streams which are:

- Streaming at the front door to ambulatory and primary care
- NHS 111 – Increasing the number of calls transferred for clinical advice
- Ambulances – active participation in the national pilot projects on dispatch and coding along with plans to increase hear and treat and see and treat to divert patients away from A&E
- Improved flow and reduced occupancy in hospitals via full implementation of the SAFER bundle
- Discharge to assess and trusted assessor models in place

I will provide a regular report on the progress of this new Delivery Board through my report to Trust Board.

11 Staff Awards Ceremony

The annual staff awards ceremony will be held at the Chateau Impney Hotel on 18 November. The event will again be fully sponsored and based on the number and quality of nominations, it promises to be another inspiring and uplifting evening.

12 Organ Donation Memorial Ceremony

On Saturday 10th September at 2pm, the Trust will be hosting a ceremony to dedicate the memorial plaques on the beautiful Organ Donation Memorial outside the front entrance of the WRH. We are expecting over 100 people from 28 families to attend and it promises to be a special and moving tribute to those that have donated their organs so others can lead a healthy life. Board members are invited.

13 Consultants

Please see the attached starters and leavers.

14 National Update

14.1 Clinical lead of A&E

Dr Clifford Mann, outgoing president of the Royal College Emergency Medicine, has been appointed as the national clinical lead for A&E.

14.2 Europe Transition Team

NHS England is establishing a Europe Transition Team (a 'Brexit Unit') to support identification of risks, impacts and opportunities for the NHS associated with Brexit, and to inform withdrawal negotiations.

14.3 New Health Ministerial Team

Philip Dunne joins the Department as Minister of State for Health. His brief includes overseeing all aspects of hospital care, NHS performance and operations, the workforce, patient safety and maternity care.

Nicola Blackwood is the Parliamentary Under Secretary of State for Public Health

and Innovation. She will lead on all aspects of public health and health protection as well as technology, life sciences innovation, and data.

The Parliamentary Under Secretary of State for Community Health and Care is **David Mowat**. His brief includes adult social care, carers, community services, cancer, dementia, learning disabilities and all elements of primary care – including dentistry and pharmacy.

Lord Prior remains at the Department as the Parliamentary Under Secretary of State for Health, covering all aspects of health in the House of Lords. His brief also includes leading on drugs spending, life sciences industry, NHS and EU issues, NHS commercial issues, and blood and transplants.

15 Recommendation

The Board is asked to

- Receive the assurance contained within the report
- Note the report.

Chris Tidman
Interim Chief Executive

New Starters

Name			Start date	Specialty
Title	First name	Surname		
Dr	**Nuno Pedro**	**Lobato Ribeiro**	25/08/2016	Consultant in Stroke Medicine
Dr	**David**	**Wilson**	05/09/2016	Consultant Cardiologist
Mr	**Harm-Jan**	**Stellingwerff**	15/09/2016	Consultant Radiologist
Dr	**Caroline**	**Fox (Moss)**	19/09/2016	Consultant O&G - Special Interest

Leavers

Date of leaving	First Name	Surname	Specialty
22/07/2016	David	Aldulaimi	Gastroenterology
02/07/2016	James	Young	Medicine
30/06/2016	Martin	Fotherby	Stroke
17/06/2016	Catherine	Lo Polito	Histopathology
31/08/2016	Anna	Moon	T & O
21/08/2016	Chandra	Bertram	Dermatology
12/08/2016	Tara	Barton	Radiology
12/08/2016	Joseph	Uhiara	O&G
12/08/2016	Charles	Robertson	Surgery
31/07/2016	Paul	Geddy	Histopathology
31/07/2016	Paul	Newrick	Diabetes

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7 September 2016 **Enc D1**

Report to Trust Board Public

Title	**Future of Acute Hospital Services in Worcestershire**
Sponsoring Director	**Chris Tidman** **Interim Chief Executive**
Author	**Dr Andrew Short** **Acting Chief Medical Officer**
Action Required	The Trust board is requested to receive the update on the recommendations within the Clinical Senate 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	2665 If we do not achieve wider service redesign in a timely way we will have inadequate numbers of clinical staff to deliver quality care
Legal Implications or Regulatory requirements	This report covers some statutory issues such as CQC or accreditation visits.
Glossary	UCC – urgent care centre

Key Messages

Following the report to Trust Board in July 2016 it was agreed that a list of actions against the key recommendations from the Clinical Senate report would be presented at the this Board meeting.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7 September 2016 **Enc D1**

Future of Acute Hospital Services in Worcestershire

Key Recommendations

No.	Recommendation	Action
1	It was noted that the majority of the Executive Team at this Provider are on an interim basis. The Panel strongly feels that substantive appointments need to be made to continue with the good momentum that has been made over the last nine months and the palpable change in culture and attitude to staff engagement	New chair appointed and due to commence September 2016 Substantive appointments to executive posts to follow
2	The lessons learnt from the anaesthetic department in terms of developing their county wide model of working are identified and shared wider across the Trust as an example of good practice	Experiences shared All new appointments will be countywide Plans for single access cards for all sites Plans to standardise operational schedules on all sites
3	The staffing levels for the ED consultants needs to be at a minimum level of 20 across (10 on each site) the 2 hospital sites to provide a safe and sustainable level of cover as per the CQC Quality Report (2015) advice	Advice received and discussed internally Plans initially to aim for 16, with cross site working Recruitment in progress for an unspecified number to try to meet target number
4	It was suggested that the normal working day for the Emergency Medicine consultants is based upon a county wide rotational basis to retain skills in terms of care of paediatrics at the WRH site. This could be separate from the out of hours provision with the identification of a main site reflecting that not all consultants will live within a response time of 20 minutes	Job plans under review by DMD and CD for Emergency Medicine – this will be linked to recruitment processes
5	Middle grade and ED consultants at AH need to rotate to maintain paediatric experience-this could be through experience at WRH as above or at alternative Providers e.g. Birmingham Children's Hospital	Agreed, this is part of the job plan review process
6	The FoAHSW Programme Board is encouraged to utilise the national model for Urgent Care service specification that is being developed by	Work has begun on UCC specification, being led by Martin Lee at CCG

Title of report	**Future of Acute Hospital Services in Worcestershire**
Name of director	**Mr Chris Tidman**

	NHS England	
7	Support for streaming rather than a triage based model: if the model relied upon a single triage nurse then this may limit capacity and patient flow through the departments	Front door service provision being reviewed as part of ECIP process
8	There was the need for a careful review of the clinical procedures proposed to be undertaken in the UCC because, with only a limited number of staff, some of the procedures could be time consuming and more efficiently carried out in the ED setting	See item 6 above
9	The staffing levels for consultant level of cover in the ED should match or exceed the planned level of GP level cover in the UCC i.e. 16 hours per day. The rationale underpinning this is that if the ED consultant cover is provided to mitigate against the impacts of a critically ill child attending the AH UCC then comprehensive data presented shows that paediatric admissions do not decrease until ~ 11pm in the evening (based upon the activity figures that the Panel reviewed after submission by the FoAHSW Programme Board).	Plans to recruit additional consultants are continuing
10	Consideration of the nomenclature for the UCC to manage public expectations of what can be delivered in this setting and again national guidance may help address this	Awaiting publication of national guidance
11	The Panel strongly supports additional further work being undertaken between the Programme Board, Trust Management and acute medical consultants across both sites to develop the vision and implementation for sustainable county wide working	Vision for acute medicine service has been developed and presented to the executive team

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 6 September 2016 **Enc D2**

Report to Trust Board

Title	**Trust Management Group (TMG)**
Sponsoring Director	**Chris Tidman** Chair of the Trust Management Group
Author	**Kimara Sharpe** Company Secretary
Action Required	The Board is requested to: • Receive assurance that the strategy for acute medicine is in development • Note the System Resilience Group has been disbanded and a Local A&E Delivery Board has been formed • 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	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances
Legal Implications or Regulatory requirements	

Date of meeting: 6 September 2016 **Enc D2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – SEPTEMBER 2016

1. Situation

To inform the Trust Board on the actions and progress of the Trust Management Group (TMG) at its August meeting.

2. Background

The Trust Management Group provides assurance to the Trust Board on operational issues. TMG meets monthly and is the successor Group to the Trust Management Committee and Improvement Board. Proposed terms of reference will be presented to the Board at its next meeting.

3. Assessment

3.1 CQC preparation

The CQC are revisiting the Trust on 21st November. The Interim CNO described the actions and governance around the management and preparation for the visit. This was discussed in more detail with the NEDs at the Board Development Seminar on 24 August.

3.2 Paediatric – emergency change in provision

The Women and Children division described the actions being taken to ensure a safe temporary transfer of services from the Alexandra Hospital to Worcestershire Royal. The move will take place on Wednesday 7 September. The divisional team and project manager were commended for the detail behind their plans and the way in which they had engaged staff, stakeholders and the public. The advice and support from our buddy trust, Birmingham Childrens Hospital, was also noted.

3.3 Medical rota

Commitment was given to the establishment of a single on call rota for medicine across the county. Support was also given to the recruitment process for county wide consultants in medicine.

3.4 Acute medicine – strategy

An update was provided by the DMD for Medicine on the work being undertaken on creating a clear countywide strategy for acute medicine as well as some earlier wins on establishing a regular and scaled up ambulatory emergency care rota at WRH to ensure patients can be assessed before a decision to admit. This was supported by TMG and in line with the Trust's Annual Plan, extra managerial resource has been committed to support the delivery of this strategy.

3.5 Seven day services

TMG received an audit report which showed that the Trust was not meeting the national standards required for seven day services. Commitment was given by the Divisions to ensure that further work was undertaken to ensure that work progresses

to meet the national standards. Separately, the CMO has now held 2 medical engagement events which have focussed on the importance of ownership and accountability for either delivering or having a plan to deliver national standards. I have asked the CMO to review the progress against meeting these standards through regular audit and to take this work through QGC.

3.6 **Revised governance structure**

The revised governance structure (within the Chairman's report) was discussed and agreed, subject to Trust Board approval.

3.7 **Local A&E Delivery Board**

We have received notification from NHSE that the System Resilience Group will be transformed into the Local A&E Delivery Board. The focus will solely be on urgent and emergency care. Local Authority colleagues will be members of this Board. The Trust CEO will chair this Board which provides an opportunity to demonstrate system leadership. The Board will focus on the following areas:

- **Streaming at the front door – to ambulatory and primary care-** This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.
- **NHS 111 – Increasing the number of calls transferred for clinical advice-** This will decrease call transfers to ambulance services and reduce A&E attendances.
- **Ambulances – DoD (dispatch on disposition) and code review pilots; Health Education England increasing workforce.** This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance and an increase in 'hear and treat' and 'see and treat' to divert patients away from the ED.
- **Improved flow – 'must do's that each Trust should implement to enhance patient flow.** This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the 'SAFER' bundle will facilitate clinicians working collaboratively in the best interests of patients.
- **Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models.** All systems moving to a 'Discharge to Assess' model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system.

3.8 **Theatre Optimisation**

The Divisional Director of Operations for Surgery outlined the commitment of the Divisions to ensure that theatres are better utilised, including starting sessions on time. The support from PWC had been helpful in establishing the scale of opportunity through new ways of working and a new protocol would now be developed to ensure

patients could be taken to Theatre earlier. Furthermore, options were discussed as to how best to implement the Theatre Admissions Unit at WRH.

3.9 **Other items considered:**

- **Listening into Action**: It was noted that staff felt really engaged by LIA but wanted to see evidence that it was central to the Division's way of working, The Divisions therefore agreed to roll out the format for the Big Conversation within their own areas and that this would be supported by the Executive team.
- **Medical engagement**: An update was given on the work the CMO is undertaking in listening to and engaging consultant staff. The latest event included a briefing by the lead for Hospital at Night. Work is underway in respect of training for managerial roles and better communications.
- **Strengthening Financial Performance in the NHS**: This was discussed at the F&P Committee.
- **Business cases approved:**
    - Ward 9 chemotherapy and ambulatory oncology at Alexandra Hospital
    - Additional staffed endoscopy sessions

4 **Recommendations**

The Board is requested to:

- Receive assurance that the strategy for acute medicine is in development
- Note the System Resilience Group has been disbanded and a Local A&E Delivery Board has been formed
- Note the report

Chris Tidman
Chair of the Trust Management Group

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 7 September 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: • Note the approval of the revised clinical governance structure • Note the improving complaints metrics • Note the Alexandra Hospital was an outlier for mortality associated with fracture neck of femur in 2014, but is not currently • Note the lack of improvement in the time to theatre for patients with a fractured neck of femur • Note the invited visit by the British Orthopaedic Society • Note the actions being taken in respect of the back log of x-rays and the CQC unannounced visit • Note that the QGC approved the annual reports for Health and Safety, Clinical Effectiveness and Infection Prevention and Control • 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 21 July and 25 August 2016.

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Date of Trust Board: 7 September 2016 **Enc E1**

REPORT TO TRUST BOARD – 7 SEPTEMBER 2016

1. Situation

This report provides the Board with key quality issues and risks discussed at the QGC's meeting held on 21 July and 25 August 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 Revised Clinical Governance Structure

The Committee unanimously endorsed the proposed revised clinical governance structure, as detailed in the Acting Chairman's report. The structure provided a level of professional scrutiny and debate which had not been present in the previous structure. The issue of patient engagement was raised by HealthWatch and it was explained that a new approach to patient engagement was being developed by the Trust in partnership with patients. The initial results of this would be presented to the Committee in October.

3.2 Patient and Carer Experience Committee

Progress was reported on the use of a system to better capture Friends and Family data. Further information will be provided on this. The metrics associated with complaints management were improving due to a better process in place and training for key managers. The metric was now based on a patient led deadline. Work was also underway in connection with the PALS service and solving issues and challenges at the front line.

3.3 Operational Governance Meetings

The interim CNO confirmed that following the proposed new clinical governance structure, from September the OGM would be superseded by a professionally led forum and a monthly serious incident meeting. The number of open serious incidents continue to decline.

3.4 Avoidable mortality

A visit has been undertaken to West Herts to learn from their experiences. A new system has been put into place with the divisions being held to account for undertaking mortality reviews. A focus was being made on sepsis and the Acting CMO stated that the metrics should improve by November. The British Orthopaedic Society would be visiting the Trust to review the pathway for people with a fractured neck of femur. This was in response to the Alexandra Hospital being an outlier for mortality in 2014. Since then, however, the metrics have improved. The length of time to theatre however was not improving and the Trust was hopeful that the visit by the Society would support a different approach.

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

3.5 Radiology – CQC visit

The Interim COO explained that the radiology backlog had grown between April and July 2016 and had not been escalated from within the Division. The CQC had undertaken an unannounced inspection on 27 July and had expressed concerns that there had been no plan to reduce the backlog of x-rays. A section 31 notice had been issued in early August.

The Acting CMO has invited the Royal College to visit to review the practice undertaken within the Trust. Initial dialogue with the Royal College has indicated that the Trust is using best practice.

The Trust is reporting weekly to the CQC on the backlog and the actions being taken. The correspondence with the CQC is available to view on the website.

3.6 Health and Safety Annual Report
Infection Prevention and Control Annual Report

QGC has approved both of these annual reports and they are on the agenda for this meeting.

3.7 7 day services

The Interim COO presented the national data. The Trust, along with other Trusts in the country, is challenged with meeting the standards. A regular report would be given to the Committee following audits which were being undertaken in each Trust.

3.8 Breach analysis – two week waits

The Interim COO presented to both meetings an analysis of harm events. No patient has come to harm from the delays incurred. Agreement had now been reached with the endoscopy consultants and this backlog should be cleared by the middle to end September.

3.9 Stroke services

The Committee heard that a new consultant had commenced within the stroke service which would ensure a more stable service. A county wide strategy was being developed to ensure that the service was attractive to potential recruits.

Clinical Effectiveness Annual Report

The Committee approved the Clinical Effectiveness Annual Report. During the year, there had been a concentration on ensuring that the audits were effective and were of high quality which is why the number had decreased from the previous year.

4 Recommendation

The Board is requested to:

- Note the approval of the revised clinical governance structure
- Note the improving complaints metrics
- Note the Alexandra Hospital was an outlier for mortality associated with fracture neck of femur in 2014, but is not currently
- Note the lack of improvement in the time to theatre for patients with a fractured neck of femur

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

- Note the invited visit by the British Orthopaedic Society
- Note the actions being taken in respect of the back log of x-rays and the CQC unannounced visit
- Note that the QGC approved the annual reports for Health and Safety, Clinical Effectiveness and Infection Prevention and Control
- Note the report

Dr Bill Tunnicliffe
Chair – Quality Governance Committee

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 07 September 2016 **Enc E2**

Report to Trust Board in Public

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

Priorities (√)

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

Related Board Assurance Framework Entries	3038 If the Trust does not address concerns raised by the CQC inspection, the Trust will fail to improve patient care
Legal Implications or Regulatory requirements	Subject to satisfactory improvement, the CQC has included conditions on the Trust's registration relating to the time to initial assessment in the Emergency Department and reporting in Radiology
Glossary	NHS I – NHS Improvement NHSE – NHS England CQC – Care Quality Commission CCG – Clinical Commissioning Group PMO – Programme Management Office

Key Messages

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

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

A resource plan was rapidly mobilised and additional PMO and project 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. This is starting to show a return in terms of the improvement approach and the pace of delivery. Potentially, there is more of the same required to deliver the step change required across all programmes.

Title of report	Patient Care Improvement Plan
Name of director	Sarah Smith, Director of Planning and Development

Date of meeting: 07 September 2016 **Enc E2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – SEPTEMBER 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) in August 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 September 2016 meeting of the QIRG and the updated version will be available at the October 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 received a further unannounced visit to the Radiology Department in August 2016 and this is the subject of a separate paper to the Trust Board.

3. Assessment

3.1 Key risks

Through the development of the PCIP, it had become evident that the Trust lacked a significant degree of improvement and project/programme management capacity and capability, and progress with the PCIP has been slow. The Trust has since identified additional central PMO support and project support for key work streams and the impact of this evident in the improved standard and consistency of reporting and the pace of delivery.

The new resources and 'fresh pairs of eyes' have led to a number of PCIP programmes being reviewed to ensure that they are fit for purpose. As a result, all of the patient safety and governance related work is being pulled together into a new single programme called Caring Safely which will be formally launched in September. This will build on the existing reducing mortality and governance and safety work streams.

The strengthened PMO approach has resulted in a clear definition of what a project comprises and how it should be executed. This has called in question a number of PCIP programmes and work streams as to whether or not they represent improvement projects or business as usual. This includes the Phase 2 Women and Children's PCIP, the PFC work stream and aspects of OD and staff engagement, and these are subject to review prior to the September PCIP report.

There are still PCIP areas that require more focussed improvement support and more consistent governance and oversight, in particular in Urgent Care and Patient Flow and resources to support this programme are under review.

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There is still insufficient line of site between the floor and Board in terms of the PCIP and its progress and work has started in preparation for the CQC re-inspection to align the PCIP and key tasks therein with Divisional and Departmental preparation.

The Trust fundamentally lacks skills around measuring for improvement and this is evident in the alignment of programme measures with deliverables. Work is ongoing to review the measures for each programme, and as part of the development of safety culture, training has commenced in measuring for improvement.

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.

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 is developing an Improvement Academy to equip staff with the skills and knowledge around planning for and delivering improvement.

3.3 Gaps in controls and mitigation

There are ongoing capacity issues in day to day operations and in delivering the required levels of improvement activity across Trust programmes and further resource may be required.

Staff engagement remains a key issue and the Trust is looking increase ownership and to tailor and 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

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Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 07 September 2016 **Enc E2**

Worcestershire Acute Hospitals NHS Trust – Patient Care Improvement Plan (PCIP)

High Level Report for Month of July 2016

Programme / SRO	Project Lead	Work Stream	Month				Deliverables	Completed during this period (July)	Tasks Delayed/ Slipped	Planned in next period (August)
			A	M	J	J				
Urgent Care & Patient Flow **SRO: COO**	**Overall Programme**									
	Lynda Ferron	**Safer Bundle**					• Introduce best practice ward rounds (Medicine) • Engage all clinicians across sites (Medicine) • Train all staff in SAFER practice (Medicine) • Implement SAFER bundle across Trust • Work stream Evaluation	• Contacted ECIP regarding a computer based training package • iPads implemented for real time reporting • Review of reports undertaken and information validated • SAFER dashboard for reports has been created • Attended meeting regarding updated functionality of Whiteboards to assist with discharges.	• Manual collection of data very time consuming for Wards • Ward/Board rounds not fully attended by MDT • Need accurate data collection on early discharge • Training attendance behind plan	• LiA style event planned for late August to focus on Care in the Morning • Continue training on AGH site • Reinforce the collection of • Look at wider roll out and communications • Continued engagement with clinicians (9 August event) • Create a computer based training package • Formal review with pilot wards • Programme Lead meeting with DDNs for SCSD and Surgery re implementation of SAFER

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Urgent Care & Patient Flow **SRO: COO**	Lynda Ferron/ Randeep Kular	**ED & Acute Care**					• To implement a permanent AEC service on both acute sites (Mon-Fri 8am-8pm) • Increase number of patients seen per day in AEC and scope specialty clinic slots • To ensure MAU functions consistently at AGH and ensure both sites treat 60% as ambulatory • Ensure 75% of GP referrals are seen in ambulatory clinics and 75% of patients referred to specialty doctors are see within an hour • Ensure that patients are triaged within 15 minutes and minimise ambulance handover times	• Warwick visit to look at the model of AEC care took place on 14 July • Discussions taken place regarding AGH/Kidderminster attendance by senior management team • Board rounds in ED were implemented w/c 11 July • Reverse queuing was implemented in ED at WRH • AEC trajectories have been agreed • SIAN nurse at the WRH ED have had a positive and sustained impact on TTIA and ambulance handovers however when there are surges in activity at WRH and AGH this is compromised.	• Regular attendance by senior team at AGH/ Kidderminster is challenging due to lean structure • Physical space in current AEC (based in outpatients) is a constraint on the numbers seen	• Analysis of data/impact of focus on specialty review • Business case for co-located AEC • Increased analysis on reporting • Review of documentation re data captured for patients • AEC to be implemented at AGH in August • Recruitment to be reviewed • Discussion to take place with GP in ED regarding patient flows • Start process regarding communications with GPs to reduce referrals in ED

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Urgent Care & Patient Flow **SRO: COO**	Lynda Ferron/ Chris Cashmore	**Patient Flow Centre**					• Electronic referral process in place with accurate reporting for receipt of referrals • Hosting of PFC to be transferred to WAHT • Integrated multi agency discharge support in place • All pathways reviewed – Pathway 1 increased capacity to meet demand and Pathways 2 and 3 integrated • Team of discharge liaison nurses established to support all discharges including complex, fast-track and out of area	• Programme Lead spent time with PFC team to see processes in action • Reporting from PFC investigated and process started to implement reports for WAHT requirements • Frameworki rolled out at WAHT for phase 1 • Amendments to Section 2 form completed to include rapid triage • Development team met with IT from Worcestershire County Council to discuss mutual access for discharge data	• Review of PFC Dashboard and reporting requirements • There has been ongoing additional work and focus outside of this work stream, to systematically review and expedite those patients waiting longest for transfer to an alternative care setting and this has had a positive impact on average non elective length of stay at the Trust. The work stream itself however remains underdeveloped as a project.	• Meeting with PFC to discuss pathways and liaison nurses • Gather information re requirements for hosting PFC • Need to look at clear deliverables for this work stream and implement appropriate metrics • Implementation plan developed for Worcestershire County Council new discharge software • Whole Team meetings initiated • DDN Capacity and Flow to review processes • Revised reporting to highlight unmet demand • PFC Manager to update the SOP to include KPIs and SLAs

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Urgent Care & Patient Flow **SRO: COO**	Lynda Ferron / Caroline Lister	**Frailty Service**					• Implement an OPAL service on WRH and Alex sites operating 5 days per week • Close Elderly Medicine Ward in Aconbury East • To ensure service reviews 5 patients per day and discharge 80% of patients seen • Establish a new Silver Ward on MSSU at WRH • Establish an OPAL Service at AGH • Liaise and integrate ED GP into OPAL service	• Pharmacy support agreed and implemented • Established reporting and data capture electronically • Team concentrates on ED/MAU in –reach • Scope of implementation of data collection on iPad for OPAL service completed and iPads ordered • Metrics for over 75s reviewed and request to Informatics to report in a different way	• Staffing issues and capacity issues in the hospital prevented service being fully operational	• Review data to date re pathways • Assess resourcing levels • Review requirements for AGH • Liaise with ED GP for OPAL service for integration • Arrange meetings re telephone advisory clinic with relevant people • Review possibility of follow up clinic after ED discharges • Engage clinical leadership • iPad and application in place for collection of data • Review situation and confirm strategy for OPAL

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Mortality Reduction **SRO: CMO**	**Overall Programme**									
	Dr McAlindon	**Sepsis**					• Identified medical clinical lead in all key areas • Ward based sepsis champions for each clinical area • Sepsis screening process for all patients with a NEWS score of 5 / PARS 3 • Antibiotic administration system for all patients with positive screening criteria according to national standards • Three day antibiotic review process for all confirmed sepsis patients	• Screening pilot undertaken and evaluated • Data capture / screening tools / Sepsis proforma agreed • Patient journey review for emergency attendances • Antibiotic pathway walked through, high level blocks identified • Transfer of clinical leadership to Dr Mike McAlindon • Patient First updated to include new screening form • NEWS training for all medical and nursing teams delivered. • All PARS paperwork in clinical areas replaced with NEWS paperwork	• Inpatient baseline audit / antibiotic delivery audit – resource has now been identified • Paediatric screening form to be agreed - delayed due to move of services from ALX to WRH.	• Ensure local documentation is updated • Sepsis proforma to be rolled out Trust wide • Data from treatment and day 3 review audit to be discussed at next sepsis meeting • Inpatient screening to be rolled out to ward areas • Link NEWS/Sepsis teams. • Create support structure for staff training and learning re Sepsis Tool. • Deliver face to face engagement and communications. • Review of Sepsis tool compliance following roll out

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Mortality Reduction **SRO: CMO**	Dr Steven Graystone	**Mortality Reviews**					• Trust Mortality Review documentation in place • Agreed process for notification and investigation of all adult patient deaths • Secondary review investigation and review process • Mortality Review Newsletter established • Trust wide 'lessons learnt' forum • Mortality Review Introduction Pack – FY1 / FY2 and New Starters	• Established consultant level data dashboard for compliance with review process • Ensured compliance data accessible to consultants and tested access • 'Processes and guidelines' communicated to consultants – Clinical Lead and acting CMO • Met with West Herts representatives to learn from their mortality review process and to discuss opportunities, accomplishments and lessons learnt	• Secondary review investigation and review structure requires update • Secondary Mortality Reviews not consistently discussed at OGM	• WRH Mortality 'World Café' event for Consultants and Jnr Drs - to seek views regarding current processes and suggestions for improvement • Arrange a second 'World Café' session at Redditch • Introduce 'Mortality Surveillance/ Oversight Group' • Clarify roles and responsibilities of Consultants & medical leadership re mortality reviews • Explore introduction of clinical coding consultant advisors • Include ED deaths in mortality reviews • Enhance process of governance re death certification

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Mortality Reduction **SRO: CMO**	Mr Charlie Docker	**# Neck of Femur**					• Implement 'Golden Patients' • Dedicate first slot on trauma list to # NOF (unless required for more urgent case) • Schedule daily trauma lists to meet demand • Dedicated trauma anaesthetist provision • Allocated trauma bed base	• WRH current state analysis undertaken • Weekly improvement meeting established • National Hip Fracture database mortality alert - external review requested from British Orthopaedic Association, probably during November 2016.		• Undertake case note reviews of 40 patients who died during 2015/16 whose primary diagnosis was #NOF • A thematic analysis of all associated SI's will also be undertaken •An action plan will be developed to address the issues identified • A monthly mortality meeting will be established to review recent cases and to monitor crude mortality

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Mortality Reduction **SRO: CMO**	Joanne Logan / Alison Spencer	**(National Early Warning Score)** **NEWS**					• NEWS integration to all relevant paperwork • Training Programme delivered • Audited escalation approach in place • Trust launch of NEWS • Communications plan Implemented	• Training programme launched and delivered • Paperwork amended and launched through Servicepoint • Immersion events held • Successful NEWS launch 4/7/16 • Site teams covered all key clinical areas during NEWS launch • NEWS aligned with Sepsis work streams	• Introduction of NEWS escalation sticker – currently being reviewed by Sepsis and NEWS clinical leads for approval	• Audit efficacy of launch – ongoing • Review progress, hold lessons learned meeting • Align with Sepsis work stream • Review of resuscitation audits / unexpected ICU admissions / agree audits to monitor escalation of deteriorating patient and effectiveness of processes

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OD & Staff Engagement **SRO: Dir HR & OD**	**Overall Programme**									
	Sandra Berry	**Leadership**					• Strengthen and equip our existing leaders to improve and raise current leadership capability. • Implement a Trust Board Leadership Plan • Develop a Talent Management Strategy • Develop "Understanding your Trust "Programme	• Coaching programmes Implemented and on-going programme agreed. • Senior Leaders and Managers Training Needs Analysis (TNA) commenced. • Reviewed all divisional leadership job descriptions to identify skills required. • Commenced sourcing potential providers for leadership programmes. • Met with FLML Solutions to discuss possible Medical Leadership programmes.	• Senior Managers Training Needs Analysis was due to be completed by 30th July, now 31st August 2016. • Review Deloittes Feedback for Board Development Programme.	• Complete Senior Leaders / Managers TNA • Source and agree provider for range of leadership programmes identified by training needs analysis. • Draft Senior Medical Leadership Programmes to include New Consultants Development Programme, aspirant Clinical Leader Programme and Senior Medical Leadership Programme. • Commission 360 Degree Appraisal Tool.

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OD & Staff Engagement **SRO: Dir HR & OD**			**A**	**M**	**J**	**J**				
	Jan Stevens	**Safety Improve-ment Culture**					Review of work stream in progress. To be incorporated within the development of a 'Caring Safely' workstream. Changes to be reported in September.	Work underway to develop Improvement Academy with initial cohort of trainees being the current LiA Leads		

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OD & Staff Engagement **SRO: Dir HR & OD**	Debbie Drew	**Workforce Plan**					• Tactical plan to reduce medical locum and agency spend • HR and Nursing Directorates to work closely on nurse recruitment and retention • Nursing Directorate to develop plan for student mentorship to increase number of students • Plan for recruitment of Physicians Associates to maximise recruitment of those on placement. • Divisional Workforce Plans developed incorporating outcome of Strategic Service Delivery Plans, Hospital at Night project and FoAHSW business case	• "What's in it for me" events in June for Physicians Associates and Nurse Associates in June 2016 (70 attended) • Adverts placed for new roles – 16 x Physicians Associates, 9 x Housekeepers and 11 x Ward Administrators • On-going Assessment Centres for HCA's and B5 Nurses • Review of Mentors and increase in Commissions for Student Nurses • Bridging Programme for Band 4 Associate Nurse roles commenced 22nd June 2016 • Produced Divisional Medical Vacancy status for review with each Divisional Medical Director.	• Divisional SSDP's not complete by end of June as anticipated which delays the development of divisional workforce plans • Management of locum co-ordinators has not transferred to HR as agreed, which limits the ability to identify and rectify discrepancies, cost pressures and adherence to protocols in utilisation of HCL locum booking system	• Appointment to new roles 7 Ward Housekeepers at AGH and 2 at WRH, and 6 Ward Administrators at AGH and 5 at WRH. • 1st Cohort of Band 4 Foundation Degree Programme to commence Sep 2016 • Agree final commissioned training plan with UofW • Conditional offers to be made to 16 Physicians Associates across Medicine and Surgery to commence in October 2016 • Recruitment of locum co-ordinators to be in post by Sep 2016. • Continue to monitor medical vacancies and agree recruitment action plans. • First Agency Control Task and Finish Group meeting

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OD & Staff Engagement **SRO: Dir HR & OD**	Diane Pugh	**Policies / Standards**					• Review and develop key policies and procedures .• Strengthen and equip the HR Advisory Team. • Strengthen and equip Line Managers .• Reduce timelines of formal case management. • Develop better KPI monitoring of Case Management.	• Restructured HR Consultancy Team to provide additional capacity .• Drafted key change from Grievance Policy to Resolution Policy • Education and training of line managers in recognising and preventing bullying and harassment .• Commenced exercise on looking at reducing timelines on formal case management .• PDR policy reviewed and in consultation process with staff side.	Recruitment of Staff Support Advisers	• Develop team key objectives and education and training programme .• Resolution Policy to be negotiated with Staff side • Staff Support Advisers to be recruited. • Complete review of mandatory training programmes • PDR policy to be approved.

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OD & Staff Engagement **SRO: Dir HR & OD**	Lisa Thomson	**Staff Engagement**					• Introduce and implement Chat-back internal staff opinion survey • Introduce and implement Listening into Action Programme • Increase effective use of social media. • Review Trust Induction process and programme. • Set up staff engagement group • Implement programme of health and wellbeing events for staff. • Implement programme of staff reward and recognition events.	• First Chat-back survey results received and communicated to Divisions. • 10 LIA projects implemented and on-going. • Development of generic induction materials commenced. • Staff Achievement awards launched and 600 nomination forms received. • Continued use of social media for recruitment, and events held and to celebrate any successes. • Medical engagement event held – 8th August 2016.		• Continue communications re achievements by the LiA teams • Trust-wide style guide completed • Staff handbook trialled with a wider user group • Corporate slides finalised • Widen membership of the Staff Engagement Group • Trust-wide communication of values / plans • Audit of all poster boards in the Trust • Life Channel – upgrade and repair existing screens • Team Brief - Improve on podcast • Weekly digest delivered and evaluated • An additional four blog posts established • Day in the life programme

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Governance & Safety **SRO: CNO**	**Overall Programme**									
	Chris Rawlings	**Complaints & Serious Incidents**					• Thursday morning incident / SI review – 1hr meetings • First of two planned Investigation training sessions held in July • Patient Safety & Risk Manager appointed • Developed weekly sitrep for discussion at DoNs meeting and Divisional Governance Meetings • New complaints training session delivered • Complaints workshop held with Divisions & Corporate team.	• New process for the Operational Governance Meeting • New template for Initial Case Reviews, and pressure ulcer root cause analysis (RCA) • Trajectories set for reducing the number of open patient safety incidents • Datix dashboards piloted • External review of PSCs and complaints in Divisions • Complaints module developed and launched • Complaints workshop help to look at current process and realignment to a user - led approach	• Set up audit / monitoring of quality of investigations and complaints by Patient Safety Team • Introduce Duty of Candour monitoring reports for Trust and Division	• Investigation training and follow-up workshops to embed practice & identify need for additional training • Deliver Datix dashboards for all Divisions • Introduce checklists to assist the quality of investigation reports • CMO to reinstate Grand Rounds • Visit wards to raise awareness and educate re Datix, incidents / complaints / risks • Complete automation of the new weekly Sitrep for governance metrics, this will include improvement trajectories.

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Governance & Safety **SRO: CNO**	Sally Batley	**Governance Capacity & Capability**					• Review of the clinical governance teams with recommendations for structure and development • Trained and competent professionals providing support at corporate and Divisional level as one team • Support Divisional Management teams around assurance • 2016/17 Governance Work plan	• Second workshop held to start setting aims and objectives for the whole Governance team • Meeting with all corporate governance staff to understand current ways of working • First version of new reporting and escalation process and re-drafted terms of reference for Divisional governance meetings • Observed divisional quality committees • Top tier meeting to discuss proposed Trust Governance framework • Drop in session (4/8) for anyone in divisions who want to have a further discussion around the governance framework and proposed reporting requirements		• Complete review of clinical governance and deliver recommendations • Divisions to review their medical input for leading governance • Development of a new reporting and escalation format for reporting ward to Board • Redesign terms of reference for divisional quality committees to ensure standard approach • Work with medical directors and nursing directors on a programme of support around assurance, • Redesign Governance Forum to become more peer support and learning set focused • Provide this revised PCIP to the Divisions for their engagement and implementation

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Governance & Safety **SRO: CNO**	Sally Batley	**Implement improved ward to board quality reporting**					• Line of sight reporting from ward to board utilising exception reporting • Enable automatic data entry and minimise preparation time. • Develop a phased plan to deliver new improved line of sight	• First version of Divisional report / exception report – used as a worked example • First Clinical Governance Committee workshop held to set out purpose and content.	• Deliver a proposal to the QGC for revised Divisional quality reporting – dashboard, Quality Meeting Agendas and timescales – the QGC chair was unable to attend the July meeting.	• Review committee structure and function / purpose of quality committees • Convene a new Clinical Governance Group • CMO and CNO quality improvement learning developed monthly to be disseminated throughout the organisation • When the proposal is agreed, commence rescheduling of Divisional Governance Committees and Directorate Committees to align with the reporting framework.

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Governance & Safety **SRO: CNO**	Chris Rawlings	**Risk Management**					• 85% of risk assessments reviewed within the set periods i.e. not overdue • 85% of risks have actions within the due date • The corporate risk register reflects the organisation's risks (survey / workshop) • Effective management of risks by Divisions and escalation as required (understood by Directors with evidence of escalation) • Deliver practical risk management / Datix training to 75% risk owners. • Implement Ward Risk Register reporting process at Ward Manager level. 100% of wards • Implement a 'stubborn risk' peer-review process.	• Escalation process amended – TMC / Improvement Board will receive new / escalated risks at each meeting. • Patient Safety & Risk Manager appointed.	• Overdue actions notification turned on in Datix	• Review BAF – plan refresh using new control plan • Establish ward risk registers via the ward dashboard report • Test comprehensiveness of the corporate risk register with clinicians • Further education of Divisional teams in respect of escalation of risks

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HDU Review	**Overall Programme**									
SRO: COO	Sarah King	HDU Improvement Plan					• HDU Audit • Nurse training and competence • HDU Governance Framework • ICNARC Data Collection	• Initial patient acuity audit completed - resource for analysis obtained • Training status of staff reviewed • Funding identified for a professional development nurse to train and assess in line with the critical care core training standards • Nursing Workforce Training plan in place • The clinical leads for vascular and upper/lower GI surgery are reviewing and updating the current SOP's for both units. • ICNARC clerk appointed • Reviewed ward dashboards to separate HDU areas	• Review and revision of current operational policies	• Improvement metrics to be defined • Ensure VHDU / Ward audits are separated • Scope joint governance arrangements for HDU's and CCU • Scope current physio support to each unit • Identify which core staff would like to go on to complete the full critical care course. • Further training to be rolled out to all nursing staff to enable earlier recognition and escalation of deteriorating patients.

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Outpatients	**Overall Programme**									
SRO: COO	Dawn Robins/ Sabrina Brown	**Outpatient Environment**					• Standardise available information for patients in waiting rooms across all three hospital sites • Produce a standardised communications folder for staff across each outpatient site • To develop generic and consistent cleaning schedules for clinical areas in outpatients • To notify patients of clinic delays in real time; displayed on whiteboards • To provide adequate signage for patients or carers suffering with dementia • Provide appropriate and applicable information to patients across all television screens within outpatients	• Staff identified requirements for dementia friendly signage • The location of all hearing loops within outpatient areas have been identified • Photographs taken of all notice boards across the OPD areas; Band 7's between the sites have discussed noticeboards and agreed standardised version • Cleaning schedules between the sites have being collated • Communication folders are in the process of being developed / standardised in all departments • Patient questionnaire available on I-Pads for patients to complete	• Delays in obtaining sign off from estates team for dementia friendly signage to be utilised in OP areas • Delays in obtaining purchase order for dementia signage	• Begin collating baseline surveys from patients • Schedule hearing loop training for teams across the sites (Charity Hearing Link will provide) • Arrange for hearing loop specialist to visit all three sites to assess and troubleshoot loops and produce report • Share agreed cleaning rotas with all sites to implement • Review paediatric areas • Review CQC actions and commence preparation

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Name of director	Sarah Smith, Director of Planning and Development

Date of meeting: 07 September 2016 **Enc E2**

Programme / SRO	Project Lead	Work Stream	Month				Deliverables	Completed during this period (July)	Tasks Delayed/ Slipped	Planned in next period (August)
			A	M	J	J				
Outpatients **SRO: COO**	Lynne Mazzocchi/Sabrina Brown	**Standards & operating procedures**					• Devise and implement a standard operating procedure for all nursing staff within the outpatient service • Devise and implement a standard operating procedure for all reception staff within the outpatient service • Devise and implement a standard operating procedure for clinical specialties utilising the service • Engage and obtain support from medical and surgical Clinical Directors in the implementation of the standard operating procedure for clinical specialties • Standardisation of working practices for reception staff	• Agreed content for patient questionnaire to establish baseline of current customer care standards • Visit to Royal Orthopaedic Hospital to review their outpatient electronic check in and scheduling system and assess its benefits • Commenced the development of a flow chart for customer care standards • Established how many staff have undertaken ACE with PACE training		• Re-draft and sign off customer care standards flowchart and arrange for this to be uploaded in poster format • Commence draft for standards operating procedure • Review CQC actions and commence preparation

Title of report	Patient Care Improvement Plan
Name of director	Sarah Smith, Director of Planning and Development

Date of meeting: 07 September 2016 **Enc E2**

Programme / SRO	Project Lead	Work Stream	Month				Deliverables	Completed during this period (July)	Tasks Delayed/ Slipped	Planned in next period (August)
			A	M	J	J				
Outpatients **SRO: COO**	Kira Mortelmans /Sabrina Brown	**Clinic room scheduling & utilisation**					• Develop a countywide tool to standardise room utilisation • Devise and implement a standard operating procedure for room scheduling, cancellations and reinstatement of clinics • Develop and implement a process for booking, cancelling and reinstating clinics • Develop a dashboard in conjunction with the information team for reporting and monitoring • Develop training materials and guidance for process change • Roll out tool and process across both central and non - centrally managed areas (phased approach)	• Obtained and reviewed reports provided by information team. • Continue liaising with OP Sisters and booking team on current methods of room / staff scheduling • Process outlined for cancelling and reinstating clinics – taken to Waiting Time & Outpatient Improvement Board for discussion • Standard operating procedure drafted for revised cancelled and reinstatement of clinic process • Met with booking services regarding cancelled clinic database and processes for cancelling clinics		• Incorporate comments and revise drafted SOP • Feedback report changes to information team (cancelled clinics) • Meet with ICT regarding generic email alerts for cancelled clinics • Continue to develop reporting with Information Team • Begin to engage with other divisions that use the outpatient service; on the envisaged changes

Title of report	Patient Care Improvement Plan
Name of director	Sarah Smith, Director of Planning and Development

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 07 September 2016 **Enc E2**

Programme / SRO	Project Lead	Work Stream	Month				Deliverables	Completed during this period (July)	Tasks Delayed/ Slipped	Planned in next period (August)
			A	M	J	J				
Outpatients **SRO: COO**	Sabrina Brown	**Efficiency and productivity**					• Increase the usage of SMS Text appointment reminders by medical and surgical specialties • Reduce the number of late start clinics (prioritise specialties by late start frequencies)	• Clinic activity data report pulled by the informatics team for workstream • Obtained baseline data for SMS Text paper; • Weekly meeting set up with informatics team • Produced a case for change paper to provide an automatic opt in SMS appointment reminder service for patients. Submission now approved and is scheduled for discussion and sign off at next IG committee meeting - 12 September 2016 • Monthly project board meeting undertaken	• Obtaining sign off from IG to revised SMS policy	• Review clinic activity report and provide comment before sign off prior to go- live on informatics webpage • Review and assess clinic activity report and establish key findings (late start and finish times clinics & DNA's) and generate next steps within action plan • Create SMS Text implementation project plan • Receive formal information governance sign off for revised SMS policy (paper scheduled at IG committee meeting 12 September 2016)

	Work stream underdeveloped
	Work stream developed but no evidence to date of sustained improvement to date
	Work stream progressing well with evidence of sustained improvement this month

Title of report	Patient Care Improvement Plan
Name of director	Sarah Smith, Director of Planning and Development

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7 September 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:
	• Take into consideration the recommendation that WAG is not disestablished in the revised governance structure
	• Note the concern expressed in relation to the increase in medical vacancies
	• Note the update on
	  ○ Implementation of the new Junior Doctor contract
	  ○ Agency expenditure
	• Note the report

Previously considered by	*N/A*

Priorities (√)

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

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

Date of meeting: 7 September 2016 **Enc F1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – SEPTEMBER 2016

1. Situation

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

2. Background

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

3. Assessment

3.1 Revised Governance Structure

The Committee discussed the proposed revised Governance Structure. All members expressed their concern about the proposed disestablishment of WAG. Given the large agenda in relation to workforce, it was agreed to recommend to the Board that WAG would not be disestablished, but would be reviewed to give a more strategic emphasis. The Director of HR/OD has confirmed that she would consider a revised remit for WAG which will be discussed at the next meeting and reported to the Trust Board, together with revised terms of reference.

3.2 Staff Engagement

The divisions are considering and actioning the feedback from the first ChatBack survey. The trust wide staff survey is being launched in the next month and consideration is being given to the timing of the next ChatBack survey.

Listening into Action is beginning to show results for example longer opening hours for the Dining Room at the Alexandra Hospital, improvements to access to mandatory training and a revised shorter procedure for procurement. Ideas are currently being sought in relation to the next Listening into Action areas. The recent medical engagement survey will be bought to the Group at its next meeting.

3.3 Medical Workforce

The process for the recruitment of medical staff was outlined and assurance was given in respect of the work being undertaken to improve the systems in place within the HR department. Concern was expressed that the number of medical vacancies had increased and it is not clear how many of them have active recruitment plans. Divisions are being monitored through the Operations Meeting to ensure that vacant posts are advertised as soon as possible. This approach will be reviewed by the Executive Management Team to ensure that all is being undertaken to appoint to these crucial posts.

Locum coordinators are now centralised which will support the drive to reduce agency costs. There should be an early impact of this centralisation.

3.4 Nursing and Midwifery report

This is a Board agenda item. Recruitment of student nurses has improved and there is extensive work in the recruitment of nurses, although with little impact. The Committee

considered the report and can assure the Board on the efforts and ideas being introduced to address the challenges. The position at June 2016 was also considered.

3.5 **Agency expenditure**

Agency expenditure increased in month and exceeded forecast, although July's position was lower than budget. Expenditure levels remain within the NHS Improvement agency ceiling. Forecasting at Month 3 indicates that further savings of £1.3m are required to be delivered to ensure that the Trust can deliver within the agency ceiling. This figure is already included in the CIP figure in the Finance report.

Maximum wage rates became mandatory in July and this has resulted in an unexplained increase cost in Nursing which is being further investigated.

3.6 **Junior Doctor Contract implementation**

The Trust is on track to implement the new contract for FY1 doctors on 7 December. This is in line with the national guidance. The rotas have been remodelled to ensure that they are compatible with the 2016 terms and conditions. The Group was assured on the progress of this area of work.

3.7 **Other items considered:**

- **Workforce KPIs** – it was noted that all were as expected apart from recruitment
- **Health Education West Midlands – use of allocated funding –** the funding is being used for supporting the band 4 associate nurse programme, ChatBack, Know Bullying Training, Medical engagement and other initiatives such as Listening into Action.

4 **Recommendations**

The Board is requested to:

- Take into consideration the recommendation that WAG is not disestablished in the revised governance structure
- Note the concern expressed in relation to the increase in medical vacancies
- Note the update on
  - Implementation of the new Junior Doctor contract
  - Agency expenditure
- Note the report

John Burbeck
Chair of the Workforce Assurance Group

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

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7 September 2016 **Enc F2**

Report to Trust Board

Title	**Nursing and Midwifery Workforce Report as at 31 July 2016**
Sponsoring Director	**Jan Stevens, Chief Nursing Officer**
Author	**Sarah Needham**
Action Required	The Board is asked to receive the report on: • Nursing and Midwifery Workforce metrics and associated actions • Safe Staffing Status • Note the actions identified and underway in section 5
Previously considered by	WAG (5-9-16)
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 TDA – Trust Development Authority NICE –National Institute for Health and Care Excellence NMC Nursing and Midwifery Council NQB National Quality Board

Key Messages

- Safe staffing status and performance against TDA benchmark remains positive.
- An update on the continuing nursing and midwifery workforce review
- Progress on the reduction of use of agency staff.
- Recruitment to vacancies have improved across the Trust

Date of meeting: 7 September 2016 **Enc F2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 7 SEPTEMBER 2016

1. Situation

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

2. Background

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

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 settings during 2016. These will include Urgent and Emergency Care, Maternity Services, Children's Services and Inpatient wards for adults in acute hospitals.

Key points within the new NQB guidance will be :

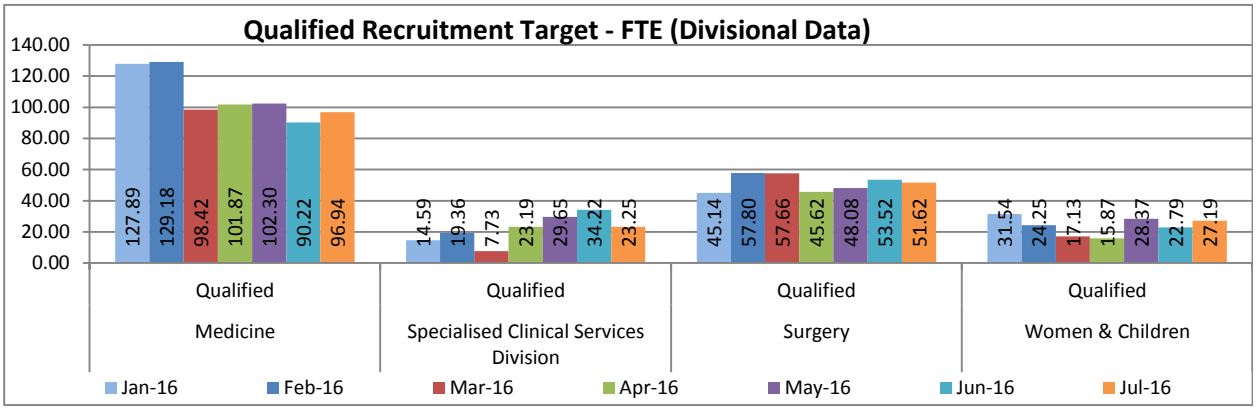
- Expectations in terms of delivery will be reframed and reduced in number.
- Boards have shared responsibility for staffing.
- Staffing models to look at multi-professional teams

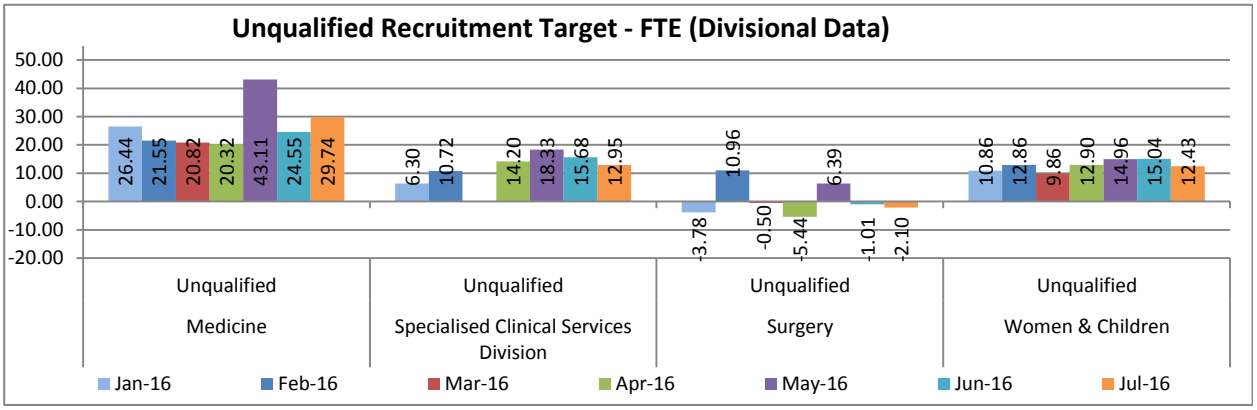
3 Assessment

3.1 Nursing and Midwifery workforce metrics.

The nursing and midwifery vacancy position reported as of 31 July 2016

Recruitment Target Data supplied by the Divisions:





Surgery

The vacancies for registered nurses within Surgery are 51.62 WTE for July 2016 This is compared to 53.52 WTE for June 2016.

Both sites are running with similar vacancies, the next cohort of new starters are to commence in September 2016. Generic job adverts and speciality adverts are out every month. Five ward administrator posts due to commence in the Division and four nurses identified from the Return to Practice Event along with one trained nurse with current pin and 2 HCAs.

Medicine

The vacancies for registered nurses within medicine was 96.94 WTE in July 2016 compared to 90.22 WTE in June 2016.

The vacancies for non- registered staff were 29.74 WTE in July, compared to 24.55 WTE in June 2016. Recruitment to the Alexandra continues to be a challenge. However, it is envisaged that with the Trusts publicity campaign to highlight that the hospital has a bright future will impact on increasing the numbers of people applying for posts.

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

TACO/Clinical Support

Vacancies within TACO/Clinical Support were 23.25 WTE in July 2016 for registered staff and 12.95 WTE for non-registered staff. The vacancy position has decreased within the Division following the workforce review.

Women & Children

Within Women and Childrens Division the vacancy position has decreased, there are 27.19 WTE for registered staff and 15.04 WTE for non-registered staff.

Gynaecology inpatient areas have a higher than normal vacancy rate which we understand from exit interviews relate to the nurses wanting to work in a woman's centred ward. They do not wish to work in a mixed sex environment. The exit interviews have also identified that gynaecology nursing supports an ambulatory model in which they are managing emergencies and inpatients as a whole pathway. This has proved to be difficult following the transfer of obstetrics and gynaecology losing its ward base.

The surgical DDN and Women and Children's DDNM are working together to develop different models which aim to demonstrate that we have listened to the staff feedback.

Obstetric theatres continue to have no permanent staff in ODP or scrub nurse posts. The division is working with the Clinical Services Division to Develop Band 4 assistant practitioner scrub roles and rotational ODP posts. The posts are being covered by Agency.

Recruitment Actions

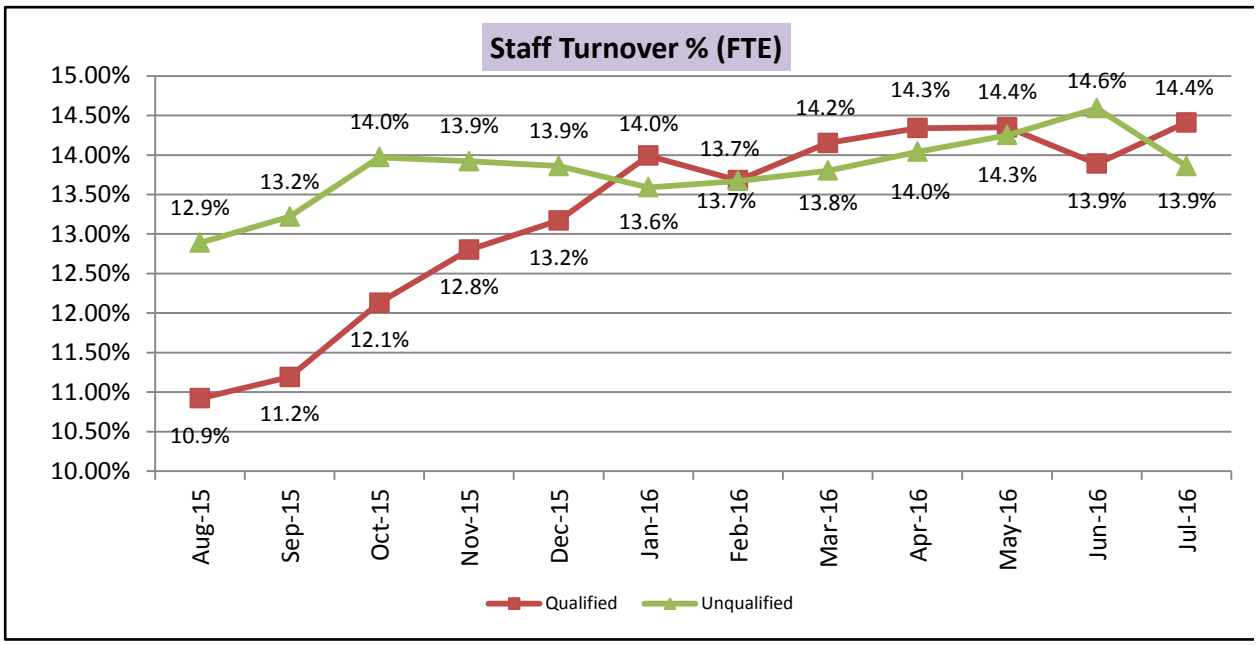
Recruitment events are being planned for the next 12 months rotating around the Trusts three sites. There is has also been work in collaboration with NHSP regarding targeting increasing the number of staff on their books and they are now due to commence fortnightly recruitment events around the trust.

The recruitment event is in partnership with Worcester University to promote funding available from HEE for return to practice training was quite successful. The outcome was;

1. Trained nurse with current registration to be offered full time post
2. 4 Return to practice nurses
3. 2 Potential HCA's.

This was advertised via Facebook, Twitter, posters and was televised on central news, who wish to do a follow up programme.

Retention



The staff turnover rate has increased slightly again across the qualified workforce and unqualified has slightly reduced over the last month. Human resources have completed a deep dive to review the rationale for staff turnover and are due to present an action plan of the way forward.

In relation to the cumulative turnover, analysis has been undertaken to identify the departments with the highest number of qualified leavers (permanent contracts) excluding those employees whom departed on Flexi-Retirement in the 12 month period up ending 31st July 2016:

QUAL STARTERS AND LEAVERS – 12 MONTHS **Exc. Fixed Term Contracts and Flexi-Retirements**				
Department	**Site**	**Starters (WTE)**	**Leavers (WTE)**	**Reasons**
365 A&E Nursing Staff WRH	WRH	17.24	13.64	13.64wte voluntary resignation
365 A&E Nursing Staff AGH	AGH	4.63	10.84	9.56wte voluntary resignation & 1.28wte retirement
365 Maternity Team 1 - WRH	WRH	11.03	9.13	8.60wte voluntary resignation & 0.53wte retirement
365 Hosp at Home Serv-Paeds	Community (Transferred to HACW)	0.00	8.65	7.85wte employee transfer & 0.80wte voluntary resignation
365 Laurel 1 Cardiology-CCU	WRH	4.00	7.36	6.36wte voluntary resignation & 1.00wte retirement
365 M A U - Alex	AGH	6.61	7.20	5.40wte voluntary resignation,

				1.00wte retirement & 0.80wte dismissal
365 ICCU - Worcs	WRH	2.96	7.20	7.20wte voluntary resignation
365 Midwifery Alex	WRH (RELOCATED)	0.00	6.96	6.16 wte voluntary resignation & 0.80 retirement
TRUST		185.04	233.57	

The top 5 reasons for permanent qualified staff leaving the Trust in the 12 month period up to 31st July 2016 were:

- Work Life Balance 52.01wte
- Retirement inc. early and flexible retirement 41.67wte (11.49wte returning to Trust)
- Relocation 40.68wte
- Better Reward Package 20.29wte
- Promotion 19.43wte

DESTINATION UPON LEAVING

The top 5 destinations for leaving for permanent qualified staff leaving the Trust in the 12 month period up to 31st July 2016 were:

- NHS Organisation 128.54wte
- No Employment 37.95wte
- Unknown 16.16wte
- Private Health/Social Care 12.04wte
- General Practice 11.37wte

The key local NHS competitors for our qualified staff in the last 12 months are:

- Worcestershire Health and Care Trust 27.60wte
- UHB 10.56wte
- South Warwickshire FTE 6.92wte
- Wye Valley NHS Trust 4.80wte
- Royal Orthopaedic Hospitals NHS Trust 3.91wte
- Dudley NHS TF 3.32wte
- Heart of England 3.00wte
- Birmingham Women's 3.00wte

The employing organisation associated with 23.44wte departing qualified leavers is unknown.

3.2 Safer staffing

Trust overall fill rates for July 2016

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

	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	90.8%	105.7%	93.4%	95.1%
KIDDERMINSTER HOSPITAL	82.0%	82.8%	98.4%	102.8%
KIDDERMINSTER TREATMENT CENTRE	100.0%	100.0%	100.0%	100.0%
WORCESTERSHIRE ROYAL HOSPITAL	92.8%	100.3%	94.3%	95.0%

The table below outlines fill rate by ward.

	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Acute Stroke Unit	87.2%	99.8%	93.0%	100.5 %
Avon 2- Gastro	103.6%	85.0%	110.0%	103.2 %
Avon 3- Infectious Diseases	93.9%	87.7%	73.2%	110.9 %
Laurel 1 Cardiology-CCU	92.7%	125.0 %	99.5%	183.9 %
Laurel 2 Resp	94.2%	88.0%	91.1%	106.9 %
Medical Assessment Unit WRH	90.7%	106.8 %	90.3%	104.7 %
Medical High Care and Short Stay	71.6%	96.8%	88.8%	83.0%
Silver Assessment Unit	102.8%	94.9%	99.9%	94.0%
GP Unit WF - ward (TCS)	82.0%	82.8%	98.4%	102.8 %
MAU ALX	76.8%	104.2 %	80.2%	84.0%
Ward 12 Medicine	75.5%	90.0%	102.5%	95.6%
Ward 2 Specialist Med	102.9%	116.1 %	75.8%	101.9 %
Ward 6	87.0%	95.7%	100.1%	134.6 %
CCU- Alex	76.7%	-	99.9%	-
Ward 14	94.1%	121.1 %	102.9%	112.6 %
Ward 11	85.8%	96.2%	103.4%	98.4%
Ward 16	88.3%	115.4 %	72.7%	85.1%
Ward 17	95.2%	108.0 %	119.7%	68.1%
Ward 18	86.6%	107.4 %	83.6%	103.0 %
SCDU & SHDU	114.3%	96.8%	79.5%	100.0 %

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

Beech B	82.7%	119.9 %	98.6%	83.1%
Chestnut	94.7%	112.6 %	103.5%	84.9%
Trauma & Orthopaedics	89.2%	117.2 %	105.0%	98.2%
Severn Unit & HDU	78.8%	72.4%	96.8%	90.9%
WRH Delivery Suite & Theatre	86.0%	99.9%	92.8%	82.3%
WRH Postnatal Ward	90.0%	95.4%	89.5%	73.1%
WRH Riverbank	91.7%	49.4%	97.4%	55.1%
Alex Ward 1	105.1%	82.1%	65.6%	90.3%
WRH Neonatal	108.9%	93.5%	105.6%	71.0%
WRH Antenatal Ward	90.7%	100.0 %	87.1%	80.6%
Laurel 3, WRH	96.0%	90.9%	94.4%	103.2 %

Key

- 80%	
80-94.9%	
95% +	

4 Progress with the use of Bank and Agency staff

Work continues to support NHSP in increasing there numbers of staff on the books. A process map has also been developed to inform staff of the Tier process and the escalation triggers and signs offs required to progress to tier 2.

5 Overview of actions and assurance taking place to address the issues which are across the Divisions.

Number	Action
1	The Trust is currently working in partnership with the University and the STP to submit a tender application for the consideration of the Nursing associate training. This has been completed and the Trust should be notified in October 2016.
2	House Keepers and Ward administrators have now been interviewed and an information sessions has been arranged at Worcester and Redditch site so that all staff are aware of new role requirements. Information sessions have now been completed and now we are working on a Rapid Spread change management programme to ensure staff engagement and buy in on implementation. This will take place in September 2016.
3	Return to practice awareness session in partnership with University to attract experience nurses into the profession. This has now been completed and 4 nurses have been identified for training, 2 HCAs into permanent posts and 1 qualified nurse with her pin will be recruited into a permanent post.

4	E –roster review has identified a number of inefficiencies and universal controls which aren't being adhered to along with the scrutiny of authorisation. It is planned that the next workforce paper will include data re e –roster compliance in order to drive improvements This will now be included in a new format NWAG report and will include the following headings; Recruit, Retain, Retire, Redesign, return, Reward, Rules. This is being done in partnership with Debbie Drew from HR and will be presented in Octobers meeting.
5	Annual recruitment plan currently being worked up and then will be cascaded to divisions
6	A workforce review is currently taking place and the aim is that the impact of this work will be seen in the NWAG report KPI's
7	A paper will be taken to the board in August requesting an 8 week pilot whereby staff are paid to band. Currently staff in maternity are doing additional shifts in Hereford which is putting staffing and safety concerns in this area.

Recommendations

The Board is asked to receive the report on:

- Nursing and Midwifery Workforce metrics and associated actions
- Safe Staffing Status
- Note the actions identified and underway in section 5

Jan Stevens
Interim Chief Nursing Officer

Worcestershire NHS
Acute Hospitals NHS Trust

7 September 2016 **Enclosure G1**

Report to Trust Board (in public)

Title	**Finance & Performance Committee Report** Meetings held on 29 July and 5 September 2016
Sponsoring Director	**Andrew Sleigh – Finance & Performance Committee Chairman/ Non-Executive Director**
Author	**Andrew Sleigh – Finance & Performance Committee Chairman/ Non-Executive Director**
Action Required	• Note that the audit conducted by PwC confirms the reality of the £10m savings in agency spend during Q4 of last financial year with this reduction continuing in 2016/2017. • Congratulate the teams for achieving the planned deficit at Q1, and completing a rigorous re-forecasting of the rest of the year. • To note the financial forecast aligns with the planned deficit, but that £15M of risks to that forecast have been identified with plans largely in place for mitigation. Also the potential upside of £2-5M from enhanced elective activity. • The Board must focus on areas where operational performance continues to fall behind the planned trajectory, in particular addressing the Referral to Treatment (RTT) targets, strengthening implementation of the Patient Care Improvement Programme (PCIP), and delivering the PwC project to improved productivity in operating theatres. • Note that the Committee has approved initiation of designs and submission of a distressed capital loan bid to complete the closure of A Block at Kidderminster, decommissioning Aconbury East and essential refurbishment of infrastructure. Also approved were Bundles 1 and 2 of the proposed car parking improvements subject to conditions being met.
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

Title of report	Finance & Performance Committee Report (Month 4)
Name of director	Andrew Sleigh

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

- While the year to date deficit was on plan at end of Q1, failure to meet Sustainability & Transformation Fund (STF) performance targets led to a modest shortfall at end of August, (both income and costs significantly below plan). The new full year forecast predicts meeting the year-end deficit with firm control of the cost element, but risks totalling £15m have been identified, the largest being concerned with Theatres productivity improvement and meeting the STF targets. Each of these risks are subject to detailed management action with plans in place to mitigate.
- The key financial challenge is to focus unremittingly on delivering these mitigation plans, and on the potential £2-5m upside if elective throughput can be fully achieved. The Board must recognise the challenge in delivering the risk mitigations, and provide the leadership necessary to motivate every employee to strain every sinew to deliver these plans.
- A significant driver of improving elective and non-elective throughput, and achieving RTT targets, is delivering the PwC improvement process relating to the theatre usage. At the July Finance & Performance Committee (FPC) meeting serious concerns were expressed about Departmental Managers engagement in fully supporting the process, which was falling behind in delivering benefit compared with other Trusts that PwC has supported, eg with only 49 of 94 additional procedures identified being delivered. Some areas (eg Urology) had achieved excellent progress, but others were yet to fully engage. At the September meeting, reassurance was given through a special joint session of PwC and Surgery Division that significant progress had been made during August, even though this was not yet showing through in the numbers. Operational, Governance, and Medium Term action plans were presented. The Executive Team will look at the specific requests for support to accelerate implementation.
- It was also agreed that selective costs can be incurred where the benefit to activity leads to a positive contribution through increased income or avoidance of penalties.
- Evidence was presented at the July meeting that where the PCIP actions had been implemented, benefits in financial and clinical performance occurred, eg proper adoption of the SAFER bundle and streaming at the front door. But this was still patchy in its adoption. At the September meeting it was reported that little further progress has been made. The Committee was not assured this programme is meeting our objectives. As a result the Chief Executive has brought this programme into special oversight by the Executive Team. The Committee received a presentation on the steps being taken to bring focus to the PCIP programme.

- Recruitment limitations are becoming a major risk to meeting both clinical and financial targets. Recruitment problems have reflected in increased premium staffing projected for the winter period. The Committee expressed serious concern that planning in advance for vacancies known to arise is weak, with delays in processing recruitment requests once initiated. The Committee asked executive members to take urgent action to address this issue.
- The Trust is struggling to meet the STF targets for RTT, A&E 4hrs and Cancer 62 Day Waits. During August plans have been put in place to address the shortfall, and crucially these plans are now owned by the clinicians. Recovery to the planned trajectory is expected by end of October except for the RTT target where, despite there being some short term opportunity, the full benefits from theatre productivity will be critical. The Chief Executive has brought RTT performance under direct oversight of the Executive Team.
- The quarterly update on procurement savings showed that savings are well on target and expect to exceed the budgeted amount.

Worcestershire NHS
Acute Hospitals NHS Trust

7 September 2016 **Enclosure G1**

REPORT TO THE BOARD

1. Situation

This report informs the Board of the actions, scrutiny and assurance undertaken by the FPC at its meetings on 29 July and 5 September 2016.

2. Background

The FPC meets to review the financial and operational performance of the Trust and reviews forecasts and plans for future performance, and gain assurance that the plans for performance improvement meet the Trust's objectives. 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 approved the Bundles 1 and 2 of the proposed car parking improvement plans on condition that the grant from the County Air Ambulance Trust is confirmed. Preparation for Bundle 3 was agreed, with approval being considered once planning is obtained.

The committee agreed the proposal to submit a distressed capital bid and develop options to complete the closure of A Block at the Kidderminster site, relocating the Occupational Health and Diabetics/Dietetics departments. It was expected that alternative revenue-generating uses of the building will be found. Distressed Capital bids were also approved for emptying Aconbury East and various essential infrastructure refurbishments.

The Committee approved the ERIC submission concerning summary data describing the Trust's estate and estate costs.

3.2 Principal Areas of Performance Scrutinised Where Assurance Was Received

- The Committee received assurance that the full year forecast has been derived soundly on a bottom-up basis with ownership by the Divisions. Assurance has also been obtained that cost controls are now in place and are effective. The Committee received reassurance that the significant risks identified to the forecast are largely mitigated by plans already in place, with noted exceptions, and recognises the challenges to fully delivering these plans.
- The presentations given by Surgery Division and PwC gave limited assurance that this programme is now making good headway, with reassurance that positive impact on the numbers will be seen next time.

Title of report	Finance & Performance Committee Report (Month 4)
Name of director	Andrew Sleigh

- The Committee reviewed the plans now in place to ensure the STF target trajectories are delivered, albeit later than planned dates. Reassurance was given that these plans are now in place and owned, with particular risk areas now being directly overseen by the Chief Executive and the Executive Team.
- A revised QIA process was presented to the Committee, which addresses assurance concerns expressed at the previous FPC meeting.
- The quarterly update on Key Performance Indicators (KPIs) for procurement and supplies was presented. This indicates the good progress that is being made on reducing non-catalogue purchase lines, reducing non-purchase order value, and delivering ahead of the planned procurement savings.

3.3 Principal Areas of Performance Scrutinised Where Assurance Was Not Received

- The Committee was not assured that the plans for the PCIP programme will be delivered successfully in a timely way. In particular managing flow through full adoption of SAFER Bundle, discharge to assess and early streaming at admission, with failure to make progress likely to impede the improvement trajectory towards key clinical targets. The committee supported the Chief Executive approach of bringing this programme under the Executive Team.
- The Committee is not assured of the effectiveness of recruitment, and see this as a major risk to the Trust's success. There is a clear need to address a forward look in planning for vacancies, coupled with eliminating delays and initiating proactive steps to promote the attractiveness of the Trust.

3.4 Review of BAF Risks

Risks 2888 and 2668 have been addressed in the Finance section of the meeting. Risk 3193 was addressed in the Performance sections. It was noted that risk 3193 was in need of updating. Risks 2665 and 2904 are expected to be transferred to the Committee under the recent sub-Committee changes. It is recommended that a new risk concerning the development and investment in a fit-for-purpose Informatics Strategy should be added to the BAF as a risk owned at main Board level.

4. Recommendations

The Board is recommended to:

- Celebrate the achievement of the Q1 deficit target and completion of a full bottom up forecast.

Title of report	Finance & Performance Committee Report (Month 4)
Name of director	Andrew Sleigh

- Note the risks totalling £15m that have been identified in the forecast, and to take steps to strength leadership at all levels to implement plans to mitigate these risks.
- Take steps to resolve weaknesses at all stages in recruitment, which is emerging as a crucial risk.

Andrew Sleigh
Non-Executive Director
Chair Finance and Performance Committee

Worcestershire NHS
Acute Hospitals NHS Trust

07 September 2016 **Enclosure G2**

Report to Trust Board in Public

Title	Integrated Performance Report (July 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 July 2016. The key performance issues and the mitigating actions are described in the report itself.
Previously considered by	Finance and Performance 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
Glossary	IPR – Integrated Performance Report SHMI – Summary Hospital Mortality Indicator HSMR – Hospital Standardised Mortality Ratio YTD – Year to Date RTT – Referral to Treatment STF – Sustainability and Transformation Fund PTL – Patient Tracking List

Key Messages

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

Worcestershire NHS
Acute Hospitals NHS Trust

07 September 2016 **Enclosure G2**

REPORT TO TRUST BOARD SEPTEMBER 2016

1. Situation

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

2. Background

This paper updates the Board on the Trust's current performance against nationally and locally agreed targets and other key priorities, and summarises the actions being taken or planned to address non - compliance. For full detail on performance in July 2016, please refer to the IPR report and Trust dashboard.

3. Assessment

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

Emergency Access Standard

The Trust did not achieve the 95% Emergency Access Standard (EAS) in July 2016. Performance remained below 95% at 85.7%; an increase from 84.7% in June 2016. There was significant pressure on the ED from levels of attendance (13,859 attendances in July 2016 compared with 13,134 in July 2015) and on-going issues with exit block resulting in overcrowding in the WRH ED in particular. The Trust is working with partners in the System Resilience Group and the Emergency Care Improvement Programme to address the range of Trust and system issues underpinning this performance.

The Trust failed to deliver the national 15 minute standard for assessment in Emergency Department (ED) for the 95th percentile wait (all patients) however performance remained relatively stable at 30 minutes compared to 28 minutes in June 2016. The median wait for treatment in the ED remained at 64 minutes, which is just greater than the national standard of 60 minutes.

18 weeks Referral to Treatment (RTT)

Since February 2016, the Trust has been unable to report compliance with the 92% 18 Week referral to treatment incomplete pathways target. Performance in July 2016 was 87.80%.

This performance challenge is largely a result of the temporary reduction in additional elective capacity (from changes in Trust policy in respect of additional 'ad hoc' clinical activity) It is anticipated that the performance will not be recovered until Q3 2016/17 in line with the STF trajectory.

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

Cancer Performance

The 62 - day target of 85% for cancer first treatment was not achieved in July 2016 and performance was 65.93%, a decrease from 68.10% in June 2016. It is anticipated that the deterioration in performance will continue over the next 3 months as the Trust works through the backlog of over 62 day waiters

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

Performance in respect of the 2 week wait (2ww) cancer waits (all) recovered to 75.62% in July. It is anticipated that performance to previous levels will not be recovered until September 2016, and target performance (93%) won't be delivered until October 2016.

For breast symptomatic patients, 2ww performance in July recovered to 74.5% compared with 55.7% in June. It is anticipated that the Directorate will return to the levels of historic performance (circa 80%) in September 2016 and target performance (93%) from October 2016.

Diagnostics Waiting Time Standard
In July 2016, the Trust failed achieved the target of < 1% of patients waiting longer than 6 weeks for diagnostic tests however actual performance improved to 2.07% from 2.70% in June. Capacity issues remain in particular in radiology and endoscopy. It is anticipated that the Trust's performance will recover and be sustained from Q2 onwards.

Stroke care
Issues with the agreed countywide stroke pathways resulted throughout the month in numbers of patients in double figures occupying acute stroke beds that were ready for transfer to community care settings. These issues are urgently being worked through with health economy partners and at the time of writing this report they have not yet been fully resolved.

There are separate Board reports from the Board sub committees relating to quality, workforce and financial performance indicators.

4. Recommendation

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

Sarah Smith
Director of Planning & Development

Worcestershire NHS
Acute Hospitals NHS Trust

Enc G2
attachment 1

INTEGRATED PERFORMANCE REPORT

July 2016

Released: August 31st 2016

Please note:

All data relates to July 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

Worcestershire NHS
Acute Hospitals NHS Trust

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attachment 1

Overview

Performance, efficiency, quality, safety and workforce metrics

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

Performance on /above target with positive trend

- Number of grade 4 pressure ulcers – *MONITORED IN QGC*
- Falls with serious harm
- MRSA bacteraemia
- Friends and Family Test – A&E score
- Never events
- 31 day cancer – first treatment (all cancers)
- Workforce - % of consultants that have had appraisal

Performance on /above target with negative trend

- VTE
- Friends and Family Test - Acute wards score
- Friends and Family Test - Maternity score
- % beds occupied by NEL stranded patients (LoS > 7 days)

Performance under target with positive trend

- Serious incidents open over 60 days and awaiting closure
- Safety Thermometer – *MONITORED IN QGC*
- Number of grade 3 pressure ulcers - *MONITORED IN QGC*
- Primary Mortality Reviews – *MONITORED IN QGC*
- *Bed occupancy WRH/AGH (DASHBOARD ONLY – REPORTED THROUGH EAS CAS)*
- A&E - 4 hour Emergency Access Standard
- A&E - Ambulance handover within 15 minutes
- A&E - Ambulance handover within 30 minutes
- A&E - Ambulance handover over 60 minutes
- A&E – unplanned re-attendance within 7 days (DASHBOARD ONLY – REPORTED THROUGH EAS CAS)
- Cancer - 2 week wait (all cancers)
- Cancer - 2 week wait (breast symptomatic)
- 6 week wait for diagnostics
- 28 day breaches as % of cancellation
- Workforce – nursing staff turnover (unqualified)
- Workforce – all staff turnover
- *Workforce – agency staff medics (DASHBOARD ONLY - MANAGED AND REPORTED THROUGH FINANCIAL PERFORMANCE REPORT)*

Performance under target with negative trend

- Secondary Mortality Reviews – *MONITORED IN QGC*
- Clostridium Difficile (Monthly)
- Category 2 Complaints responded to within complainant deadline
- Friends and family test response rates
- Hip fracture - time to theatre
- % approved risks with overdue action
- 18 week Referral to Treatment – Incomplete
- A& E – Time to initial assessment (all patients and ambulance) - 95th percentile
- Cancer - 62 days wait for first treatment from all GP referral (all cancers)
- Workforce – nursing staff turnover (qualified)
- Workforce-sickness absence monthly
- Workforce - % of medical staff that have had appraisal
- Workforce - % of non-medical staff that have had appraisal
- Workforce - % of eligible staff completing statutory and mandatory training
- Stroke/TIA metrices – (*JUNE AND JULY DATA STILL TO BE VALIDATED FOLLOWING CHANGE TO NATIONAL DEFINITIONS FOR REPORTING)*

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Summary

National / NHS Constitution Standards

The Trust continues to experience significant challenges in respect of key waiting time performance indicators (such as cancer waits and non-cancer referral to treatment times) following the temporary reduction in additional elective and diagnostic capacity. 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 performance during 2016/17 and there has been some recovery in Q1 (cancer 2 week waits) however there will be on-going adverse impact across the board in Q2 as the Trust continues to work through the patient backlog, with recovery anticipated mainly in Q3.

For many months the Trust has struggled with patient flow in the Emergency Departments due to exit block and poor flow elsewhere in the hospital. There remains considerable overcrowding and pressure on the EDs from poor patient flow and, in addition, from an increase in ED attendances compared with the same period last year (13,859 in July 2016 vs 13,134 in July 2015) and from surges in attendance. This impacts the 4 hour wait target and these issues are being mitigated through the Patient Care Improvement Plan. This month and last, there have been signs of some sustained impact, especially in terms of ambulance handovers and time to initial assessment in the ED. The Trust is not planning to fully recover 4 hour performance during 2016/17 but improvement to above 90% is expected.

Issues with the agreed countywide stroke pathways resulted throughout the month in numbers of patients in double figures occupying acute stroke beds that were ready for transfer to community care settings. These issues are urgently being worked through with health economy partners although at the time of writing this report they have not yet been fully resolved.

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. Poor patient flow and high levels of bed occupancy also impact the Trust's elective programme which has also been adversely affected by temporary reductions in additional elective and diagnostic capacity.

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)
- 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)
- 4 Hour Waits (%) - Trust inc. MIU (CAE1.1a) referencing Stranded Patients (PIN2.3)
- 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)
- 6 Week Wait Diagnostics (Proportion of waiting list)(PW1.1.1)
- 28 Day Breaches as a % of Cancellations (PEL3.0) reference to Urgent Operations Cancelled for 2nd time (PEL4.2)

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)

Situation

Performance against this standard has been declining since February 2016 and has plateaued around 88% from the beginning of the financial year. Performance in July 2016 is 87.80% which is an underperformance against both the 92% national standard and the Trust's sustainability and transformation fund (STF) trajectory of 91.39%. The challenged specialties remain Thoracic Medicine (72.40%), Dermatology (78.14%), Oral Surgery (80.96%), Trauma and Orthopaedics (80.51%), Gynaecology (84.54%), General Surgery (84.54%) and Neurology (86.50%). The specialty showing most improvement is Dermatology (backlog reduced by 140 patients and performance of 78.14% versus 74.17% in June). There are no 52+week waiters as at the end of July 2016. It is anticipated that the performance will be recovered in Quarter 3 in line with the STF trajectory.

Gaps in control

Significant data quality issues remain and validation both in-month and month end validation is undertaken on a specialty by specialty basis. General Surgery has shown the greatest deterioration in performance linked to the reduction of additional activity (routine and 2ww) followed by T&O and Rheumatology. Ophthalmology continues to meet the 92% standard, however, has deteriorated further compared to the previous month position (92.9% v 93.62% in June).

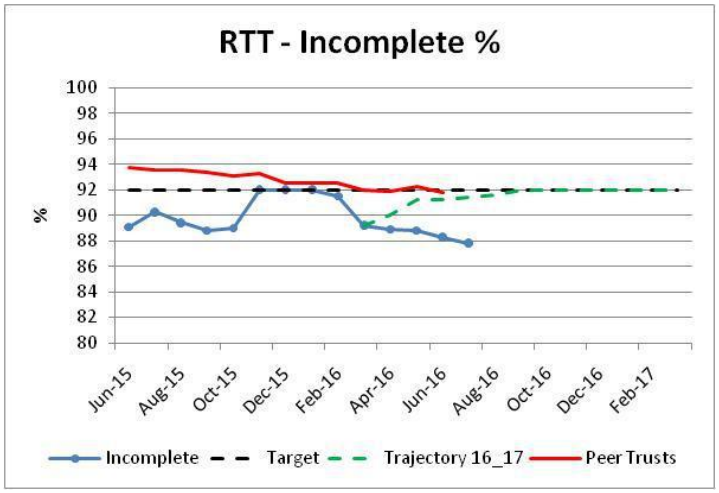
Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Remedial action plans with recovery trajectories for all challenged specialties to be agreed with commissioners	Deputy COO	27/07/2016	August 2016 onwards
2.	Weekly PTL meetings with dedicated specialty slots	Head of Elective Performance and Patient Access	On-going	Forward look and proactive avoidance of potential 52 week breaches
3.	Robust waiting list validation and management	Head of Elective Performance and Patient Access / DDOps	On-going	August 2016 onwards

Recovery forecast

Below are the trajectories agreed with the Clinical Commissioning Groups as part of the STF:

TARGET	August	September	October	November	December
92.00%	91.58%	92.00%	92.00%	92.00%	92.00%



SRO: Chief Operating Officer
Current reporting month performance: 87.80%
Last reported month performance: 88.26%
YTD performance: N/A

Key Performance Indicator: Cancer – 62 days wait for first treatment from GP referral

Situation

The Trust has not achieved the 62 - day standard in July 2016; current *unvalidated* July performance against the 85% national standard is 65.93%. This is an underachievement and is below the Trust's submitted sustainability and transformation fund STF trajectory. This is a predicted underperformance as there were fewer breaches than planned in Quarter 1 and the reduction of backlog has continued into Quarter 2. 36% of the breaches are in Urology (18), followed by Lower GI (11) and Skin (5). Looking forward, as at 15/08/16 the backlog of patients over 62 days is 148; this poses a significant risk to performance in Quarter 2 as it is worked through, and it is anticipated that the standard will not be recovered until Quarter 3.

Gaps in control

Performance against this standard has been significantly impacted as a result of reduced additional activity at various stages of the 62 day pathways (mainly 2ww and diagnostics) which has been slow to reset. Colorectal 2ww, endoscopy and urology surgery capacity remain a challenge and are the main causes of the increase in backlog of patients waiting over 62 days. Other contributing factors include increase in 2ww referrals (Colorectal, Skin, Breast, Head and Neck, Urology) and sub-optimal patient tracking processes.

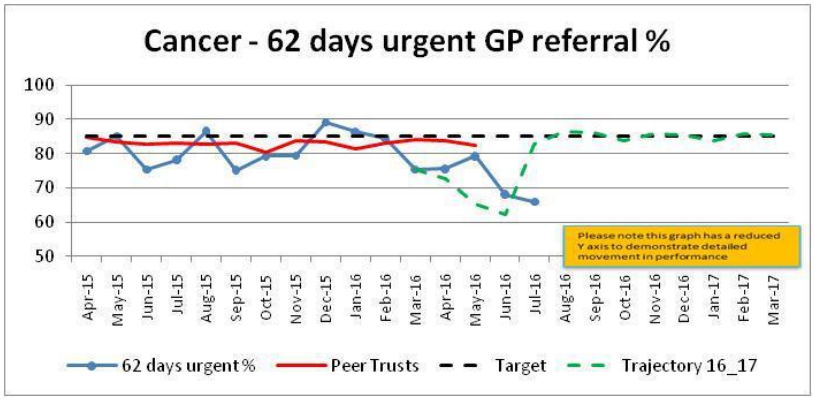
Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Achieve compliance with 2ww standard (in line with remedial action plan shared with commissioners)	DDOPs – Surgery, Medicine and W&C	October 2016	November 2016 onwards
2.	Achieve compliance with diagnostic standard (in line with remedial action plan shared with commissioners)	DDOPS - SCS	**July 2016**	September 2016 onwards
3.	Implement weekly confirm and challenge reviews of patients waiting 62 days and over	Deputy COO	15/07/2016	Initially performance will deteriorate whilst backlog is being reduced; improved performance from September 2016 onwards
4.	Bring on line additional urology surgery capacity through utilisation of Theatre 6 at AGH and Independent Sector	DDOPs Surgery	August 2016	Initially performance will deteriorate whilst backlog is being reduced; improved performance from September 2016 onwards

Recovery forecast

Below are the trajectories agreed with the Clinical Commissioning Groups as part of the STF:

TARGET	August	September	October	November	December
85.00%	86.3%	86.1%	83.6%	85.8%	85.4%



SRO: Chief Operating Officer
Current reporting month performance: 65.93% (not finalised until (early Sept)
Last reported month performance: 68.1%
YTD performance: 71.9%

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

Situation

Current July performance shows improvement compared to June (75.50% v 69.19%), however, it remains significantly below the 93% target. The largest numbers of breaches in July were in Colorectal (178), Skin (63), Upper GI (25) and Urology (23). It is anticipated that breach numbers will increase in August due to continued low uptake of additional activity in Colorectal and reduced capacity in Breast Surgery. Forecast performance against the trajectory is 65% in August followed by return to the historic levels of performance from September onwards (80-85%) and achievement of the standard from October 2016.

Gaps in control

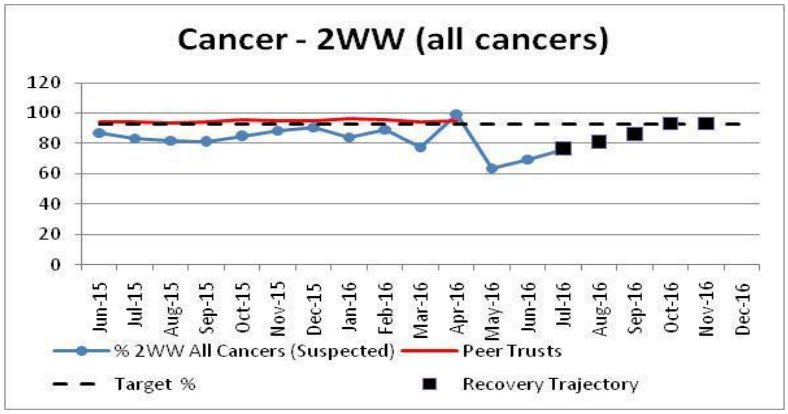
The backlog of patients waiting over 14 days has been cleared in most specialties with the exception of colorectal surgery and Skin. An agreement has been reached with the clinical team to hold additional colorectal 2ww clinics in August and September and a long term plan to introduce nurse led triage of 2ww referrals is being worked up by the clinical lead. In the medium term the Directorate are exploring options of replacing routine clinics with 2ww and redirecting routine activity to the independent sector. Patient choice remains a significant factor, particularly, in relation to the choice of hospital site. Updated referral forms are due to be re-launched following recent NICE guidance.

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Daily monitoring of 2ww escalation lists and identification of sufficient capacity	DDOPs/Directorate Managers	On-going	July 2016 onwards
2.	Reconfiguration of colorectal clinics and identification of additional clinic capacity	DDOps Surgery	July 2016	July 2016 onwards
3.	Launch updated 2ww referral proformas in line with the latest NICE guidance	Head of Elective Performance and Patient Access/Deputy Director of Commissioning	August 2016	August 2016 onwards
4.	Work with commissioners to ensure GPs increase patient awareness of the reason and urgency of their referral	Deputy COO/Deputy Director of Commissioning	October 2016	October 2016 onwards

Recovery forecast

TARGET	August	September	October	November	December
93.00%	81%	86%	93%	93%	93%



SRO: Chief Operating Officer
Current reporting month performance: 75.6% (not finalised until early Sept)
Last reported month performance: 69.2%
YTD performance: 61.1%

Key Performance Indicator: 2 week wait for symptomatic breast patients (Cancer Not initially Suspected) (CCAN9.0)

Situation

Current July performance shows improvement compared to June (74.55% v 56.19%), however, it remains significantly below the 93% target. There were 28 breaches of the standard in July. It is anticipated that the breach numbers will increase in August due to reduced capacity and will return to the average historic number of monthly breaches in September. Forecast performance against the trajectory is 50% in August followed by return to the historic levels of performance from September onwards (80-85%) and achievement of the standard from October 2016.

Gaps in control

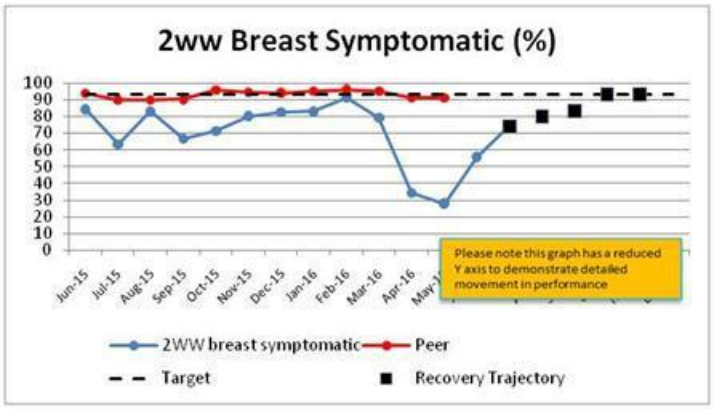
Aligning surgical capacity with breast radiology capacity remains a challenge; this is mitigated by daily review of the escalation lists and micromanagement of all available capacity. Patient choice remains a significant factor and the trust is working with the commissioners to increase patient awareness of the referral reason and urgency of their appointment.

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Daily monitoring of 2ww escalation lists and identification of sufficient capacity	DDOPs/Directorate Managers	On-going	July 2016 onwards
2.	Full utilisation of all sessions supported by breast radiology by re-allocating registrars from theatre sessions to 2ww clinics	Directorate Manager	On-going	July 2016 onwards
3.	Launch updated 2ww referral proformas in line with the latest NICE guidance	Head of Elective Performance and Patient Access/Deputy Director of Commissioning	August 2016	August 2016 onwards
4.	Work with commissioners to ensure GPs increase patient awareness of the reason and urgency of their referral	Deputy COO/Deputy Director of Commissioning	October 2016	October 2016 onwards

Recovery forecast

TARGET	July	August	September	October	November
93.00%	74%	80%	83%	93%	93%



SRO: Chief Operating Officer
Current reporting month performance: 74.5% (not finalised until early Sept)
Last reported month performance: 55.7%
YTD performance: 46.0%

Key Performance Indicator: 4 Hour Waits (%) - Trust inc. MIU (CAE1.1a) referencing Stranded Patients (PIN2.3)

Situation

For the month of July performance in respect of the 4 hour Emergency Access Standard is 85.7%. This is an improvement on June's performance of 84.7%. The year to date performance currently is 84.3%. 'Exit block' from the ED on WRH site remains the key factor affecting delivery of this standard. A number of work streams are in train to remove 'exit block' and improve patient flow through the hospital, including SAFER bundle rollout, reverse queuing in ED, rollout of ambulatory emergency care (AEC) and a pilot of early identification and 'pulling' of patients from ED by destination wards.

Gaps in control

High bed occupancy and high numbers of stranded patients (emergency admissions with LoS > 7 days) negatively impact on the delivery of this standard. Early senior review of emergency admissions is also important and there is still a significant reliance on agency locum staff whilst substantively recruiting to vacant consultant posts. Ward staffing requires a review to enable the nurse in charge to work on early discharges, support board and ward rounds and expedite and escalate complex patient pathways.

Corrective Actions

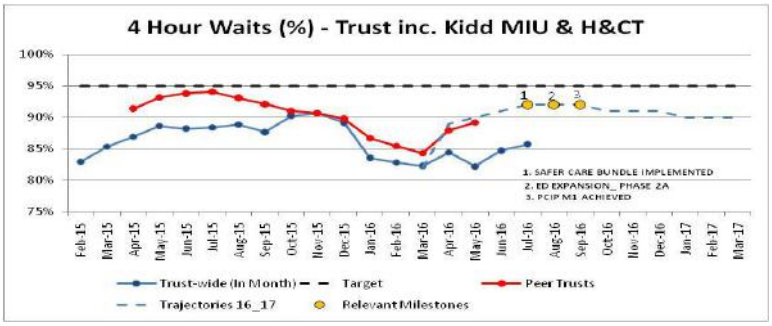
	Action	Lead	Completion due date	When will this have an effect on performance
1.	A dedicated Minors area in WRH ED to come on line at the end of August. This will protect the Minors work stream and reduce the Minors breaches.	Medicine Divisional Medical Director	Minors stream on line end August 16	September 16 onwards
2.	AEC at WRH will be moved from Mulberry Suite (currently an outpatient's area) to an area adjacent to ED. This will allow us to expand on the current types of conditions seen within the AEC setting and allow better use of equipment and staff in both areas.	Medicine – Deputy Director of Ops	August 16	August 16 onwards
3,	Continue to work on delivery of emergency care improvement programme (ECIP) concordat priorities.	Medicine – Project Manager	On-going	Improvement on performance will be gradual as work streams start to deliver. The first improvement is expected from September 16

				onwards.

	Action	Lead	Completion due date	When will this have an effect on performance
4.	Work with Health Economy partners to facilitate more timely discharges to community beds and other care settings	COO	On-going	September 16 onwards

Recovery forecast

TARGET	August	September	October	November	December
95%	92%	92%	91%	91%	91%



SRO: Chief Operating Officer

Current reporting month performance: 85.7%

Last reported month performance: 84.7%

YTD performance: 84.3%

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)

Situation

In July 2016 the Trust failed to reach the national 15 minute "Time to Initial Assessment" target. Whilst this was a slight decline in performance compared to June, the Trust met the Patient Care Improvement Plan (PCIP) trajectory for ambulance arrivals (95th percentile wait 28 mins) and for all patients (95th percentile wait 30 mins).

Gaps in control

Performance is dependent on the Trust's ability to sustain the provision of the Senior Initial Assessment Nurse (SIAN) in the WRH ED and can be adversely affected by surges in ambulance conveyances across the Trust compounded by 'exit block' from the ED. The Trust was on escalation level 3 most of the month and triggered level 4 on 1 occasion (19 July).

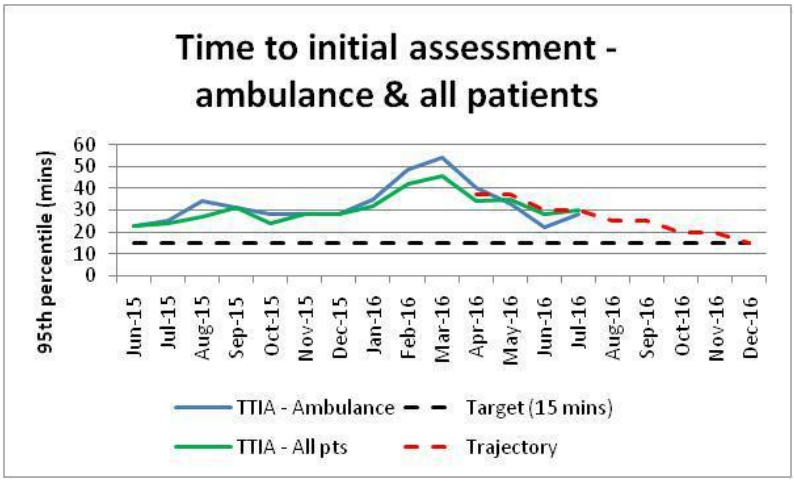
Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Roll out of the SIAN nurse workforce. The next phase, which will provide 7/7 cover of SIAN nurses is September 2016 due to recruitment timescales.	ED Matron WRH	September 2016	September 2016
2.	Expansion of ambulatory emergency care AEC provision at the Alexandra Hospital. This service will 'pull' patients directly from ED and contribute to improved flow.	Acute Medicine/ ED Matron AGH	August 2016	August 2016 onwards

Recovery forecast

This is the forecast from the Urgent Care and Patient Flow, Patient Care Improvement Plan (PCIP)

TARGET (Ambulance/all attendances)	August 16	September 16	October 16	November 16	December 16
15 mins	30 mins	25 mins	25 mins	20 mins	15 mins



SRO: Chief Operating Officer
Current reporting month performance: Amb: 28 All: 30 (met trajectory)
Last reported month performance: Amb: 22 All: 28 (met trajectory: 30)
YTD performance: Amb: 35 All: 38

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)

Situation

In July 2016, there was slight improvement in Ambulance handover times within 15 minutes with performance at 59.1% compared to 56.6% in June and there was a significant improvement in handovers within 60 minutes; with 26 exceeding 60 minutes compared to 34 in June 2016.

Gaps in control

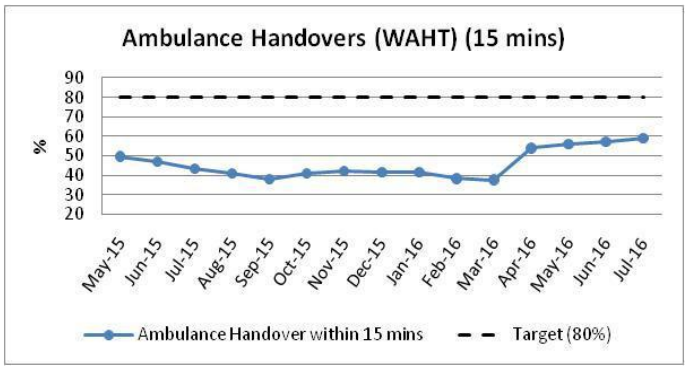
Performance is dependent on the Trust's ability to ensure continued availability of the Senior Initial Assessment Nurse (SIAN) in the WRH ED and can be affected by surges in ambulance conveyances. The majority of breaches of the 15 minute standard were during periods of surge in ambulance conveyances. The department continues to experience patient flow challenges resulting in regular overcrowding in the ED.

Corrective actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Work with Health Economy partners to facilitate more timely discharges to community beds and other care settings	COO	On-going	September 16 onwards
2.	Embedding of Best Practice Ward Rounds and the SAFER care bundle	Medicine DDN	September 16	August / September 16
3.	Champion the adoption of the Pathfinder Paramedic role by WMAS through SRG and subsequently the Emergency Care Delivery Board	COO	TBC	Acute Trust CEO will chair the Emergency Care Delivery Board from September onwards. This action will be updated following the first meeting.
4.	Ambulatory emergency care (AEC) at WRH will be moved from Mulberry Suite (currently an outpatient's area) to an area adjacent to ED. This will allow us to expand on the current types of conditions we see within the AEC setting and allow better use of equipment and staff in both areas.	Medicine – Deputy Director of Ops	August 16	August 16 onwards
5.	AEC Workshop to take place 9th September to look at optimisation of AEC service.	Medicine – Deputy Director of Ops COO	September 16	September 16 onwards

Recovery forecast

TARGET (Ambulance/all attendances)	August	September	October	November	December
15 mins	Not provided	Not provided	Not provided	Not provided	Not provided
30 mins	Not provided	Not provided	Not provided	Not provided	Not provided
60 mins	Not provided	Not provided	Not provided	Not provided	Not provided

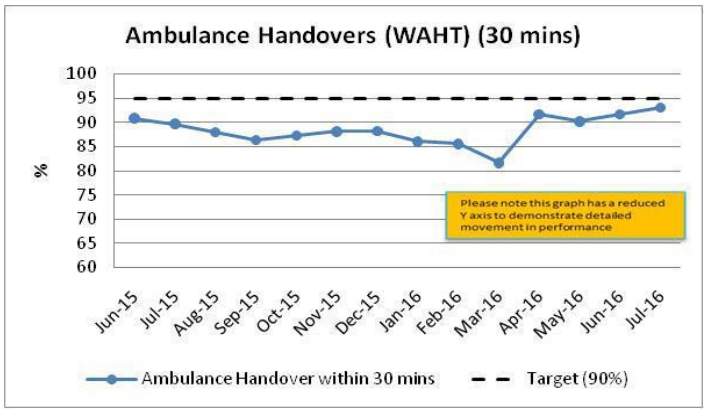


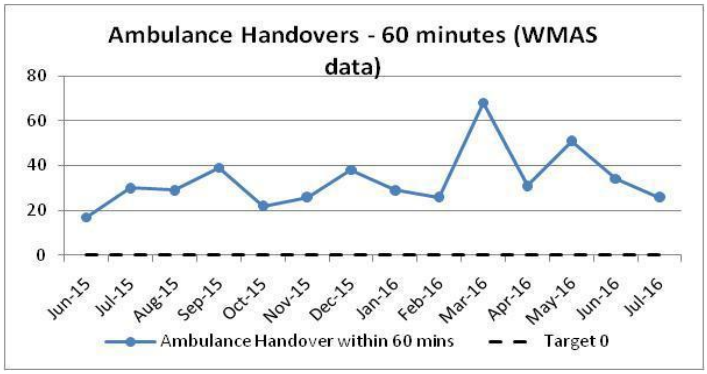
SRO: Chief Operating Officer

Current reporting month performance:
Within 15m – 59.1%, Within 30m – 93.0%, Over 60m - 26 ambulances

Last reported month performance:
Within 15m – 57.3%, Within 30m – 91.7%, Over 60m - 34 ambulances

YTD performance: 15m – 56.6%, 30m – 91.7%, 60m – 142





Key Performance Indicator: 28 Day Breaches as a % of Cancellations (PEL3.0)

Situation

The indicator relates to the rescheduling of operations cancelled for non-clinical reasons within 28 days. There were 11 breaches of the 28 day standard in July 2016 compared to 15 in June 2016. The total number of cancellations as a % of admissions was 1%, which is the lowest position since April 2016. 10 breaches to the standard occurred on the WRH site with 1 breach occurring on the Kidderminster site.

Gaps in control

Of the 11 patients cancelled, 6 cancellation episodes were due to no available bed, 3 were due to staff issues, 1 was due to running out of theatre time and finally 1 was due to issues with theatre equipment. Patients were unable to be booked within 28 days due to lack of available consultant capacity within the time period, 1 was due to patient being offered a date but delay in patient responding. 1 patient classified as being "urgent" was cancelled twice in July compared to 4 in June. This patient was under the care of the vascular team and was admitted to Worcester Hospital initially in June. Their TCI was cancelled on this occasion due to equipment failure and on the 2nd occasion on the 8/7, they were cancelled due to no bed being available. The patient was admitted on 21/7/16 and operated on the following day.

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Improved operational reporting process	DDOps Surgery	31/08/16	An improvement in performance will be seen from August 2016
2.	Improved operational management process	DDOps Surgery	31/08/16	An improvement in performance will be seen from August 2016
3.	Improved theatre utilisation / access to theatre time	DDOps Surgery	30/09/16	An improvement in performance will be seen from October 2016
4.	Agreed process to send for all 1st cases listed regardless of bed position on WRH site.	Deputy COO	01/09/16	An improvement in performance will be seen from September 2016

Recovery forecast

TARGET	August	September	October	November	December
<5%	15%	10%	5%	5%	5%

SRO: Chief Operating Officer
Current reporting month performance: 15.71%
Last reported month performance: 20.00%
YTD performance: 23.30%

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

Situation

Performance against the diagnostic target improved in July (2.07%) compared to previous month (June 2.7%) as additional waiting list activity was provided, specific areas for improvement were Colonoscopy, Gastroscopy, Ultrasound and CT.

Gaps in control

Demand is greater than capacity in some areas and even with utilising all available external capacity, there remains a gap particularly in Endoscopy.

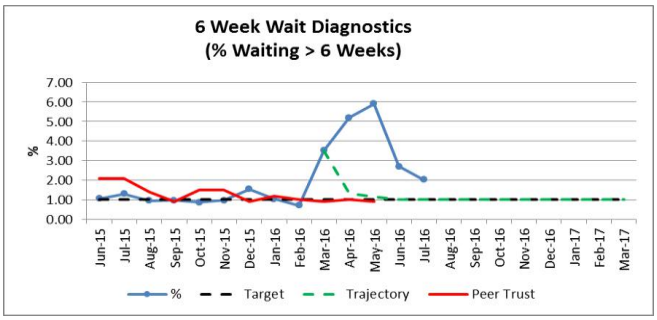
Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Cross divisional meeting to identify potential additional endoscopy capacity	DOps	26/8/2016	September 2016 onwards
2.	Additional internal waiting list radiology activity sessions	Radiology Operational Manager	Ongoing	September 2016 onwards
3.	Utilisation of external radiology capacity	Radiology Operational Manager	Ongoing	September 2016 onwards
4.	Sourcing additional Endoscopy capacity	Endoscopy Service Manager	September 2016	September 2016 onwards
5.	Weekly PTL review for undated patients	DDOps SCSD	Weekly	September 2016 onwards

Recovery forecast

Below are the trajectories agreed with the Clinical Commissioning Groups as part of the STF:

TARGET	August	September	October	November	December
<1.0%	0.997%	0.999%	0.999%	0.991%	Not provided



SRO: Chief Operating Officer
Current reporting month performance: 2.03%
Last reported month performance: 2.70%
YTD performance: 4.06%

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)

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)

Situation

We have been closely monitoring all staff turnover since it started steadily increasing in July 2015 peaking at 13.01% in April 2016. Overall cumulative turnover for all staff for the 12 month period ending on 31st July 2016 reduced by 0.11% from the previous month to 12.7%. Turnover is now showing a steady improvement month on month. In March 2016 the average turnover of local trusts surveyed was 12.47%; 0.50% lower than the Trust's March position (12.97%) which would indicate that we are not an outlier. As there is no regular benchmark information available centrally we will contact neighbouring trusts to repeat this data collection. In view of the fact that the average turnover in neighbouring Trusts is over 12%, our target of between 9-11% could be reviewed as this is probably unrealistic in the current labour market, a more realistic target would be 10-12% for the next 12 months. Cumulative turnover of permanent staff by division in the 12 month period ending 31st July 2016 is:

Division	May-16	Jun-16	Jul-16	Difference Jun-Jul-16
365 Asset Management and IT	14.19%	13.96%	13.28%	0.68%
365 Corporate	13.95%	13.64%	13.30%	0.34%
365 Medicine	15.65%	15.59%	15.15%	0.44%
365 Specialised Clinical Services	10.19%	10.06%	10.22%	-0.16%
365 Surgery	11.83%	11.92%	12.14%	-0.22%
365 Women & Children	14.07%	14.00%	13.97%	0.03%
Trust	**12.91%**	**12.81%**	**12.70%**	**0.11%**

We have had 55.29 wte leavers this month spread across the divisions as follows:

Leavers in July 2016	
365 Asset Management and IT	3.67
365 Corporate	5.85
365 Medicine	16.23
365 Specialised Clinical Services	13.84
365 Surgery	8.34
365 Women & Children	7.35
Grand Total	55.29

Gaps in control

The top 5 reasons for permanent staff leaving the Trust in the last month are:

- Retirement /Early Retirement 12.83 wte
- Work Life Balance 10.55 wte
- Relocation 10.34 wte
- Better Reward Package 5.24 wte
- Incompatible working relationships 3.41 wte

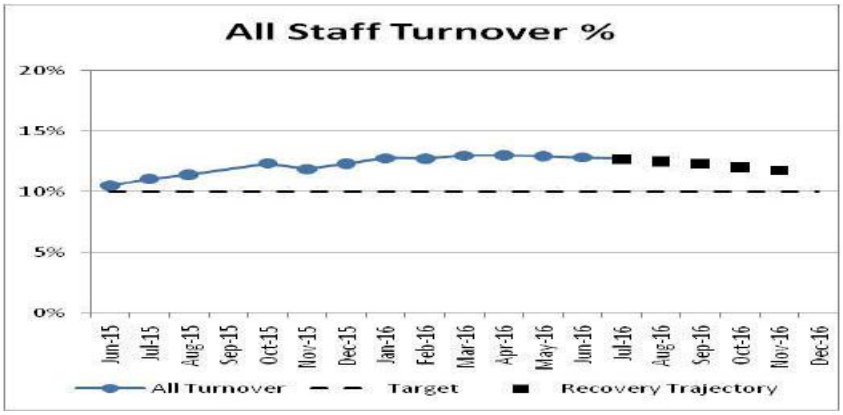
- Promotion 3.32 wte

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Deep dive report into turnover	Head of HR	June 2016	Improvement noted from May 2016
2.	Monitoring of turnover quarterly to assure ourselves of improvement (as this is masked by 12 month cumulative report)	Head of HR	On-going	Improvement noted from May 2016
3.	Benchmarking with local Trusts to ensure that we are not an outlier	Head of HR	On-going	Improvement noted from May 2016
4.	Understanding and where feasible mitigating, reasons why our staff leave to join local competitor Trusts	Head of HR	June 2016	Improvement noted from May 2016

Recovery forecast

TARGET	July	August	September	October	November
9- 11%	12.5%	12.3%	12%	11.75%	11.5%



SRO: Director of HR
Current reporting month performance: **12.7%**
Last reported month performance: **12.8%**
YTD performance: **12.7%**

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

Situation

The qualified nurse cumulative turnover rate has increased this month by 0.75% to 14.65% which represents 22.08 wte staff. This is a disappointing bearing in mind Trust turnover is showing an improving trend. Looking at the last 3 years August has historically been a month of higher turnover, primarily because new starters delay their start dates till after school holidays.
Qualified leavers include 4.01 wte retirements. Resignations are due to:

- 5.64 relocation,
- 4.61 work life balance,
- 2.61 incompatible working relationships,
- 2.64 better reward package
- 1.0 wte lack of opportunities
- 0.96 wte health, and
- 0.61 wte adult dependants

Gaps in control

Nurse recruitment continues to be a national challenge and local Trusts are reporting that they are unable to recruit sufficient qualified nurses to fill current vacancies. This is being exacerbated locally by a higher number of students at the University of Worcester being from out of county and subsequently returning back to their home following qualification. Retention issues continue due to work pressures and capacity issues at the Trust. Recruitment continues at pace and new starters have been recruited but have not yet commenced with the Trust.

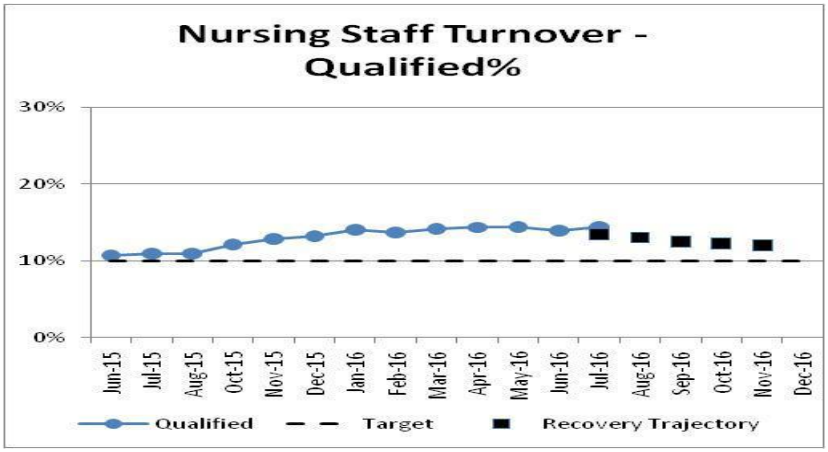
Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Recruitment action plan monitored through the Nursing and Midwifery Workforce Assurance Group.	Deputy CNO	Ongoing	Performance improved from April 2016.
2.	A range of recruitment initiatives and careers fairs are planned for Nurses and HCA's throughout the year.	Deputy CNO	Ongoing	Performance improved from April 201.
3.	Internal transfer process implemented for qualified nurses.	Deputy CNO	Ongoing	Open until 14th September 2016 – monitor interest
4.	Nurse Recruitment event	Lead Nurse Education and Workforce	Sept 2016	3 months after event
5.	Additional placements for student nurses agreed with Worcester University	Deputy CNO	Sept 2016	When course complete
6.	There are 103 qualified nurses due to graduate from Worcester University in August 2016. We are actively seeking to employ as	Lead Nurse Education and Workforce	Oct 2016	As PIN numbers are issued but reportedly 50% are going out of county.

	many as possible			

Recovery forecast

TARGET	August	September	October	November	December
9-11%	14%	13.75%	13.5%	13.25%	13%



SRO: Director of HR
Current reporting month performance: **14.65%**
Last reported month performance: **13.9%**
YTD performance: **14.65%**

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

Situation

Turnover of unqualified nursing staff has reduced by 0.7% from 14.6% to 13.9%. Benchmarking data for this staff group is being sourced from other Trusts in the West Midlands to ascertain if the target of 9 to 11% is realistic.

Gaps in control

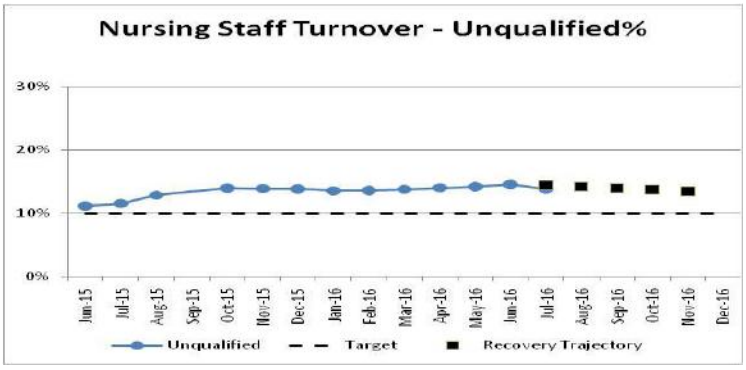
This is traditionally a staff group with high turnover as the skills are highly sought after and transferable to care homes and primary care. However, following active steps to recruit through regular assessment centres on all sites this situation does seem to be improving. We are ahead of our original recovery forecast.

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Action plan monitored through the Nursing and Midwifery Workforce Assurance Group.	Deputy CNO	Ongoing	From July 2016
2.	A range of recruitment initiatives and careers fairs are planned for Nurses and HCA's throughout the year.	Deputy CNO	Ongoing	From July 2016
3.	52 places commissioned with the University of Worcester Band 4 Associate Nurse programme to commence in September 2016.	Deputy CNO	Sept 2016	When course complete

Recovery forecast

TARGET	August	September	October	November	December
9-11%	14%	13.8%	13.75%	13.5%	13.5%



SRO: Director of HR
Current reporting month performance: **13.9%**
Last reported month performance: **14.6%**
YTD performance: **13.9%**

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

Situation

The Trust sickness absence rate for July 2016 is 4.14% which shows an increase on the previous month (3.72%) and above the Trust stretch target of 3.5%. Progress continues to be made in the management of sickness and last month we were ranked 3rd in a benchmarking review of 17 Trusts. Long term sickness has remained on or around 2.7% (July 2.77%) consistently over the last 12 months. In July there were 145 open cases, of those 3 employees have been off sick for over 12 months, 1 has a planned return, 1 has been progressed to a hearing and 1 is ongoing. 24 employees have been off for 6 months or more with appropriate case management plans. The remaining 118 cases have either returned or a being managed within the Trust Policy. Short term sickness has reduced slightly since last month by 0.14% to 1.52%.

Gaps in control

The sickness rate in Asset Management & IT remains high with a further increase this month from 5.95% to 6.2%. The Women & Childrens Division showed a spike this month at 5.56% from 3.99% last month and Specialised Clinical Services Divisions remain above Trust target at 4.21%. Medicine showed a small increase this month from 3.44% to 3.89%. Surgery is below trust target at 3.42% this month. Ancillary and Registered Nursing & Midwifery staff remain the highest risk areas.

Top 3 reasons for sickness in July 2016 are:

- Anxiety/Stress/Depression (1763 calendar days lost)
- Musculoskeletal (1282 calendar days lost)
- Gastro-intestinal (596 calendar days lost)

Corrective Actions

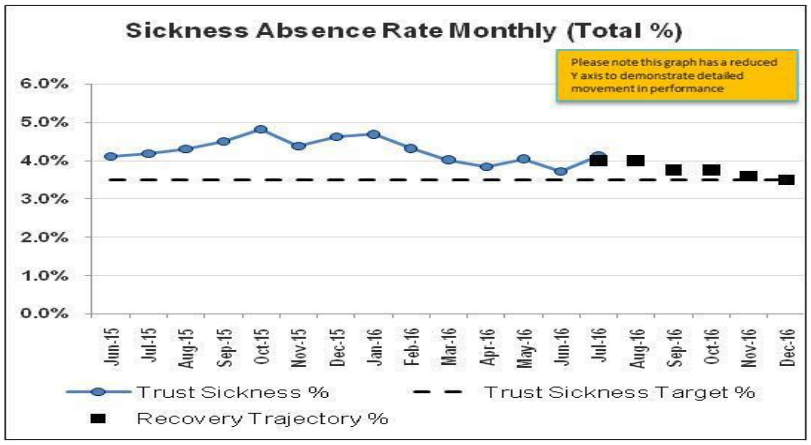
	Action	Lead	Completion due date	When will this have an effect on performance
1.	Monthly meetings with Matrons/Ward managers to review action plans for long term and episodic absences, to identify and target hot spots and ensuring appropriate timely management action is taken	HR Consultancy Team	Ongoing	Immediate effect
2.	The Trust's Health and Wellbeing Department are supporting a number of CQUIN strands in the interest of staff absence in the longer term	Head of HR	March 2017	Counselling service has already had an impact. Fast track Physiotherapy to be launched in August 2016
3.	Absence levels are reported monthly at Divisional Board meeting and hot spots highlighted for action, and in addition to ensure that	HR Consultancy Team	Ongoing	Immediate effect

	awareness at senior level			
4.	To recognise that employees need not be fully fit to attend work, and therefore encouraging managers at their discretion to make temporary workplace adaptations	HR Consultancy Team	Ongoing	Immediate effect with phased returns and modified duties.
5.	Current sickness absence training should be evaluated to ensure that the appropriate staff are being trained, and that a return on the investment has been achieved in terms of a corresponding reduction in sickness levels	Deputy Director HR	Ongoing	Three months after training

Recovery forecast

We would anticipate a decrease in August and September as these are historically lower months for sickness absence at the Trust.

TARGET	August	September	October	November	December
<3.50%	4.0%	3.75%	3.6%	3.5%	3.5%



SRO: Director of HR

Current reporting month performance: 4.14%

Last reported month performance: 3.72%%

YTD performance: 4.14%

Key Performance Indicator: Appraisals (Total) (WAPP1.2, WAPP2.2 and WAPP3.2)

Situation

Medical staff:

The appraisal completion rate as at 31st July 2016 for all medical staff is 82.6% which is a slight decrease against the June figure of 82.9%. Whilst slightly below the Trust target of 85%, 8 further appraisals being completed would achieve this. July 2016 breakdown by Staff Group:

- Consultants – 86.4% (229 out of 265 completed).
- SAS/Career Grade doctors – 68.1% (47 out of 69 completed) a decrease from the June figure of 71.8%

Both the Specialised Clinical Services and W&C divisions have achieved the Trust 85% compliance target however Medicine and Surgery have decreased to 75.4% and 79.5% completion rates respectively, which is of concern.

Non-medical staff:

The current appraisal rate of non-medical staff is 78.9% against a target of 85%. Non-medical appraisal shows a decline of 0.6% overall. Two Divisions have made steady progress in increasing compliance – Asset Management & IT and Surgery.

Gaps in control

Medical staff:

- Lack of understanding of the appraisal process/implications of non-completion by SAS/Career grade doctors - specifically timely planning and appraisal completion of doctors on short term contracts.
- Inconsistent appraisal reminder process administered by directorates.
- The Clinical Lead for Appraisal and Revalidation (Quality Assurance role) remains vacant with the potential risk of poor quality appraisal inputs/outputs not being identified in real time.

Non-medical staff:

- Movement of staff within the organisation results in a delayed appraisal being undertaken by new manager/ department
- Lack of reviewers within some departments and capacity to carry out appraisals due to clinical pressures.
- Lack of capacity of appraisers due to increased annual leave during the summer months.

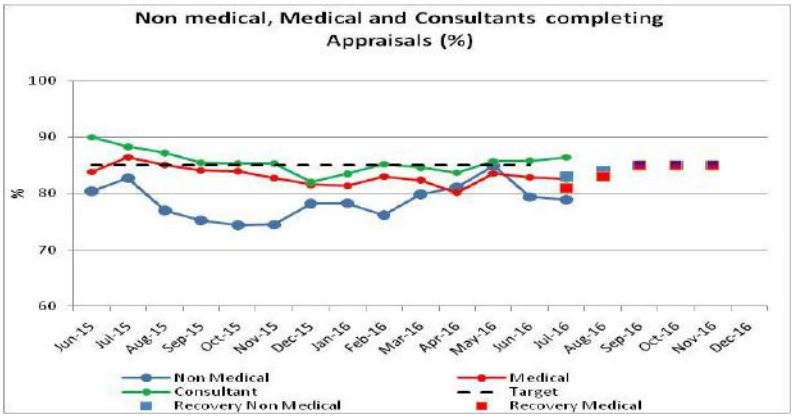
Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Roll out of Trust Medical Appraisal and Revalidation policy including 'apparent non-participation in appraisal'	CMO	End of August	August/September 2016.
2.	Appointment to the full Trust Clinical Appraisal Lead for Appraisal and Revalidation (both appraisal training and quality assurance elements).	CMO	September/ October 2016	October 2016 subject to successful appointment to the role.

3.	2 x dedicated appraisal workshops for SAS/ career grade doctors to support this staff group in appraisal preparation and completion.	Dr Andrew Short/Dr Sally Millett	End of June, further update in December.	July - September 16 once doctors have prepared for, arranged appraisal dates and undertaken appraisal meetings/achieved sign off.
4.	Implemented monthly reviewer training across the sites for the next 12 months.	Training Manager	April 2016	Immediate positive impact on compliance %
5.	Implemented departmental reviewer training on request.	Training Manager	September 2016	From September 2016
6.	Send letters to those staff who have not received an appraisal reminding them of appraisal and how this can affect pay progression.	Training Manager	September 2016	From September 2016
7.	Meet with low compliance areas to assist with planning of appraisals and identify any additional reviewers.	Training Manager	Monthly meetings	Ongoing

Recovery forecast

TARGET	August	September	October	November	December
Non Med: >85%	84%	85%	85%	85%	85%
Med: >85%	83%	85%	85%	85%	85%



SRO: Director of HR		
Current reporting month performance:		
NM: 78.9%	**M: 82.6%**	**C: 86.4%**
Last reported month performance:		
NM: 79.4%	**M: 82.9%**	**C: 85.8%**
YTD performance:		
NM: 81.8%	**M: 82.4%**	**C: 85.4%**

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

Situation

The Trust's mandatory training performance as at July 2016 is 84.5% which shows a decrease of 3.5% since June 2016 against an agreed target of 90%. Out of the 10 mandatory training topics currently only one surpasses the 90% target. There has been a decrease on average of 2% across the topics.

Gaps in control

- Difficulties in trying to capture out of hours (nights & weekend) staff for mandatory training.
- Issue regarding capturing the information on departmental training registers following the delivery of the sessions.
- Training dates of a large amount of staff expired and/or are due to expire in the months of July/August
- It's been identified that staff are not completing the E-Learning module correctly and therefore the system is not updating & recording correctly.

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Continue to raise at mandatory training meeting with Leads regarding the need to address out of hours staff group.	Deputy Director HR	August 2016	September 2016
2	At Divisional performance reviews with Execs each division is now challenged on its appraisal and mandatory training performance and uses "best Practice shared" model	Deputy Director HR	August 16	Ongoing
3	Dedicated resource to implement competencies to staff roles via ESR/OLM. Provide e learning workshops to staff to ensure correct use of system.	Deputy Director HR	October 16	November 16
4.	Mandatory training lead to raise issue of non-collection of data with Facilities & other identified departments that have raised concerns.	Deputy Director HR	September 2016	September 2016
5.	Mandatory training programmes being revised to ensure they are specific to staff roles this will reduce the amount of time spent on programmes and introducing facilitated eLearning sessions.	Deputy Director HR	January 2017	January 2017

Recovery forecast

TARGET	August	September	October	November	December
>90%	90%	90%	90%	90%	90%

SRO: Director of HR
Current reporting month performance: **84.5%**
Last reported month performance: **88.0%**
YTD performance: **87.7%**

Corrective Action Statements:

Quality and Safety

Key Performance Indicator Names;

- Category 2 complaints responded to within agreed deadline with the complainant - NEW DEFINITION (QEX1.18)
- The total number of Serious Incidents open longer than 60 day (QPS3.1)
- Clostridium Difficile (Monthly) (QPS12.1)
- % 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)
- Friends & Family - (Response Rate % for A&E, Acute Wards and Maternity) (QEX 2.2, 2.62 & 2.8)

***Please note: The following Corrective Action Statements below have not been included as the national data used for them will not be updated until August as part of the annual reconciliation process*.**

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)

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

Forecast not to achieve

Key Performance Indicator: Category 2 complaints to within agreed deadline with the complainant – NEW DEFINITION (QEX1.18)

Situation

The trajectory for complaints response times reflects changes to the national guidance which states that the Trust should meet the timescale agreed with the complainant. Our expectation is that most complaints will be responded to within 25 working days. For more complex cases we would expect that to be individually agreed but in most cases to be within 45 working days. The standard set this year by CCG's is 60% in Q1, 65% in Q2, 70% in Q3 and 75% in Q4. The Trust exceeded the Q1 requirement by achieving 70%. In June we have achieved 68% within 25 days. A weekly Situational Report is now produced which is discussed with each Director of Nursing to agree the required number of complaints to be closed each week to meet standards.

Gaps in Control

To meet our required performance, It was important to address the backlog of complaints in Medicine External support has been provided to address this.

A process review of our current practices has been undertaken and shown that a leaner approach will also enable the trust to meet its targets. The focus moving forward will be to ensure wherever possible local resolution is adopted as analysis shows that a number of complaints should have been able to have been addressed at the time. To facilitate this we will provide additional support, advice and training to front line staff.

The Datix complaints module has been transformed into a step by step investigation template with a number of reporting functions built in. This should make it much easier to see exactly where in the process a complaint is and enable much better oversight. We are working closely with informatics and our DATIX Manager to better automate our reporting processes. Hitherto these have been entirely manual. We have also changed the monthly report to those closed during the month which removes the previous time lag and are working on changing the weekly outstanding list from an excel spread sheet to a Datix report.

Women's & Childrens and SCSD continue to receive a relatively small number of complaints each month. Surgery as a Division have shown sustained improvements through allocating complaints to Directorate Managers , the DDN and her PA regularly ask for updates and know which complaints are due each week. This is also reviewed at their monthly Quality Governance Meetings.

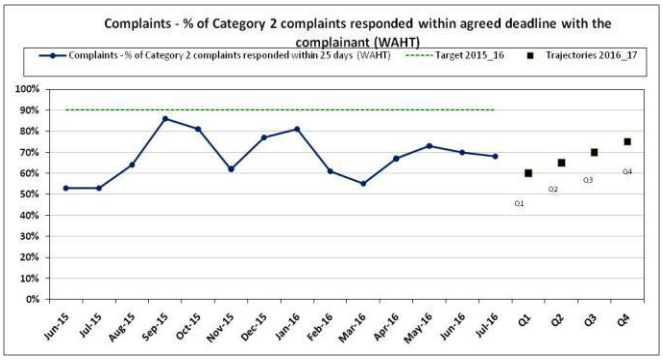
Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1	Complaints workshop held 10.08.16 to agree consistent process for handling complaints across Trust with clear lines of responsibility and accountability	Governance Consultant	September 2016	A revised process was agreed and is currently being incorporated into our new policy and procedure.
2	New Complaints Policy to be implemented to reflect above	Associate Director Patient Experience	September 2016	From September 2016
3	Consultant working with Medicine team to clear backlog	DDN Medicine / (Consultant)	August 2016	From July 2016 onwards
4.	Weekly Sitrep introduced to provide weekly updates and improve transparency	Head of Governance and Safety	August 2016	From September 2016
5.	Further automation of reporting from DATIX to give better complaints management information linked to sitrep and outstanding list	Complaints Team / Informatics & Datix Manager	August 2016	From September 2016

Recovery forecast

TARGET	August	September	October	November	December
>90%	60%	65%	65%	65%	65%

Note: Change in definition from April 2016 – reported as closed in month, previously reported as open in month.



SRO: Chief Nursing Officer

Current reporting month performance: 68%

Last reported month performance: 70%

YTD: Not applicable

Key Performance Indicator: The total number of serious incidents open longer than 60 days (QPS3.1)

Situation

Only one SI investigation report was overdue at the end of July. This performance is likely to fluctuate until the actions and improved controls described below are effectively implemented and a sustainable position of meeting the national requirement of zero overdue SI investigations is achieved.

Gaps in control

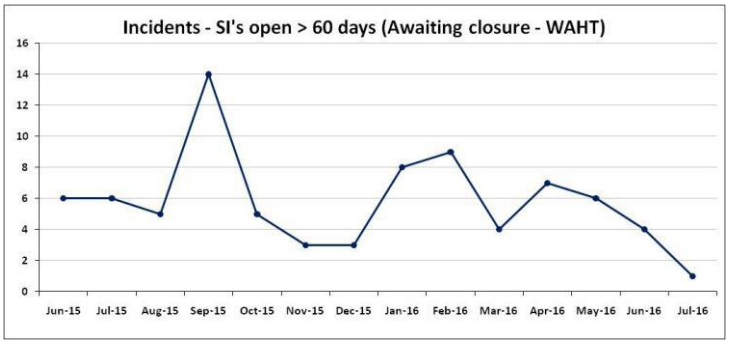
There is some lack of consistent application of processes guiding incident investigation. A skills gap in undertaking investigations has been identified. Divisional governance systems are still developing so required on-going support

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Production and agreement of a revised process to investigate, communicate and approve SI investigations	Risk Manager	08/07/16	From this point forwards.
2.	Provide investigation training to staff nominated by the Divisions.	Head of Governance	30/09/16	From September 2016
3.	Medical Division to implement a weekly incident / SI review meeting with the DMT and Governance Team	DMD/DDN Medicine	31/07/16 –	A gradual improvement from September 2016 as the investigation training and meeting embed
4.	Reconfiguration of the Operational Governance Meeting to provide a one hour new incident review and SI investigation report review	CMO / Head of Clinical Governance	14/7/16 -	A Thursday SI Review and Learning Group has been established.
5.	Introduction and development of new investigation reports for falls and pressure ulcers	Head of Clinical Governance	30/9/2016	September 2016 onwards

Recovery forecast

TARGET	August	September	October	November	December
0	Not provided	Not provided	Not provided	Not provided	Not provided



SRO: Chief Nursing Officer

Current reporting month performance: 1

Last reported month performance: 4

YTD performance: **n/a**

Key Performance Indicator: Clostridium Difficile (Monthly) (QPS12.1)

Situation

Currently *C.difficile* is marginally over trajectory. The annual trajectory for 2016-17 is no more than 32 attributable cases trust wide. On an apportioned trajectory of no more than 2 or 3 cases per month (as indicated in graph below); the trust should have no more than 10 cases at end of July. On a linear (equally divided) trajectory there should be no more than 10.6 cases by this time. As indicated below there have been 11 cases at end of July.

Gaps in control

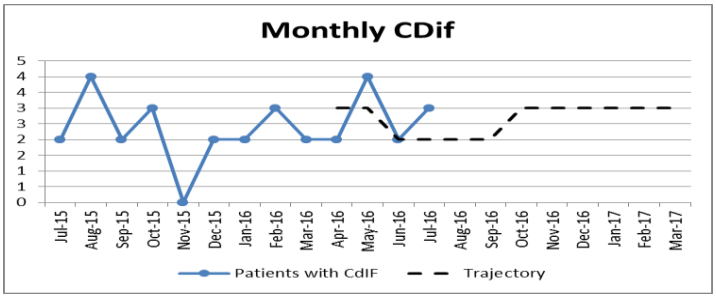
There are two key issues that could be affecting control in this area. One is around antimicrobial prescribing and specifically audit of compliance to policy and subsequent remedial action. The second is around cleanliness of nurse equipment where in one case review, deficiencies were identified.

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Appointment of dedicated Antimicrobial Pharmacist.	Director of Pharmacy	Appointment August 16	Post holder expected to be in place November 16.
2.	Increased Infection Control Nurse visits / presence to clinical areas to identify any areas where nurse cleaning may be an issue.	Associate Chief Nurse IPC	30/09/16	Presence has increased and increased spot checks will continue including as part of CQC visit preparations.
3.	Nurse cleaning schedules will be redeveloped and re-issued during September 2016.	Associate Chief Nurse IPC	30/09/16	Spot checks increase profile of nurse cleaning but expected to improve with re launch of schedules during September.

Recovery forecast

TARGET	August	September	October	November	December
32	2	2	3	3	3



SRO: Chief Nursing Officer

Current reporting month performance: 3

Last reported month performance: 2

YTD performance: 11

Key Performance Indicator: Percentage of approved risks with overdue actions (QR1.2)

Situation

Performance deteriorated at the end of July 2016 to 32% of risks with overdue actions, which is the highest it has been since the indicator commenced in May 2015 and equal to September 2015. Performance was poorest in Women & Children, Specialised Clinical Support and Corporate Services – Finance, Human Resources, Estates and Facilities and Corporate Nursing.

Gaps in control

- No automated reminder system where an action is due
- Insufficient challenge by directorate/division management
- Interim Trust Risk Officer post part time

Corrective Actions

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Hold workshop with Safeguarding team to develop strategies to improve performance on the Safeguarding Committee risk register	Risk Manager	Completed 07/07/16	The Safeguarding register has already improved significantly and results will be seen in the Corporate Nursing results in August 2016
2.	Improve Executive oversight and challenge of Divisional high risks through: • Changes to Executive level meeting agendas • Enhancements to the risk escalation process • Interim Trust Risk Officer to provide CEO and CNO with a critique of CRR and BAF to ensure challenge to Divisions	Head of Clinical Governance	31/08/16	A longer term cultural change which will take several months to take effect
3.	Implement automated alerts for overdue actions within Datix	Risk Manager	31/08/16	Action is presently delayed by Datix functionality. Remains high priority and is actively being managed by Datix administrator and IT. Impact on performance within one month of go-live date, September 2016 at the latest.

Recovery forecast

It is thought that the deterioration at the end of July is an anomaly and the Interim Trust Risk Officer will ensure timely reminders for all divisional and corporate leads are sent until automated alerts from Datix is implemented. Therefore the trajectory will revert to 16% in August and continue at one percentage point per month improvement.

TARGET	August	September	October	November	December
<15%	16%	15%	14%	13%	12%

SRO: Chief Nursing Officer

Current reporting month performance: 32%

Last reported month performance: 17%

YTD performance: 32%

Key Performance Indicator: % of patients admitted with a fractured hip undergoing surgery within 36 hours of admission

Situation:

The Division is failing to meet the time to theatre target of 36 hours post admission for patients admitted with a hip fracture. July 2016 performance is 48% which is 37% below target. Our Peer Trusts are currently performing at 82.4%. Note: the target for 2016/17 has been reduced from 90% to 85%.

Gaps in control:

- Challenges on the Worcester site are the amount of trauma and complex cases, lack of theatre capacity and a higher number of unfit patients.
- Weekday Theatre 3 & Theatre 4 – PM Sessions are required to support performance. Currently there is no dedicated weekend Trauma Theatre session at the Alexandra site and only one weekend AM theatre session dedicated at the Worcester site.
- There is an issue with availability of hip surgeons across the county to do THR for hip fractures; 6 patients were delayed in July waiting for THR.

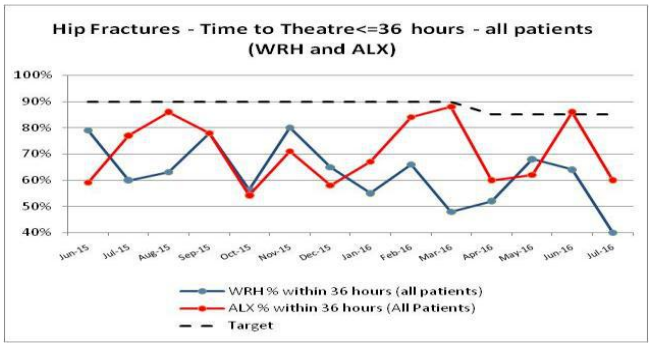
Corrective Actions:

	Action	Lead	Completion due date	When will this have an effect on performance
1.	Prioritisation of the #NoF cases to be done first on the PM Trauma Theatre Sessions. At the regional NHFD meeting a project was presented; the Golden Hip. This is a method of identifying a patient who is fit to go to theatre the night before the list and ensuring the patient is optimised and seen by the duty anaesthetist so that the list starts on time without delays the following day.	Trauma Nurse Practitioners and Clinical Teams	August 2016 on-going	Immediate
2.	Hip Fracture Escalation Policy disseminated to the T&O Clinical Teams to support the following:- #NoF first on the list – Hip Fracture Escalation Policy to be enforced – delaying fracture care needs to the challenged – 36 hour breach time to be added onto Bluespier (support required from IT to implement – on-going).	Clinical Teams	August 2016 on-going	Immediate
3.	Trauma Nurse Practitioners submit a daily #NoF Report on the achievement of the 36 hours target; report submitted to the COO & Surgical Division. Directorate Manager or Support Manager to attend daily trauma meeting.	Trauma Nurse Practitioners	August 2016 on-going	Immediate
4.	#NoF performance reviewed and discussed at the	Clinical Lead	August	Immediate

	Monthly T&O Directorate Meeting; this will be a monthly standard agenda item for discussion. Attending fortnightly Improvement Programme Meeting to monitor performance.		2016 on-going	
5.	Business Case to be submitted for additional weekend Trauma Theatre Sessions for both the Alexandra & Worcester Sites. The document "Case for Change – Weekend Trauma Sessions" Business Case to be submitted August 2016	Directorate Manager	31/08/2016	Once additional capacity has been agreed.

Recovery forecast:

TARGET	July	August	September	October	November
85%	Not provided	Not provided	Not provided	Not provided	Not provided



SRO: Chief Medical Officer

Current reporting month performance: 48%

Last reported month performance: 70%

YTD performance: 58%

Key Performance Indicator: Friends & Family - (Response Rate % for A&E, Acute Wards and Maternity) (QEX 2.2, 2.62 & 2.8)

Situation

FFT completions remain challenging across the Trust and performance in terms of response rates remains poor across all areas. Where these are being completed the scores are generally exceeding target and indicate a good level of patient satisfaction with services provided however as clearly indicated only relatively low numbers of patients are providing feedback. Maternity is closer to meeting the 30% target response rate.

Gaps in control

Completion rates in A&E are very poor. On-going pressure on the A&E departments impacts on FFT completion with staff regularly stating that this is not a priority when dealing with a constant stream of patients. The PE Lead and ADPE are regularly visiting the A& E departments and work is ongoing work to raise awareness and staff engagement. We are also working with Communications and Servicepoint to introduce consistent and more engaging posters and cards along with new FFT post boxes. A new volunteer initiative is also being developed. The DCNO has also written to all A&E and MAU matrons to request their support to improve our completion rates. We are also working with IT to look at incorporating a range of info, including FFT, under the additional information part of the Electronic Discharge Summary.

Corrective Actions

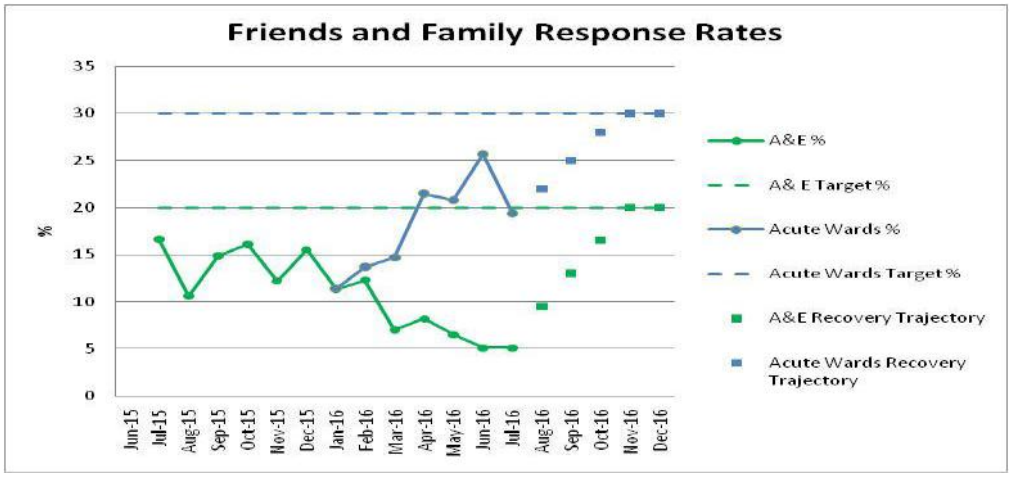
Action	Lead	Completion due date	When will this have an effect on performance
1. Patient Experience (PE) Lead is visiting wards / departments and increasing awareness and engagement. PE Lead will target worst 5 performing areas including both A&Es during August	Associate Director PE	September 16	From September 16 onwards
2. PE Team working with IT, Servicepoint and Communications to develop suite of 8 cards - reducing from 18, a new poster for FFT and to incorporate FFT into 'Additional information' on EDS	Associate Director PE	August 16	From September 16 onwards
3. PE Team and Medicine QGL working with volunteer Co-ordinator on WRH site to develop new A&E volunteers	Associate Director PE	September 16	From September 16 onwards
4. Trust looking at making free Wi-Fi available to patients / visitors but to access need to complete short survey – FFT plus	DDOps SCS	September 16	From October 16 onwards

Recovery forecast

Area	TARGET	August	September	October	November	December
A&E	>20%	9.5%	13%	16.5%	20%	20%
Acute Wards	>30%	22%	25%	28%	30%	30%

Actual Performance

SRO: Chief Nursing Officer	A&E Response Rate	Acute Wards Response Rate	Maternity Response Rate
Current reporting month performance:	**5.1%**	**19.4%**	**23.3%**
Last reported month performance:	**5.1%**	**23.5%**	**27.6%**
YTD performance:	**6.2%**	**21.7%**	**34.3%**



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 04 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: July 2016

Patient Safety

Area	Indicator Type	Indicator		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Current YTD	Prev Year	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)	6	5	14	5	3	3	8	9	4	7	6	4	1	-	-	0	-	>0	CMO	
	National	QPS4.1	Never Events	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2	0	-	>0	CMO	
	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	2	1	3	0	2	2	6	2	0	3	1	1	1	6	26	<=1	-	>=2	CNO	
	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	0	0	3	2	0	1	0	0	2	1	0	2	1	4	12	0	1 - 3	>=4	CNO	
	Contractual	QPS7.7	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 4 Avoidable (Monthly)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	-	>=1	CNO	
Mortality*	National	QPS9.1	Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge - rolling 12 months	113	113	110	108	109	111	110	108						-	-	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months*	109	109	106	105	107	106	106	106	107					-	-	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.21	% Primary Mortality Reviews completed			18%	42%	69%	64%	73%	65%	66%	60%	40%	52%				60		<60	DPS	
	National	QPS.9.22	% Secondary Mortality Reviews completed			0%	14%	0%	7%	0%	0%	17%	0%	0%	0%				20		<20	DPS	
Safety Thermometer	National	QPS10.1	Safety Thermometer - Harm Free Care Score	93.25%	94.57%	92.86%	93.09%	94.20%	92.86%	94.28%	94.82%	93.77%	90.97%	93.33%	92.86%	94.47%	-	-	>=95%	90% - 94%	<90%	CMO	
VTE	National	QPS11.1	VTE Risk Assessment	96.67%	95.43%	96.17%	95.65%	94.91%	94.19%	93.20%	93.86%	93.58%	93.82%	95.94%	96.07%	95.34%	95.39%	95.00%	>=95%	94% - 94.9%	<94%	CMO	
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	2	4	2	3	0	2	2	3	2	2	4	2	3	8	29	15/16 Threshold <= 33 16/17 Threshold < =			CNO	
	National	QPS12.4	MRSA Bacteremia - Hospital Attributable (Monthly)	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	-	>0	CNO	
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective	96.65%	96.68%	99.14%	91.86%	95.70%	97.97%	95.31%	98.61%	95.40%	94.50%	95.00%	95.40%	95.80%	-	-	>=95	-	<95%	CNO	

Patient Experience

Area	Indicator Type	Indicator		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Current YTD	Prev Year	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Complaints & Compliments **	Local	QEX1.1	Complaints - Numbers (In Month)	59	47	50	54	68	36	63	57	64	59	58	65	53	235	629	-	-	-	CNO	
	Local	QEX1.3	Complaints - Number per 10,000 Bed Days (YTD)	18.66	18.86	19.13	19.44	20.57	19.80	20.02	20.32	20.74	24.81	24.34	25.09	24.66	24.66	20.74	-	-	-	CNO	
	Local	QEX1.14	Complaints - % of Category 2 complaints responded within complainant deadline (WAHT) - NEW	53.0%	64.0%	86.0%	81.0%	62.0%	77.0%	81.0%	61.0%	55.0%	67.0%	73.0%	70.0%	68.0%	64.0%	67.0%	>=90	80-90%	<79%	CNO	
Friends & Family***	National	QEX2.1	Friends & Family - A&E (Score)	68.0	66.2	61.9	69.6	76.6	70.7	72.4	61.6	63.2	70.2	57.4	63.8	74.7	70.2	70.8	>=71	67-<71	<67	CNO	
	National	QEX2.2	Friends & Family - A&E (Response Rate %)	16.6%	10.6%	14.9%	16.1%	12.2%	15.5%	11.3%	12.3%	7.0%	8.2%	6.5%	5.1%	5.1%	8.2%	15.1%	>=20%		<20%	CNO	
	National	QEX2.61	Friends & Family - Acute Wards (Score)							77.0	74.6	77.1	83.2	80.1	84.4	0.8	83.2	76.0	>=71	67-<71	<67	CNO	
	National	QEX2.62	Friends & Family - Acute Wards (Response Rate %)							11.4%	13.7%	14.7%	14.8%	16.2%	23.5%	19.4%	14.8%	15.7%	>=30%		<30%	CNO	
	National	QEX2.7	Friends & Family - Maternity (Score)	87.4	86.4	88.5	86.0	82.5	84.9	86.7	78.2	76.1	85.7	89.0	87.6	83.21	85.9	84.2	>=71	67-<71	<67	CNO	
	National	QEX2.8	Friends & Family - Maternity (Response Rate %)	25.8%	26.0%	28.3%	29.5%	25.2%	26.3%	26.6%	28.4%	27.1%	29.4%	25.2%	27.6%	23.3%	29.3%	26.3%	>=30%		<30%	CNO	
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	-	>0	CNO	

Effectiveness of Care

Area	Indicator Type	Indicator		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Current YTD	Prev Year	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Hip Fracture****	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	68.0%	71.0%	78.0%	56.0%	76.0%	61.8%	59.0%	76.0%	63.1%	55.0%	65.9%	70.0%	48.0%	58.0%	66.0%	>=85%	-	<85%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Treatment Pts	76.0%	75.0%	88.0%	63.0%	87.0%	76.0%	68.0%	80.0%	75.9%	63.0%	79.4%	81.3%	65.0%	71.0%	75.9%	>=85%	-	<85%	CMO	

Risk Register Activity

	Indicator Type	Indicator		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Current YTD	Prev Year	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Risks	Local	QR1.0	% of approved risks overdue for review	21.0%	19.0%	27.0%	17.0%	14.0%	11.0%	18.0%	12.0%	18.0%	9.0%	14.0%	14.0%	37.0%	37.0%	18.0%	<15	15-49	>=50	CNO	
	Local	QR1.1	% of approved risks with overdue actions	26.0%	29.0%	32.0%	23.0%	18.0%	26.0%	29.0%	20.0%	23.0%	20.0%	27.0%	17.0%	32.0%	32.0%	23.0%	<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. HED data from April onwards will not be reported until August 2016 whilst HSCIC undertake a validation exercise of all data impacting all Trusts from reporting from the tool.
**Complaints data is reported one month in arrears. In April 2016 the definition was amended to ensure deadlines for response were agreed with complainants. The Trust expects these to be no longer than 25 days.
***Friends and Family definitions have been reviewed and agreed by Operational Senior Management. All data shown here reflects this definition.
**** The target for Fractured NoFs has changed to 85% from 90% - effective April 1st, 2016. The 2015/16 performance is RAG rated against 90%.
Worcestershire Acute Hospitals NHS Trust (WAHT)is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register. This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

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

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: July 2016

Area	Indicator Type		Indicator	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances On Target	Of Concern	Action Required	SRO	Data Quality Kitemark
Waits	Local	PW4.0	Backlog > 18 weeks (Admitted)	2952	3008	3122	2997	3134	2764	2770	3083	4202	4483	4556	4680	4,932	4,932	4,202	Local	-	-	-	COO	
	Local	PW4.1	Backlog > 18 weeks (Day Case + Elective Inpatients)	1348	1193	1186	1172	1303	1256	1310	1537	1940	1993	2014	2101	2,290	2,290	1,940	Local	-	-	-	COO	
	National	PW1.1.3	6 Week Wait Diagnostics (Proportion of waiting list)	1.30%	0.95%	0.98%	0.87%	0.97%	1.55%	1.05%	0.71%	3.52%	5.20%	5.90%	2.70%	2.03%	4.06%	1.28%	National	<1%	-	>1%	COO	
	National	CW3.0	RTT - Incomplete 92% in 18 Weeks	90.28%	89.44%	88.81%	89.00%	92.05%	92.05%	92.04%	91.50%	89.20%	88.90%	88.80%	88.26%	87.80%	87.80%	89.20%	National	>=92%	-	<92%	COO	
	Local	CW4.1	Over 52 week waiters who have been treated in month	3	0	0	1	0	0	0	0	0	1	0	0	0	1	7	Local	0	-	>0	COO	
Theatres	Local	PT2.1	Booking Efficiency - ALX	73.00%	70.00%	71.00%	70.00%	72.00%	71.00%	71.00%	77.00%	75.00%	74.00%	69.00%	75.00%	67.00%		-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT2.2	Booking Efficiency - WRH	86.00%	82.00%	81.00%	82.00%	84.00%	77.00%	82.00%	77.00%	85.00%	86.00%	80.00%	83.00%	87.00%		-	Local				COO	
	Local	PT2.3	Booking Efficiency - KGH	67.00%	74.00%	68.00%	69.00%	70.00%	70.00%	68.00%	71.00%	71.00%	74.00%	74.00%	78.00%	70.00%		-	Local				COO	
	Local	PT1.1	Utilisation - ALX	70.00%	69.00%	71.00%	68.00%	70.00%	70.00%	70.00%	72.00%	70.00%	72.00%	66.00%	72.00%	66.00%		-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT1.2	Utilisation - WRH	74.00%	74.00%	76.00%	72.00%	73.00%	70.00%	72.00%	70.00%	72.00%	74.00%	68.00%	72.00%	76.00%		-	Local				COO	
	Local	PT1.3	Utilisation - KGH	65.00%	71.00%	67.00%	68.00%	68.00%	66.00%	65.00%	68.00%	68.00%	67.00%	70.00%	71.00%	66.00%		-	Local				COO	
A & E	National	CAE1.1	4 Hour Waits (%) - Trust	85.61%	86.43%	85.00%	88.21%	88.83%	86.97%	81.37%	78.70%	78.77%	80.60%	78.28%	81.70%	82.20%	80.60%	85.30%	National	>=95%	-	<95%	COO	
	National	CAE1.1a	4 Hour Waits (%) - Trust inc. MIU - from September 14	88.35%	88.83%	87.64%	90.25%	90.66%	89.07%	84.30%	82.40%	82.30%	84.40%	82.20%	84.70%	85.70%	84.30%	87.90%	National	>=95%	-	<95%	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile ^ (inc Kidd MIU)	25	34	31	28	28	28	35	49	54	40	33	22	28	35	-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment (All Patients) (Mins) - 95th Percentile ^ (inc Kidd MIU)	24	27	31	24	28	28	32	42	46	34	35	28	30	31	-	National	<=15mins	-	>15mins	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	43.50%	41.16%	38.20%	41.09%	42.04%	41.58%	41.74%	38.40%	37.74%	54.00%	56.10%	57.30%	59.10%	56.60%	43.43%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	89.69%	87.99%	86.34%	87.23%	88.10%	88.18%	86.02%	85.58%	81.65%	91.70%	90.20%	91.70%	93.00%	91.70%	88.62%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes - WMAS data	30	29	39	22	26	38	29	26	68	31	51	34	26	142	381	Local	0		>0	COO	
Cancer *	National	CCAN1.0	31 Days: Wait For First Treatment: All Cancers	98.50%	100.00%	97.90%	96.40%	97.20%	98.10%	98.50%	97.50%	96.10%	95.90%	96.90%	96.60%	98.60%	97.00%	97.50%	National	>=96%	-	<96%	COO	
	National	CCAN5.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	78.10%	86.50%	75.10%	79.30%	79.40%	89.10%	86.30%	84.40%	75.30%	75.60%	79.30%	68.10%	65.90%	71.90%	81.20%	National	>=85%	-	<85%	COO	
	National	CCAN8.0	2WW: All Cancer Two Week Wait (Suspected cancer)	83.10%	81.80%	81.40%	85.00%	88.30%	90.40%	84.10%	89.00%	77.30%	39.40%	63.70%	69.20%	75.60%	61.10%	85.70%	National	>=93%	-	<93%	COO	
	National	CCAN9.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	63.50%	83.10%	66.90%	71.40%	80.10%	82.60%	82.90%	91.20%	79.40%	34.50%	28.00%	55.70%	74.50%	46.00%	80.00%	National	>=93%	-	<93%	COO	
	National	CCAN10.1	Cancer Long Waiters (104 Day +) includes suspected and diagnosed - treated in month - NEW			6	12	10	6	2	4	5	10	12	18	12			-	-	-	-	COO	
Stroke	Local	CST1.0	80% of Patients spend 90% of time on a Stroke Ward (Local Definition - until March 2016)	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	CST1.1	80% of Patients spend 90% of time on a Stroke Ward (National Definition - from April 2016)											76.20%					Local	>=80%	-	<80%	COO	
	Local	CST2.0	Direct Admission (via A&E) to a Stroke Ward (Local Definition - until March 2016)	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	CST2.1	Direct Admission (via A&E) to a Stroke Ward (National Definition - from April 2016)											22.60%					Local	>=70%	-	<70%	COO	
	Local	CST3.0	TIA (Local Definition - until March 2016)	66.70%	61.50%	56.41%	71.05%	68.20%	65.90%	62.07%	64.70%	60.00%	-					64.23%	Local	>=60%	-	<60%	COO	
	Local	CST3.1	TIA (National Definition - from April 2016)										62.50%	50.00%					Local	>=60%	-	<60%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH **	100%	100%	101%	101%	102%	102%	108%	102%	102%	102%	103%	101%	101%	102%	102%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX **	85%	91%	93%	94%	96%	94%	104%	104%	96%	91%	93%	89%	88%	90%	94%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN2.3	Beds Occupied by NEL Stranded Patients (>7 days) - last week of month										55.60%	55.70%	45.40%	47.50%			Local	<=45	-	>45		
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute***	41	39	31	59	25	34	26	33	27	36	33	33	22	124	457	-	-	-	-	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute***	1178	1010	778	1362	817	918	807	1,090	725	739	788	1,063	704	3,294	14561	-	-	-	-	COO	
	Local	PIN4.2	Bed Days Lost Due To Acute Bed No Longer Required (Days)	2,783	3,438	3,057	3,900	3,133	3,832	3,966	3,320	3,468	3,038	3,252	3,106	2,409	11,805	40,369	-	-	-	-	COO	
Elective	National	PEL3.0	28 Day Breaches as a % of Cancellations****	23.8%	16.4%	18.4%	12.3%	12.7%	42.6%	19.7%	14.6%	36.1%	38.3%	14.9%	20.0%	16.42%	23.20%	20.1%	TBC	<=5%	6 - 15%	>15%	COO	
	National	PEL3.1	Number of patients - 28 Day Breaches (cancelled operations)				7	7	17	14	14	26	23	13	15	11			TBC	-	-	-	COO	
Emergency	National	PEL4.2	Urgent Operations Cancelled for 2nd time	0	0	0	1	1	1	1	0	0	0	1	4	1	6	4	National	<=0	-	>0	COO	
	Local	PEM2.0	Length of Stay (All Patients)	5.3	4.9	4.8	4.5	4.3	4.7	5.0	4.6	4.7	4.7	4.4	4.8	4.25	4.5	4.8	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	7.0	6.5	6.4	6.3	5.9	6.5	6.9	6.5	6.5	6.5	6.1	6.6	5.94	6.3	6.6	-	-	-	-	COO	

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

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

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Worcestershire Acute Hospitals NHS Trust

Workforce Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: July 2016

Area	Indicator Type	Indicator		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO
																				On Target	Of Concern	Action Required	
Vacancies & Recruitment	Local	WVR1.0	Number of Vacancies - Total	400	408	375	329	374	392	408	379	383	522	439	406	461		383	Local	<=200	201-229	>=230	DCE
Turnover	Local	WT1.0	Staff Turnover WTE %	11.0%	11.4%	11.6%	12.3%	11.9%	12.3%	12.8%	12.7%	13.0%	13.0%	12.9%	12.8%	12.7%		12.97%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.3	Nursing Staff Turnover - Qualified	10.9%	10.9%	11.2%	12.1%	12.8%	13.2%	14.0%	13.7%	14.2%	14.3%	14.4%	13.9%	14.4%		14.2%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.4	Nursing Staff Turnover - Unqualified	11.6%	12.9%	13.2%	14.0%	13.9%	13.9%	13.6%	13.7%	13.8%	14.0%	14.3%	14.6%	13.9%		13.8%	Local	9-10%	<>9-10%	-	DoHR
Sickness & Absence	Local	WSA1.0	Sickness Absence Rate Monthly (Total %)	4.18%	4.31%	4.50%	4.81%	4.39%	4.63%	4.69%	4.32%	4.03%	3.85%	4.05%	3.72%	4.14%		4.03%	Local	<= 3.50%	>=3.51% & <=3.99%	>= 4.00%	DoHR
Temporary Staffing	Local	WTS1.0	Agency Staff - Medics (WTE) Indicative	165.8	173.0	176.0	176.7	170.7	163.4	159.4	154.8	158.7	126.6	128.1	126.4	129.3		158.7	Local	<=85	85.1-100	>100	DCE
Induction	Contractual	WIN1.3	% of eligible staff attended Induction	89.2%	92.1%	93.5%	73.8%	87.3%	94.6%	100.0%	73.4%	87.0%	100.0%	93.6%			97.0%	88.2%	Contractual	>= 90%	80 - 89%	< 80%	DoHR
Statutory and Mandatory Training*	Contractual	WSMT10.2	% Of Eligible Staff completed Training	85.8%	82.1%	84.2%	84.4%	85.5%	87.2%	87.1%	86.9%	86.8%	87.7%	89.9%	88.0%	84.5%	87.7%	85.1%	Contractual	>= 90%	60.1-89.9%	<=60%	DoHR
Appraisals	Contractual	WAPP1.2	% Of Eligible non-medical Staff Completed Appraisal	82.7%	77.0%	75.2%	74.4%	74.5%	78.2%	78.3%	76.2%	79.9%	81.1%	84.9%	79.4%	78.9%	81.1%	77.9%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP2.2	% Of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	86.4%	85.1%	84.1%	84.0%	82.7%	81.6%	81.4%	83.0%	82.4%	80.2%	83.6%	82.9%	82.6%	82.4%	83.6%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP3.2	% Of Eligible Consultants Who Have Had An Appraisal	88.3%	87.2%	85.5%	85.3%	85.3%	82.0%	83.5%	85.2%	84.6%	83.7%	85.7%	85.8%	86.4%	85.4%	86.2%	Contractual	>= 85%	71 - 84%	< 71%	DoHR

** Please note that the thresholds for Mandatory Training now reflect the required CCG reporting trajectory of 95% by year end.*
With the exception of IG the mandatory training target has been revised from 95% to 90% effective from Feb 2016. Data from Feb 2015 is now calculated against 90% (except IG)

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

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Worcestershire Acute Hospitals NHS Trust

Maternity Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: July 2016

Area	Indicator Type	Indicator		Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Current YTD	Prev Year
Scheduled Bookings	National	MSB1.1	Women Booked Before 12 + 6 Weeks	89.0%	87.7%	89.0%	88.5%	93.3%	92.0%	88.5%	88.6%	91.3%	85.5%	89.6%	90.5%	89.4%	88.7%	89.2%
	Contractual	MSB1.2	Total Bookings	543	529	526	540	491	497	479	493	503	523	502	504	452	1981	6114
Deliveries	Contractual	MDEL1.0	Deliveries	507	472	484	496	484	439	447	462	496	441	458	460	497	1856	5782
Births	Contractual	MBIR1.0	Total Births	515	478	490	504	492	447	454	470	502	449	465	468	506	1888	5876
Normal Vag. Deliveries	Contractual	MNVD1.0	Maintain Normal Vaginal Delivery Rate	57.7%	62.7%	63.7%	56.9%	56.8%	56.7%	57.3%	60.6%	63.3%	56.0%	60.5%	60.4%	62.0%	60%	59.3%
C- Section	Contractual	MCS1.0	Total Caesareans	32.6%	28.1%	26.6%	31.3%	32.6%	30.5%	29.8%	28.6%	27.6%	32.7%	27.3%	28.3%	28.2%	29.0%	29.6%
	Contractual	MCS1.1	Elective Caesareans	12.3%	10.0%	11.0%	15.0%	13.6%	13.2%	11.6%	13.0%	11.7%	13.8%	12.0%	12.6%	12.1%	12.6%	12.2%
	Contractual	MCS1.2	Emergency Caesareans	20.3%	18.1%	15.6%	16.3%	19.0%	17.3%	18.1%	15.6%	15.9%	18.8%	15.3%	15.7%	16.1%	16.4%	17.4%
Outcome Indicators	National	MOI1.0	Breast Feeding Initiation Rates	73.0%	72.0%	74.6%	73.0%	68.6%	69.7%	70.1%	71.1%	70.6%	71.7%	68.6%	72.8%	67.5%	70.1%	71.4%
	Contractual	MOI3.0	Midwife Led Care %	21.1%	20.5%	23.9%	20.1%	20.9%	19.4%	18.3%	22.5%	22.4%	19.5%	24.7%	22.0%	23.5%	22.5%	21.3%

Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kite mark
	On Target	Of Concern	Action Required		
National	>=90%	-	<90%	CNO	
Local	>=6290 bookings in the year			CNO	
Local	>=5890 deliveries in the year			CNO	
Contractual	<=480	481 - 531	>532	CNO	
Contractual	>63%	63% - 60%	<60%	CNO	
Contractual	<27%	27% - 30%	>30%	CNO	
Contractual	<=11.2%		>11.2%	CNO	
Contractual	<=15.2%		>15.2%	CNO	
National	> 74%	70% - 74%	< 70%	CNO	
Contractual	>= 37.7%		<37.7%	CNO	

NB: Please note that tolerances are adjusted between financial years

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Worcestershire NHS
Acute Hospitals NHS Trust

7 September 2016 **Enclosure G3**

Report to Trust Board (public)

Title	**Financial Performance – Month 4 2016/17**
Sponsoring Director	**Rob Cooper – Interim Director of Finance & Information**
Author	**Haq Khan – Deputy Director of Finance** **Jo Kirwan - Assistant Director of Finance** **Katie Osmond – Assistant Director of Finance**
Action Required	The Trust Board is asked to note the financial position and to seek assurance that the risks identified are being appropriately managed.
Previously considered by	Finance & Performance Committee

Priorities (√)

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

Related Board Assurance Framework Entries	2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service. 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability
Legal Implications or Regulatory requirements	The Trust must ensure plans are in place to achieve the Trust's financial forecasts. The Trust has a statutory duty to breakeven over a 3 year period.
Glossary	***Commissioning for Quality and Innovation (CQUINs)*** – payments ensure that a proportion of providers' income (currently up to 2.5%) is conditional on quality and innovation and is linked to service improvement. The schemes that qualify for CQUIN payments reflect both national and local priorities.

Earnings before interest, taxation, depreciation and amortisation (EBITDA) – is a measure of a trust's surplus from normal operations, providing an indication of the organisation's ability to reinvest and meet any interest associated with loans it may have. It is calculated as revenue less operating expenses less depreciation less amortisation.

Liquidity – is a measure of how long an organisation could continue if it collected no more cash from debtors. In Monitor's Risk Assessment Framework, it is measured by the number of days' worth of operating costs held in cash or cash-equivalent forms and is a key component of the continuity of services risk rating.

Quality, innovation, productivity and prevention (QIPP) – is a programme designed to identify savings that can be reinvested in the health service and improve quality of care. Responsibility for its achievement lies with CCGs; QIPP plans must therefore be built into planning (and performance management) processes.

Marginal rate emergency tariff (MRET) – is an adjustment made to the amount a provider of emergency services is reimbursed. It aims to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid 70% of the national price for each patient admitted as an emergency over and above a set threshold.

Introduced in 2003, ***payment by results (PBR)*** was the system for reimbursing healthcare providers in England for the costs of providing treatment. Based on the linking of a preset price to a defined measure of output of activity, it has been superseded by the national tariff.

Key Messages:

- In July the Trust recorded an in month deficit of £3.2m resulting in an adverse variance against plan of £0.3m. This is the first month that the Trust has reported an adverse variance.

- Failure to achieve any of the £327k operational performance related element of the STF is largely responsible for the adverse variance. The Trust achieved the financial control target, earning the full £764k financial performance element of STF for July.

Title of report	Financial Performance – Month 4 2016/17
Name of director	Rob Cooper

- YTD patient care revenue is £2.2m under plan due to under performance against activity plans (£1.7m) and the impact of fines and contractual issues (£0.5m). Improvement of income performance against the plan requires a significant increase in elective activity.

- YTD Operating Expenditure is £2m under spent on Pay. This is mostly due to ST&T vacancies (£0.4m), below plan expenditure on non-clinical staff (£0.9m) and reduced levels of activity (£0.7m). The rate of under spending has reduced due to increased agency costs; it is expected to reduce further as the CIP target ramps up and following the inclusion of £1m of the £2.5m of cost pressures.

- Agency costs increased in month and exceeded forecast by £0.2m. The forecast outturn is £22.8m against the £22.9m Agency Expenditure Ceiling but this does rely on a delivery of a further £1.3m of CIP.

- CIP delivery is on plan but the target is back ended with £4.3m more CIP in the second half of the year.

- The forecast shows that the £34.6m planned deficit is expected to be delivered though there are risks that need to be robustly managed as set out below:

    - Increased agency costs resulting in a breach to the agency control target
    - Cost pressures assessed by the operational management team to be unavoidable
    - CIP delivery
    - CQUINs
    - STF achievement
    - Ambulance charges related to Paediatric move
    - Agreement of prior year end settlement with CCGs

A financial risk management plan is presented at Finance & Performance committee and will be assessed next month to determine the value of any residual risk.

ROB COOPER
Interim Director of Finance

Report to Trust Board

Worcestershire NHS
Acute Hospitals NHS Trust

Finance Report
Month 4

Rob Cooper

Interim Director of Finance

5th September 2016

Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

Income & Expenditure Position (Page 6)

In July (M4) the Trust recorded an in month deficit of £3.2m resulting in a £287k adverse variance against the YTD plan. At £13.2m the YTD deficit is £442k worse than the forecast. It is the first time this year the Trust has reported an adverse variance against the plan. Failure to achieve any of the £327k operational performance related element of the STF is largely responsible for the adverse variance. However, the Trust achieved the financial control target, earning the full £764k financial performance element of STF for July (page 10).

The table below provides a summary of the key variances :

	YTD Variance from Forecast £m	YTD Variance from Plan £m	Variance Analysis	Pages
Income	(0.2)	(2.3)	**Forecast variance** - RTT, A&E 4 hours and 62 day cancer waits performance all fell short of trajectory. As a result of this performance the Trust did not qualify for the performance related element of the STF (£0.3m). **Plan variance -** YTD patient care revenue is £2.2m below plan excluding STF. Adverse variances on Inpatient activity (£2.4m), maternity deliveries (£0.8m) and fines/penalties (£0.5m) are being partially offset by the lack of a discernible impact of Commissioner QIPP programmes (£1.7m) and performance against Other Contract Income (£0.2m).	Pages 4, 6 Page 6
Expenditure	(0.2)	2.0	**Forecast variance** – Under delivery of CIP targeted against agency and the theatres improvement programme. **Plan variance -** Vacancies across non clinical and ST&T staff groups contribute £1.2m with the remaining variance due to reduced levels of activity. The level of underspend is starting to decrease due to increasing costs related to cost pressures identified by operational management and ramp up of the CIP target.	Page 4 Pages 11-13
Total	**(0.4)**	**(0.3)**		

Values are net of non PbR pass through movements

The forecast remains in line with the planned deficit of £34.6m and therefore assumes the performance element of the STF will be recovered and the CQUIN underperformance will be mitigated.

Financial Risks and Opportunities

Worcestershire NHS
Acute Hospitals NHS Trust

Ref		Risk or Opportunity	Pages
	Pay Expenditure - Pay costs overall remained flat but above forecast - nursing expenditure normalised following retention payments to theatres staff in June - offset by increased non-clinical expenditure driven by recruitment to vacancies and increased agency usage.	Risk	Pages 11-12
R1a	Agency costs increased in July by £60k compared to June, exceeding forecast by £205k due to non delivery against CIP. Although July agency spend remains below plan, a continued spend at this increased level and non delivery of the £1.3m CIP will threaten delivery against the Trust's £22.9m Agency Expenditure Ceiling. Assurance is required that agency expenditure can be maintained within the expenditure ceiling.		Page 5
R1b	With increasing senior medical vacancies, urgent action is required to stem the increase in agency costs and support rapid permanent recruitment processes. Assurance is required from WAG that all vacant medical posts have robust recruitment and agency cost management in place.		Page 5
R2	**Cost pressures** - The Trust currently has a £2.5m risk associated with what are considered by operational management to be unavoidable cost pressures related to the maintenance of safe services, service developments and improvements in RTT performance. Controls are in place to prevent unauthorised expenditure with the impending re-launch of the business case process intended to improve management of expenditure growth. The forecast assumes £1.0m of this risk will materialise.	Risk	Page 7
R3	**CIP** - The gap against the £24.3m CIP target has reduced to £4.7m following the addition of £1m of schemes in July (Procurement £0.5m and Medicine £0.5m). YTD CIP delivery is to plan but this could move to an adverse variance as the target ramps up over the coming months unless plans are formulated to address the gap. In addition to the agency CIP detailed above, the forecast assumes £2.9m of the remaining gap is closed through the Theatres Improvement Programme. The Trust needs to maximise the benefit from the opportunities that PwC have identified.	Risk	Page 8
O1	**Income -** YTD income is £2.3m under plan and is forecast to be £1.9m below plan at year end. Elective activity is under performing significantly against plan (£1.3m) and is also lower than the comparable period last year (partly due to reduced use of additional activity sessions and the independent sector). Specialty level plans are being developed to ensure delivery of elective activity at contracted levels.	Opportunity	Page 6
R4	**CQUINs –** Total CQUIN is worth £7.6m. Currently, £4.5m is risk rated Green, £0.6m is rated Amber and £2.5m is Red. The DoF has written to CQUIN leads seeking assurance that plans are in place and that these are on track.	Risk	
R5	**Sustainability Transformation Fund –** M4 forecast assumes full delivery, i.e. trajectories will be recovered in future months: • Finance – Green £9.2m • RTT- Red £1.2m, Green £0.4m • A&E 4 hour target – Red £1.2m, Green £0.4m • 62 day cancer waits – Red £0.5m, Green £0.2m	Risk	

Trustwide Position

Worcestershire NHS
Acute Hospitals NHS Trust

Table 1

July 16 (Month 4)

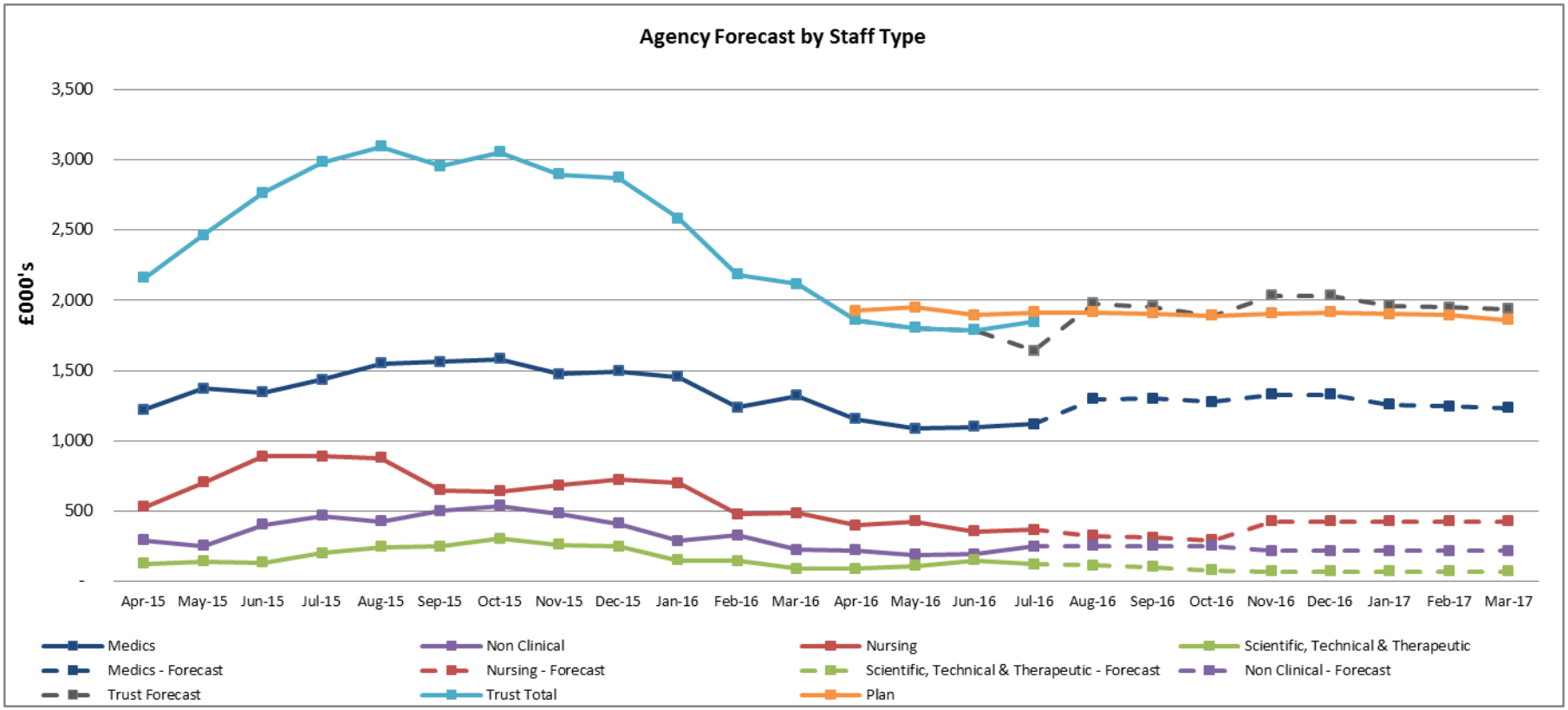
Income & Expenditure	Current Month			Year to Date			Full Year		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Revenue & Income									
Patient Care Revenue	26,340	25,843	(497)	106,382	104,142	(2,240)	317,624	315,404	(2,220)
Other Operating Income	2,162	2,237	75	8,639	8,935	296	26,512	26,761	249
Non PBR Drugs & Devices	2,899	2,899	(0)	12,303	12,303	0	40,275	40,372	97
STF	1,092	764	(327)	4,367	4,039	(327)	13,100	13,100	0
Total Operating Revenue	**32,492**	**31,743**	**(749)**	**131,690**	**129,419**	**(2,271)**	**397,511**	**395,637**	**(1,874)**
Operating Expenses									
Pay	(21,096)	(20,685)	411	(84,576)	(82,527)	2,049	(251,752)	(249,518)	2,234
Non Pay	(9,197)	(9,310)	(113)	(39,173)	(39,272)	(99)	(114,503)	(114,769)	(266)
Non PBR Drugs & Devices	(2,899)	(2,899)	0	(12,303)	(12,303)	0	(40,275)	(40,372)	(97)
Total Operating Expenses	**(33,192)**	**(32,894)**	**298**	**(136,052)**	**(134,102)**	**1,950**	**(406,530)**	**(404,659)**	**1,871**
EBITDA *	**(700)**	**(1,150)**	**(451)**	**(4,362)**	**(4,682)**	**(321)**	**(9,019)**	**(9,022)**	**(3)**
EBITDA %	-2.2%	-3.6%		-3.3%	-3.6%		-2.3%	-2.3%	
Depreciation	(956)	(863)	93	(3,452)	(3,452)	0	(10,054)	(10,054)	0
Net Interest, Dividends & Gain/(Loss) on asset disposal	(1,239)	(1,179)	61	(5,134)	(5,101)	34	(15,582)	(15,579)	3
Reported Total Surplus / (Deficit)	**(2,895)**	**(3,192)**	**(297)**	**(12,948)**	**(13,235)**	**(287)**	**(34,655)**	**(34,655)**	**0**
Less Impact of Donated Asset Accounting	6	6	0	24	24	0	72	72	0
Surplus / (Deficit) against Control Total	**(2,889)**	**(3,186)**	**(297)**	**(12,924)**	**(13,211)**	**(287)**	**(34,583)**	**(34,583)**	**0**
Surplus / (Deficit) %	-8.9%	-10.0%		-9.8%	-10.2%		-8.7%	-8.7%	

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

- Overall, the Trust is £0.3m over plan in month and YTD due to non achievement of the operational performance element of the STF.
- The forecast remains in line with the planned deficit of £34.6m.
- YTD patient care revenue is £2.2m under plan due to under performance against activity plans (£1.7m) and the impact of fines and contractual issues (£0.5m). Improvement of income performance against the plan requires a significant increase in elective activity.
- YTD Operating Expenditure is £2m under spent on Pay. This is mostly due to ST&T vacancies (£0.4m), below plan expenditure on non-clinical staff (£0.9m) and reduced levels of activity (£0.7m). The rate of under spending has reduced due to increased agency costs; it is expected to reduce further as the CIP target ramps up and following the inclusion of £1m of the £2.5m of cost pressures.

Agency Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust



Staff Group	Actuals					Forecast									Full Year Control Total	FOT Var against Control Total
	Apr-16	May-16	Jun-16	Jul-16	*YTD Actual*	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	FY Forecast		
Medics - Agency	1,153	1,084	1,096	1,116	*4,450*	1,297	1,299	1,276	1,326	1,326	1,256	1,245	1,232	14,709		
Non Clinical - Agency	219	186	190	247	*842*	251	251	251	213	213	213	213	213	2,657		
Nursing - Agency	398	426	352	366	*1,542*	321	308	288	425	425	425	425	425	4,581		
ST&T - Agency	87	106	149	119	*461*	110	98	74	69	69	69	69	69	1,085		
TOTAL	**1,857**	**1,803**	**1,787**	**1,847**	***7,294***	**1,978**	**1,955**	**1,890**	**2,032**	**2,032**	**1,962**	**1,951**	**1,937**	**23,032**	**22,940**	**(92)**
Forecast at Month 3	*1,857*	*1,804*	*1,787*	*1,642*		*1,978*	*1,955*	*1,890*	*2,032*	*2,032*	*1,962*	*1,951*	*1,937*	*22,829*	**22,940**	**111**

- Agency expenditure exceeded forecast by £0.2m.
- Although agency expenditure increased by £60k and exceeded the forecast, the July position was £56k lower than the agency budget.
- However, non delivery of the CIP gap targeted to agency would result in the Trust exceeding the agency ceiling by £1.3m.

Income by Point of Delivery

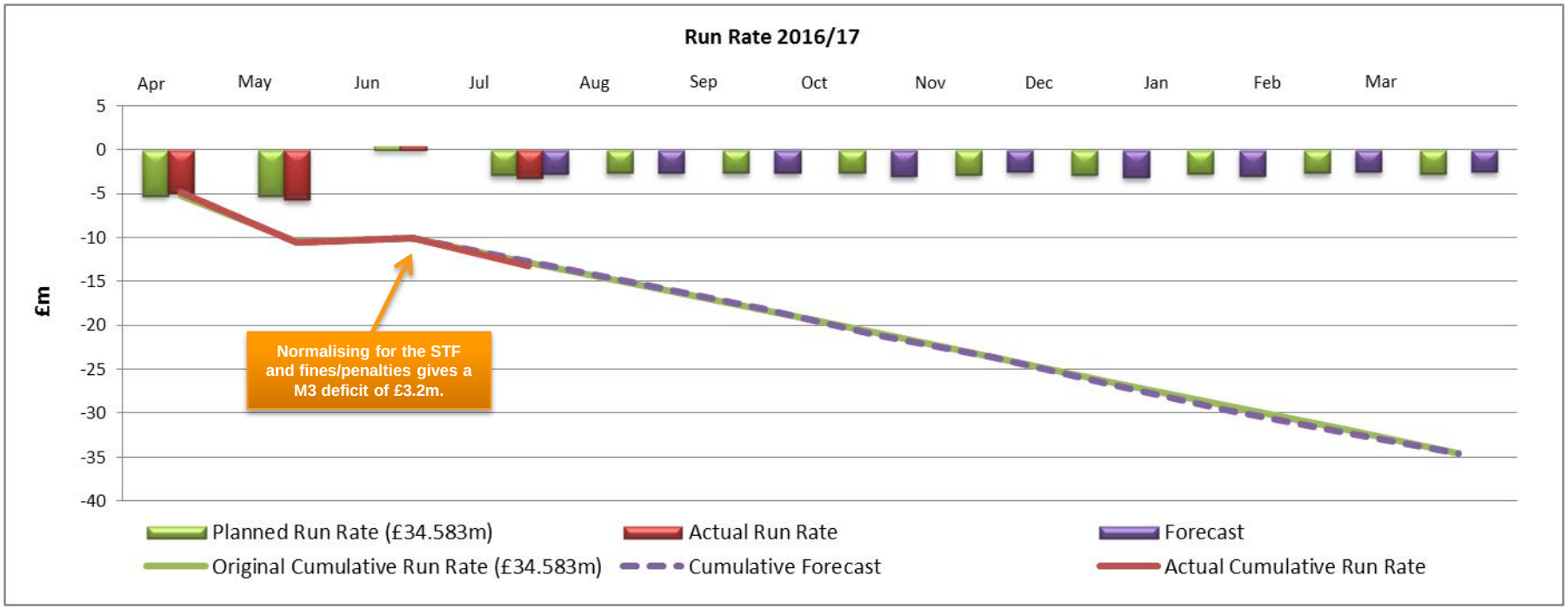
Worcestershire NHS
Acute Hospitals NHS Trust

	In Month				YTD				Full Year				
	Plan £'000	Actual £'000	Var £'000	% £'000	Plan £'000	Actual £'000	Var £'000	% £'000	Initial Plan £'000	Current Plan £'000	Forecast £'000	Var £'000	% £'000
Elective	2,351	2,095	(256)	(11%)	9,399	8,139	(1,260)	(13%)	27,293	27,293	24,372	(2,921)	(11%)
Daycase	2,927	2,782	(146)	(5%)	11,465	11,246	(219)	(2%)	35,063	35,063	35,040	(23)	(%)
Non Elective - Emerg	7,537	7,634	98	1%	29,896	29,017	(880)	(3%)	88,795	88,795	85,975	(2,820)	(3%)
Non Elective - Other	143	83	(61)	(42%)	553	493	(59)	(11%)	1,610	1,610	1,638	28	2%
Total Inpatients	**12,958**	**12,594**	**(365)**	**(3%)**	**51,313**	**48,895**	**(2,418)**	**(5%)**	**152,760**	**152,760**	**147,025**	**(5,736)**	**(4%)**
Outpatients New	1,586	1,504	(82)	(5%)	6,596	6,324	(272)	(4%)	19,953	19,953	19,567	(386)	(2%)
Outpatients F Up	1,528	1,453	(75)	(5%)	6,352	6,164	(187)	(3%)	19,312	19,312	19,383	71	%
Outpatients Procedure	681	656	(25)	(4%)	2,821	2,922	100	4%	8,525	8,525	9,196	671	8%
Total Outpatients	**3,795**	**3,613**	**(182)**	**(5%)**	**15,769**	**15,410**	**(359)**	**(2%)**	**47,790**	**47,790**	**48,146**	**356**	**1%**
ED Attendances	1,435	1,499	65	4%	5,545	5,705	161	3%	16,645	16,645	17,034	389	2%
Community MIU	186	214	28	15%	718	789	71	10%	2,155	2,155	2,328	173	8%
Total ED/MIU	**1,620**	**1,713**	**93**	**6%**	**6,263**	**6,495**	**232**	**4%**	**18,800**	**18,800**	**19,363**	**562**	**3%**
Maternity - Delivery	1,193	1,069	(125)	(10%)	4,802	4,045	(757)	(16%)	13,267	13,267	12,182	(1,085)	(8%)
Maternity Ante Natal	767	680	(87)	(11%)	2,900	2,960	60	2%	8,625	8,625	9,218	593	7%
Maternity Post Natal	139	133	(6)	(4%)	542	488	(54)	(10%)	1,598	1,598	1,409	(190)	(12%)
Total Maternity	**2,105**	**1,884**	**(221)**	**(11%)**	**8,267**	**7,502**	**(765)**	**(9%)**	**23,555**	**23,555**	**22,836**	**(720)**	**(3%)**
Paed - Daycase/Elective	20	15	(5)	(23%)	81	77	(3)	(4%)	250	250	253	3	1%
Paed - Non Elective	422	423	0	%	1,722	1,697	(25)	(1%)	5,527	5,527	5,397	(130)	(2%)
Paed - Outpatient	207	198	(9)	(4%)	869	908	39	5%	2,645	2,645	2,849	203	8%
Paed - BPT, Drugs, CQUIN	114	152	38	33%	478	532	54	11%	1,501	1,434	1,500	66	5%
Paed - Neonatal Cot Days	354	339	(15)	(4%)	1,417	1,344	(73)	(5%)	4,250	4,250	4,019	(231)	(5%)
Total Paediatrics	**1,117**	**1,128**	**10**	**1%**	**4,566**	**4,558**	**(7)**	**(%)**	**14,174**	**14,107**	**14,018**	**(89)**	**(1%)**
Chemotherapy Delivery	**341**	**325**	**(16)**	**(5%)**	**1,289**	**1,332**	**43**	**3%**	**3,828**	**3,828**	**4,069**	**241**	**6%**
Drugs PBR Excluded	2,047	2,047	0	%	8,217	8,217	0	%	25,700	27,347	27,444	97	%
Critical Care ITU/HDU	854	845	(8)	(1%)	3,414	3,140	(274)	(8%)	10,242	10,242	9,177	(1,065)	(10%)
Other Contract Income	5,020	4,985	(35)	(1%)	19,883	20,048	165	1%	60,663	59,642	60,200	558	1%
Total Other Contract Income	**7,921**	**7,878**	**(43)**	**(1%)**	**31,515**	**31,405**	**(110)**	**(%)**	**96,605**	**97,231**	**96,821**	**(410)**	**(%)**
Contractual Deductions/Penalties	**(135)**	**(316)**	**(181)**		**(541)**	**(1,066)**	**(525)**		**(1,624)**	**(1,624)**	**(3,002)**	**(1,378)**	**85%**
Commissioner QIPP	(417)	0	417		(1,667)	0	1,667		(5,000)	(5,000)	0	5,000	(100%)
Non Contract Income	415	406	(9)	(2%)	2,028	2,031	4	%	7,970	6,451	6,502	51	1%
Phasing Adj	(482)	(482)	0	%	(117)	(117)	0	%	0	(0)	(0)	0	
Pre STP Total	**29,239**	**28,742**	**(497)**	**(2%)**	**118,684**	**116,445**	**(2,239)**	**(2%)**	**358,859**	**357,899**	**355,776**	**(2,123)**	**(12%)**
STF	1,092	764	(327)	(30%)	4,367	4,039	(327)	(7%)	0	13,100	13,100	0	%
	30,330	**29,506**	**(824)**	**(3%)**	**123,051**	**120,484**	**(2,567)**	**(2%)**	**358,859**	**370,999**	**368,876**	**(2,123)**	**(1%)**

- In Month 4 the Trust has achieved the Financial Control Target earning 70% of the available STF funding for the month, but the RTT, A&E and Cancer 62 day waits standards were non-compliant. This creates a £327k under performance in month and YTD. There is the opportunity to recover this through achieving targets for Q2.
- Across all commissioners and nearly all specialties elective activity is down and this has had a c.£1.3m impact YTD.
- Non Elective activity is also down by c.£1m YTD. Whilst Trauma and Cardiology activity is lower than previous year's an in month improvement in Trauma along with higher A&E and General Medicine activity has prevented the YTD variance from deteriorating further.
- Maternity deliveries are down on 15/16 and under plan by £757k YTD.

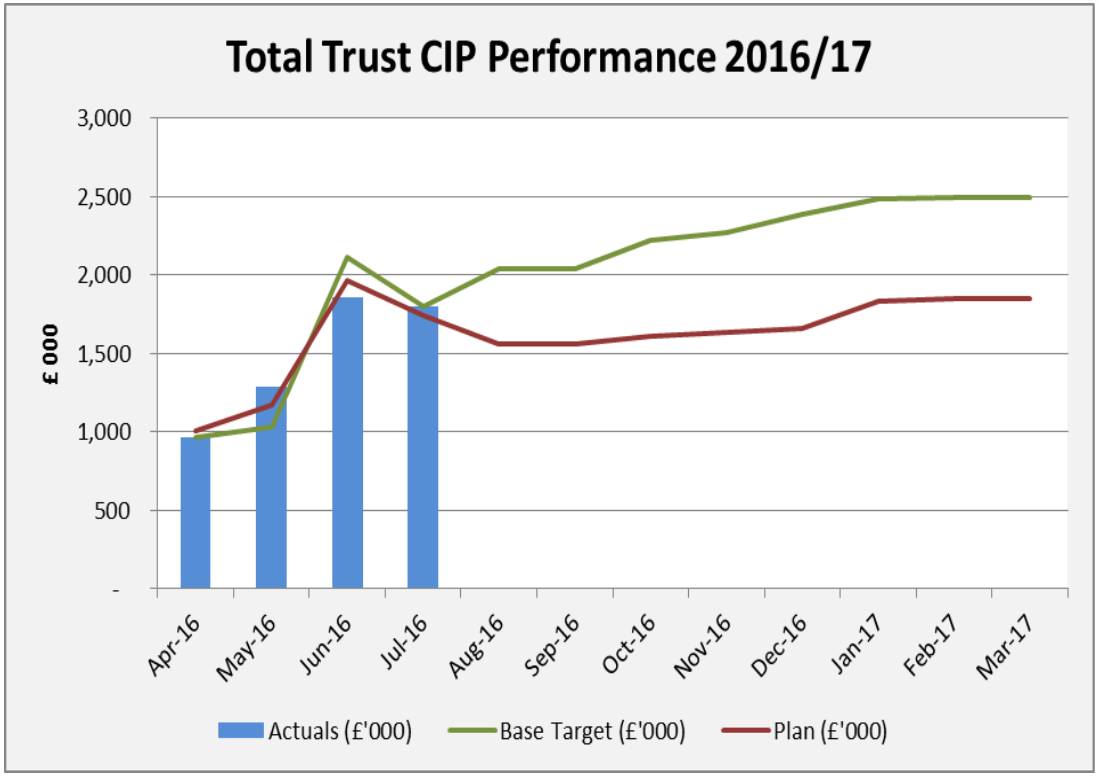
Run Rate

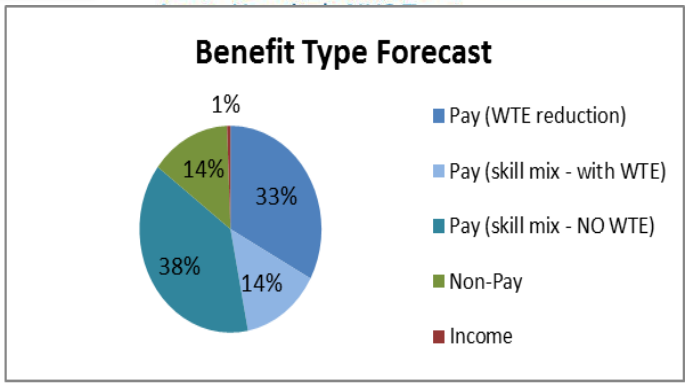
Worcestershire NHS
Acute Hospitals NHS Trust

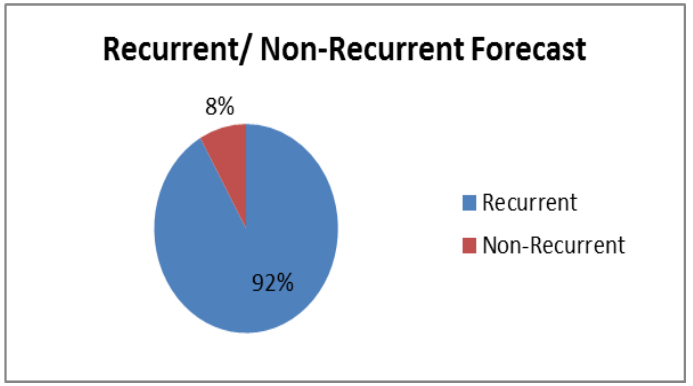


The chart shows that the FY forecast remains in line with the £34.6m planned deficit. This requires delivery of average monthly deficits of £2.7m and recovery of the £0.3m YTD adverse variance.

CIP – Target £24.3m





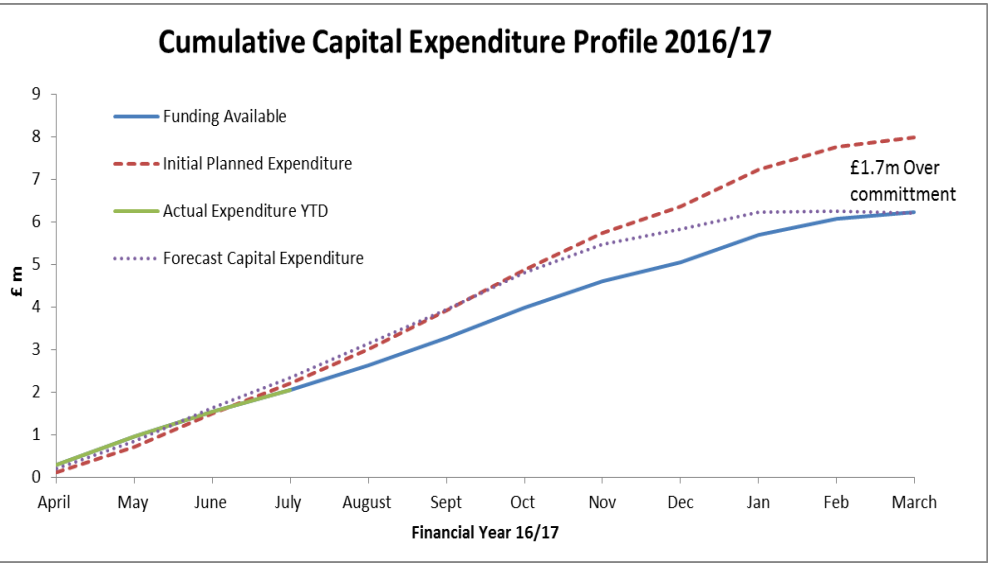


The Trust has achieved its CIP target YTD. However, as chart above highlights, the monthly targets significantly increase from month five onwards.

The CIP target was increased to £28.0m due to the control target adjustment required by NHSi. A further £3.7m of savings were required in order to meet conditions of the STF agreement. Therefore at present the Trust target is reported as £24.3m with schemes in development for the additional £3.7m.

Capital Programme 16/17

Worcestershire NHS
Acute Hospitals NHS Trust



The capital programme started the year £1.7m over committed, however finance and work stream leads have produced a trajectory to ensure the actual schemes are within the funding available and the Trust meets its CRL. However this position is subject to change as a number of other potential schemes and requirements are being worked through.

The capital programme excludes planned loans for backlog maintenance (£2.4m) and invest to save schemes (£1m). These loan applications are scheduled to be submitted in September pending internal approval for the backlog maintenance and Aconbury East closure business cases. The car parking (Bundles 1&2) and A Block business cases were approved at the July FPC.

Preparation of the ASR OBC is progressing at risk. In the meantime, the emergency service moves have created pressures that require capital investment. The DoF has written to NHSI seeking assurance that the £2m capital loan required this year will be forthcoming.

A mid year review is underway to reprioritise the capital programme and contain it within available resources.

The YTD position is showing an overspend of £174k within ICT projects.

	£000's	In Month			YTD			Full year			
Workstream	Highlevel Summary	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Expenditure Details
Development	ED Expansion	(300)	(300)	(0)	(1,074)	(1,074)	(0)	(1,386)	(1,386)	0	Main capital expenditure YTD relates to the ED department. The TAU and MRI scheme are progressing. Other ASR schemes are in the development stages but are expected to be completed in this financial year subject to funding.
	ASR Loan						(0)	(2,000)	(2,000)	0	
	MRI Enabling Works(Alex)	0	0	0	0	0		(255)	(255)	0	
Development Total		(300)	(300)	(0)	(1,074)	(1,074)	(0)	(3,386)	(3,641)	(255)	
Equipment	Equipment	(1)	1	(2)	(5)	(5)	(1)	(500)	(500)	0	
Equipment Total		(1)	1	2	(5)	(5)	(0)	(500)	(500)	0	
ICT	Other ICT/Inflight Project	(9)	37	(46)	(37)	(108)	(71)	(119)	(119)	0	YTD £174k overspend relates to the EPR and other inflight projects. Finance are working with ICT to ensure a balanced plan in 16/17.
	EPR	(54)	(100)	46	(97)	(225)	(128)	0	0	0	
	Data Centre	(150)	(151)	1	(550)	(551)	(1)	(1,800)	(1,800)	0	
	Systems & Infrastructure Maintenance Programme	(68)	(35)	(33)	(173)	(147)	26	(1,058)	(1,058)	0	
ICT Total		(281)	(249)	32	(857)	(1,031)	(174)	(2,977)	(2,977)	0	
Property and Works	Clinical Developments/Strategic Schemes	0	(7)	7	0	(44)	(44)	0	0	0	Replacement of RO plant KTC £156k Kings Court and Aconbury Decant costs £63k KTC Steam Condenser replacement £25k Project Management staffing costs £61k Water Safety and Legionella £28k
	Staffing	(3)	(8)	5	(13)	(61)	(48)			0	
	External Regs/ Stds	(34)	5	(39)	(172)	(64)	107			0	
	LiA							(100)	(100)	0	
	Routine works/Backlog Maintenance	(47)	(25)	(22)	(229)	(245)	(16)	(1,909)	(1,654)	255	
Property and Works Total		(85)	(35)	49	(414)	(414)	0	(2,009)	(1,754)	255	
Total Expenditure		(667)	(583)	83	(2,350)	(2,524)	(174)	(8,872)	(8,872)	0	
Alex Land Sale		0	0	0	0	0	0	325	325	0	
Grand Total		(666)	(582)	84	(2,350)	(2,524)	(174)	(8,547)	(8,547)	0	

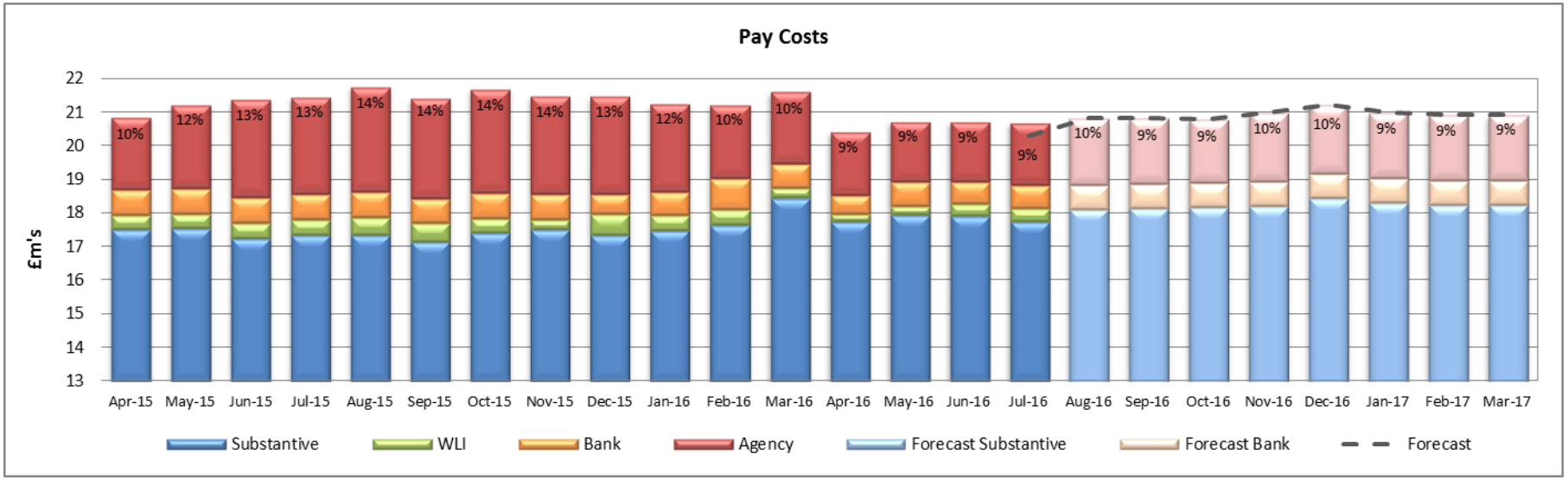
Worcestershire NHS
Acute Hospitals NHS Trust

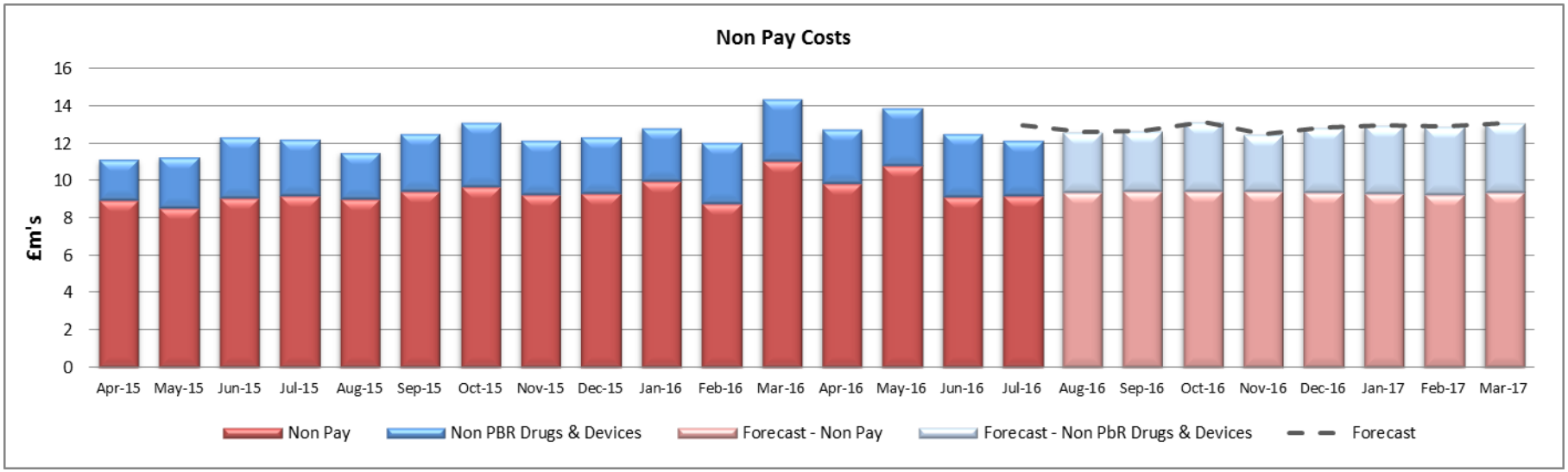
Appendices

Pay & Non Pay Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust

Percentages shows proportion of agency spend against total spend.

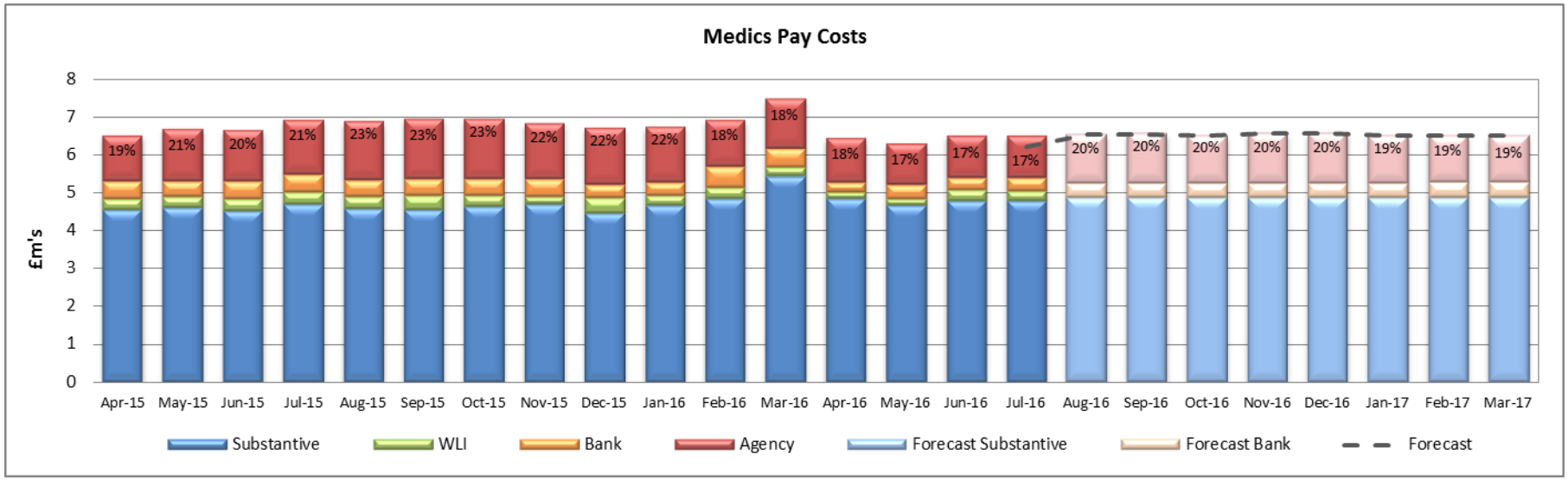


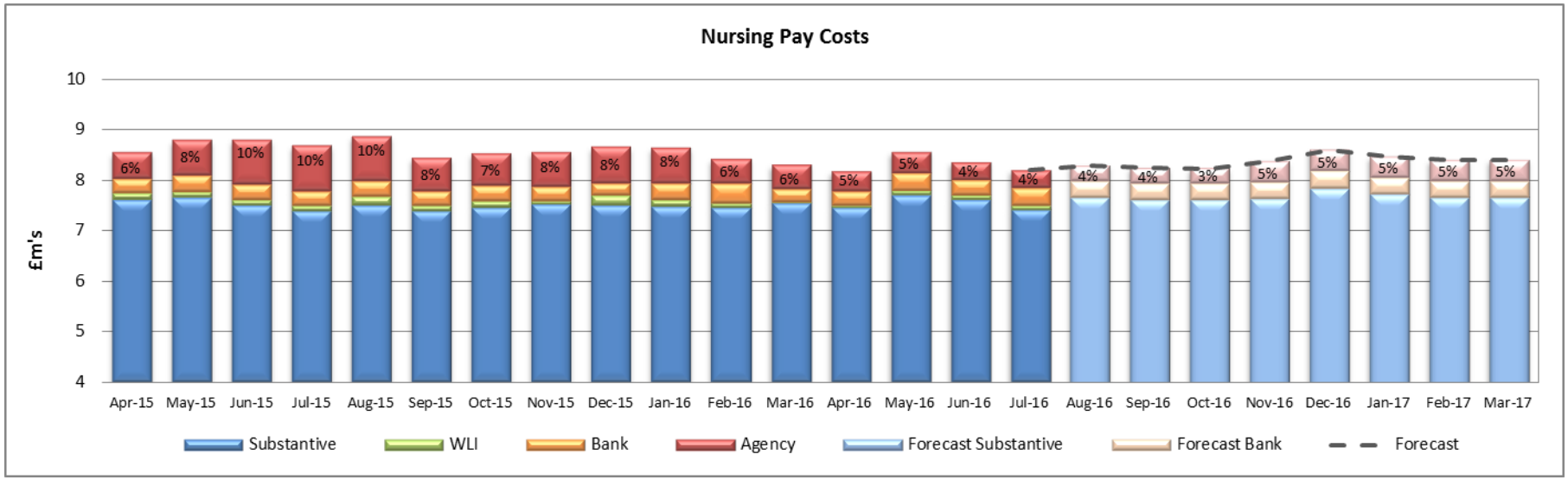


Medics & Nursing Pay Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust

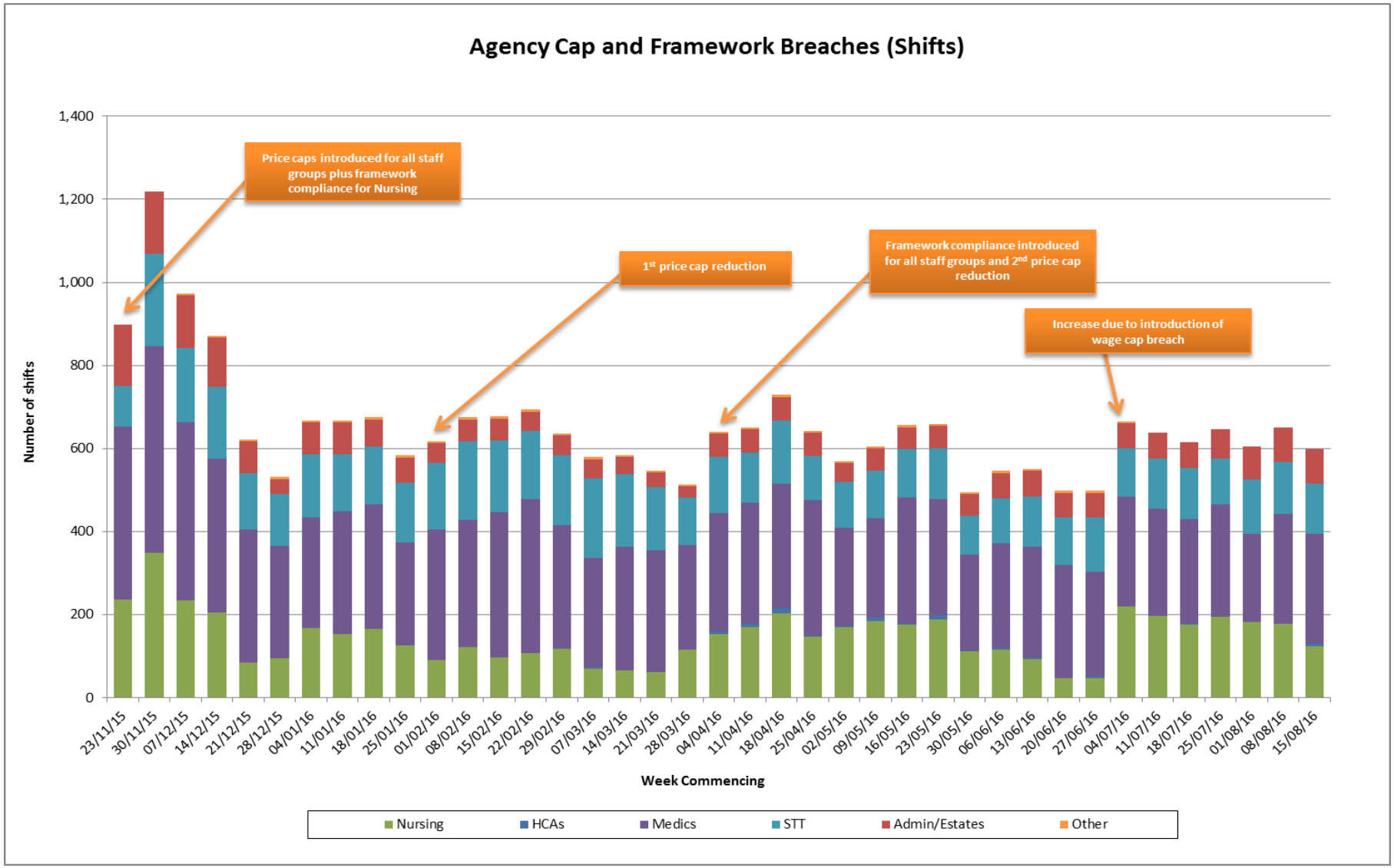
Percentages shows proportion of agency spend against total spend.





Agency Cap Breaches

Worcestershire NHS
Acute Hospitals NHS Trust



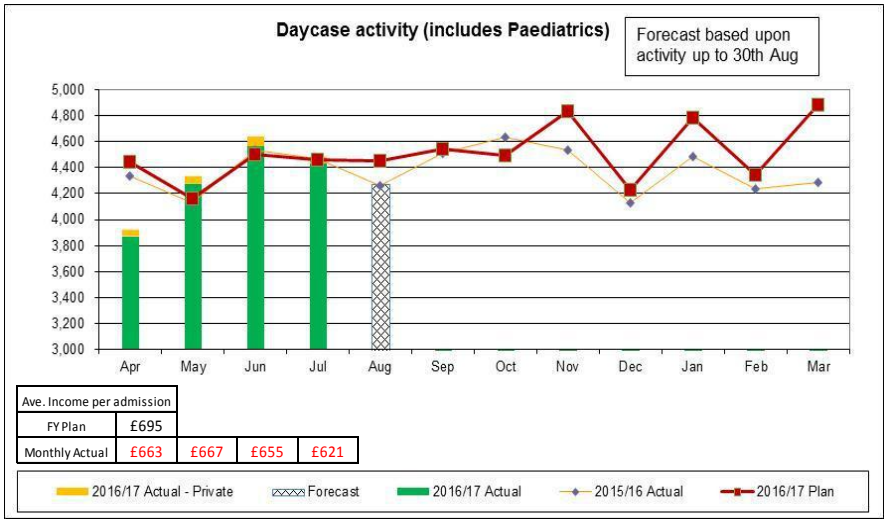
Activity

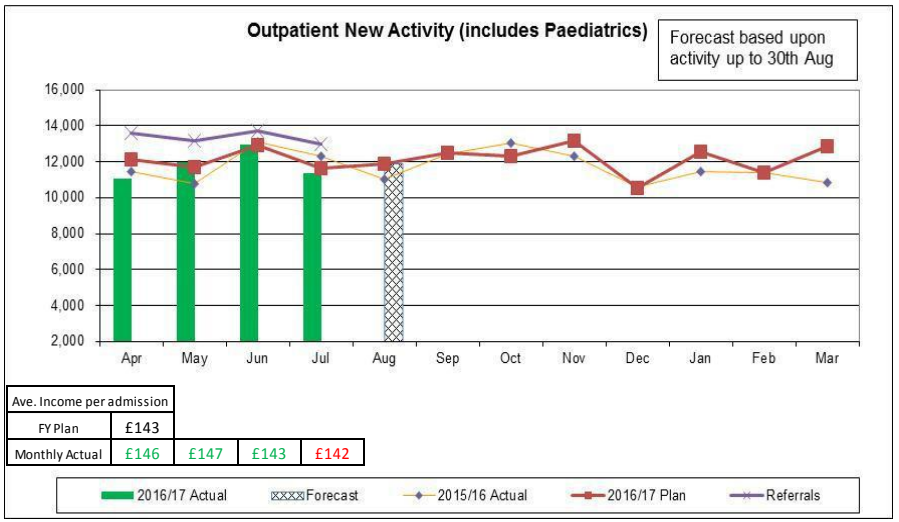
Worcestershire NHS
Acute Hospitals NHS Trust

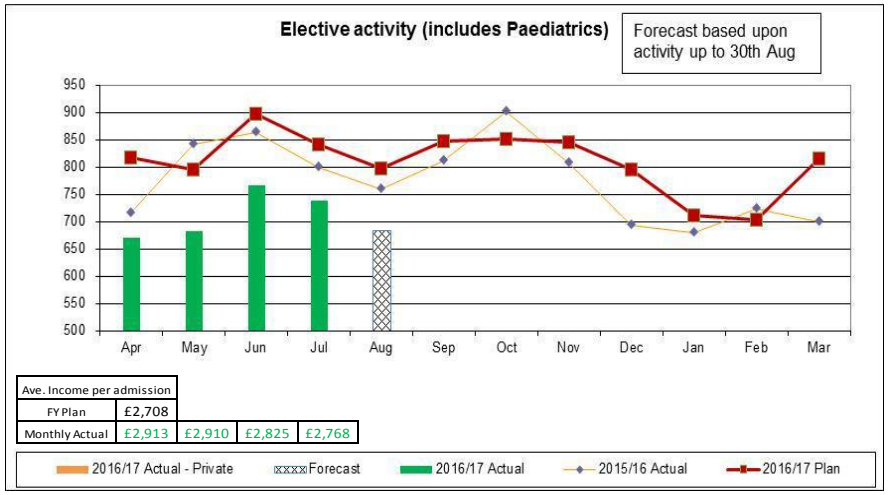
	In Month				YTD				Full Year				
	Plan	Actual	Var	%	Plan	Actual	Var	%	Initial Plan	Current Plan	Forecast	Var	%
Elective	836	735	(101)	(12%)	3,338	2,849	(489)	(15%)	9,679	9,679	8,478	(1,201)	(12%)
Daycase	4,437	4,394	(43)	(1%)	17,452	17,268	(184)	(1%)	64,901	53,771	53,726	(45)	(%)
Non Elective - Emerg	3,560	3,654	94	3%	14,087	14,184	97	1%	42,403	42,403	42,565	161	%
Non Elective - Other	51	26	(25)	(49%)	198	230	32	16%	575	575	812	236	41%
Total Inpatients	**8,884**	**8,809**	**(75)**	**(1%)**	**35,075**	**34,531**	**(544)**	**(2%)**	**117,559**	**106,429**	**105,580**	**(848)**	**(1%)**
Outpatients New	11,070	10,869	(201)	(2%)	46,097	44,825	(1,272)	(3%)	138,738	138,738	136,950	(1,789)	(1%)
Outpatients F Up	19,264	18,885	(379)	(2%)	80,268	79,119	(1,149)	(1%)	243,400	243,400	247,932	4,532	2%
Outpatients Procedure	3,887	3,806	(81)	(2%)	16,161	16,466	305	2%	48,800	48,800	51,212	2,411	5%
Total Outpatients	**34,221**	**33,560**	**(661)**	**(2%)**	**142,525**	**140,410**	**(2,115)**	**(1%)**	**430,939**	**430,939**	**436,093**	**5,154**	**1%**
ED Attendances	13,168	13,754	586	4%	50,890	52,345	1,455	3%	152,768	152,768	156,286	3,518	2%
Community MIU	3,149	3,630	481	15%	12,172	13,376	1,204	10%	36,539	36,539	39,470	2,931	8%
Total ED/MIU	**16,317**	**17,384**	**1,067**	**7%**	**63,062**	**65,721**	**2,659**	**4%**	**189,307**	**189,307**	**195,755**	**6,448**	**3%**
Maternity - Delivery	524	508	(16)	(3%)	2,112	1,830	(282)	(13%)	5,845	5,845	5,417	(428)	(7%)
Maternity - Non Delivery	200	208	8	4%	806	763	(43)	(5%)	2,312	2,312	2,117	(195)	(8%)
Maternity - Outpatient	3,467	3,592	125	4%	14,215	14,859	644	5%	44,112	44,112	45,328	1,217	3%
Maternity Ante Natal	533	467	(66)	(12%)	2,014	2,033	19	1%	5,989	5,989	6,332	343	6%
Maternity Post Natal	504	479	(25)	(5%)	1,968	1,754	(214)	(11%)	5,802	5,802	5,054	(749)	(13%)
Total Maternity	**5,228**	**5,254**	**26**	**1%**	**21,114**	**21,239**	**125**	**1%**	**64,061**	**64,061**	**64,248**	**187**	**%**
Paed - Daycase/Elective	30	21	(9)	(30%)	124	121	(3)	(3%)	415	415	408	(7)	(2%)
Paed - Non Elective	552	547	(5)	(1%)	2,249	2,179	(70)	(3%)	7,220	7,220	6,948	(272)	(4%)
Paed - Outpatient	1,249	1,218	(31)	(3%)	5,305	5,493	188	4%	16,080	16,080	17,043	962	6%
Paed - BPT, Drugs, CQUIN	18	0	(18)	(100%)	74	0	(74)	(100%)	270	221	0	(221)	(100%)
Paed - Neonatal Cot Days	736	669	(68)	(9%)	2,946	2,611	(335)	(11%)	8,816	8,838	7,768	(1,070)	(12%)
Total Paediatrics	**2,586**	**2,455**	**(131)**	**(5%)**	**10,697**	**10,404**	**(294)**	**(3%)**	**32,801**	**32,774**	**32,167**	**(608)**	**(2%)**
Chemotherapy Delivery	**831**	**946**	**115**	**14%**	**3,206**	**3,897**	**691**	**22%**	**11,130**	**11,130**	**12,109**	**978**	**9%**
Drugs PBR Excluded	0	0											
Critical Care ITU/HDU	806	832	25	3%	3,224	3,056	(169)	(5%)	9,673	9,673	8,896	(777)	(8%)
Other Contract Income	0	0											
Total Other Contract Income	**806**	**832**	**25**	**3%**	**3,224**	**3,056**	**(169)**	**(5%)**	**9,673**	**9,673**	**8,896**	**(777)**	**(8%)**
Non Contract Income													
Phasing Adj													

Elective, Day Cases & Outpatients New

Worcestershire NHS
Acute Hospitals NHS Trust



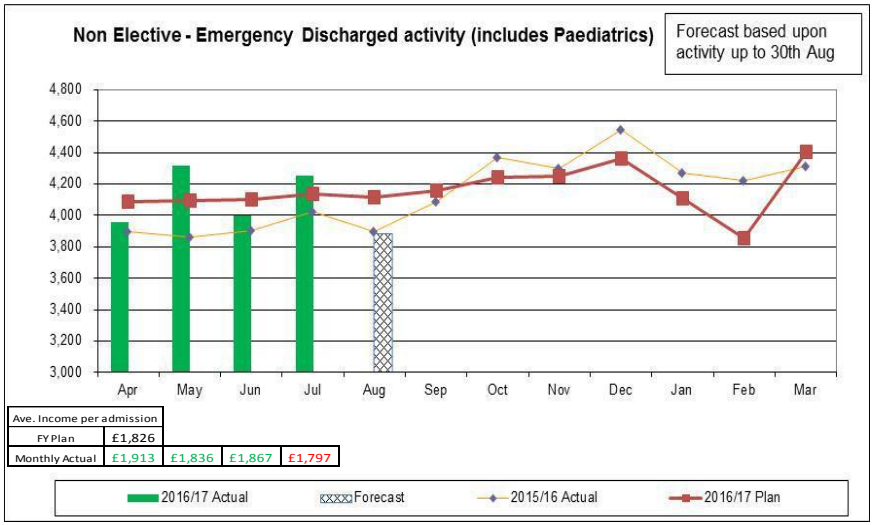


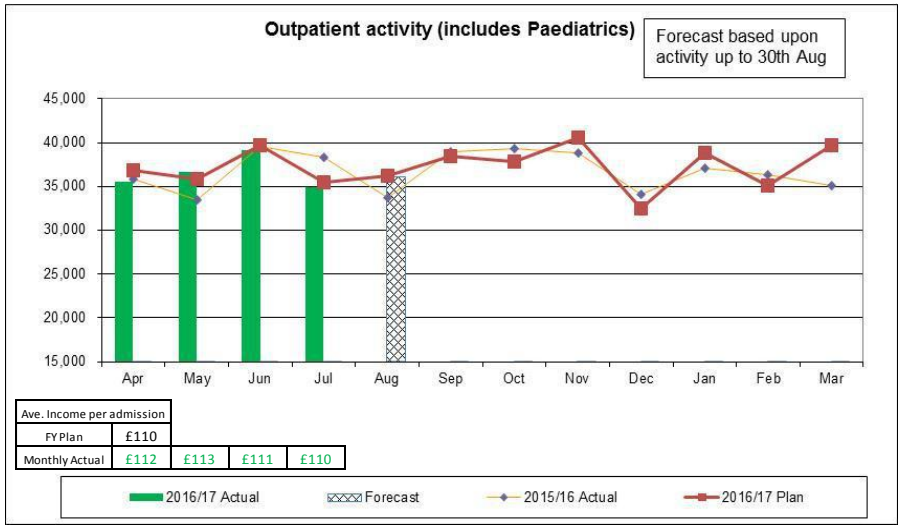


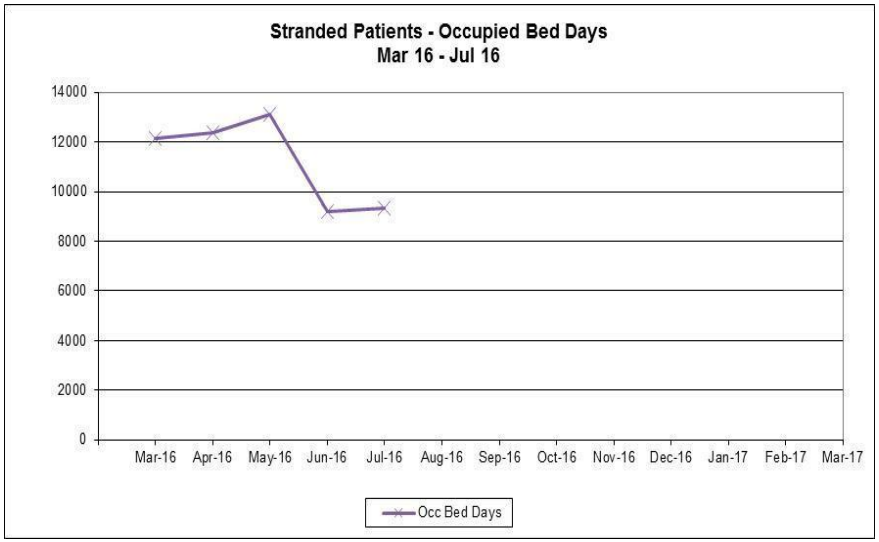
Activity performed within Trust and sent Private				
	Daycase		Elective IP	
	Trust	Private	Trust	Private
Apr	3,876	50	670	0
May	4,275	50	682	0
Jun	4,649	71	768	0
Jul	4,366	48	737	0
Aug	0	0	0	0
Sep	0	0	0	0
Oct	0	0	0	0
Nov	0	0	0	0
Dec	0	0	0	0
Jan	0	0	0	0
Feb	0	0	0	0
Mar	0	0	0	0
YTD	17166	219	2857	0

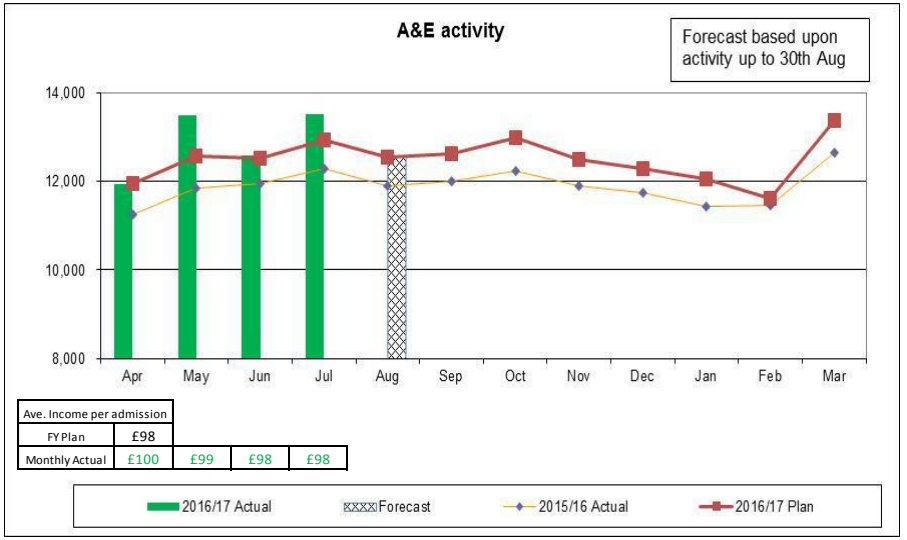
Outpatients, Non Elective and A&E

Worcestershire NHS
Acute Hospitals NHS Trust









Stranded Patients – there was a reporting issue for Feb to May 2016, which has been corrected from June onwards.

Balance Sheet

Worcestershire NHS
Acute Hospitals NHS Trust

				Full Year			
Balance as at 30 June 2016	Balance as at 31 July 2016	Movement in Month	Balance Sheet	Annual Plan	Forecast 31st March 2017	Variance from Plan	Balance at 31st March 2016
£000s	**£000s**	**£000s**	**ASSETS, NON CURRENT**	**£000s**	**£000s**	**£000s**	**£000s**
249,776	249,256	(520)	Property, Plant and Equipment and intangible assets, Net	270,605	270,605	0	250,590
3,793	3,795	3	Other Assets, Non-Current	3,238	3,238	0	1,669
253,568	**253,051**	**(518)**	**Assets, Non-Current, Total**	**273,843**	**273,843**	**0**	**252,259**
			ASSETS, CURRENT				
7,808	8,098	289	Inventories	5,800	5,800	0	7,081
21,564	16,110	(5,454)	Debtors	15,121	15,121	0	25,823
11,301	18,070	6,768	Cash and Cash Equivalents	1,900	1,900	0	1,474
40,674	**42,278**	**1,604**	**Assets, Current, Total**	**22,821**	**22,821**	**0**	**34,378**
294,242	**295,328**	**1,086**	**ASSETS, TOTAL**	**296,664**	**296,664**	**0**	**286,637**
			LIABILITIES, CURRENT				
1,936	**1,936**	0	PFI leases, Current	1,936	1,941	5	1,936
41,804	**41,055**	(749)	Creditors < 1 Year	38,367	41,466	3,099	48,270
43,740	**42,991**	**(749)**	**Liabilities, Current, Total**	**40,303**	**43,407**	**3,104**	**50,206**
(3,066)	**(713)**	**2,352**	**Net Current Assets/(Liabilities)**	**(17,482)**	**(20,586)**	**(3,104)**	**(15,828)**
			LIABILITIES, NON CURRENT				
120,362	125,544	5,182	Creditors > 1 Year	4,580	4,568	(12)	95,757
71,571	71,410	(161)	PFI leases, Non-Current	70,058	70,114	56	72,055
0	0	(0)	Other Liabilities, Non-Current	148,451	144,539	(3,912)	0
191,933	**196,953**	**5,021**	**Liabilities, Non-Current, Total**	**223,089**	**219,221**	**44**	**167,812**
58,570	**55,384**	**(3,186)**	**TOTAL ASSETS EMPLOYED**	**33,272**	**34,036**	**(3,148)**	**68,619**
£000s	**£000s**		**FINANCED BY :- PUBLIC EQUITY**	**£000s**	**£000s**	**£000s**	**£000s**
184,564	184,564	0	Public Dividend Capital	184,564	184,564	0	184,564
54,320	54,320	0	Revaluation reserve	54,320	54,320	0	54,320
(861)	(861)	0	Other reserves	(861)	(861)	0	(861)
(179,454)	(182,639)	(3,186)	I&E Reserve	(204,751)	(203,987)	764	(169,404)
58,570	**55,384**	**(3,186)**	**TOTAL PUBLIC EQUITY**	**33,272**	**34,036**	**764**	**68,619**

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7 September 2016 **Enc H1**

Report to Trust Board

Title	**Annual Health and Safety Report**
Sponsoring Director	**Rab McEwan** **Interim COO**
Author	**Paul Graham** **H&S Manager**
Action Required	The Trust Board is requested to approve the Annual Report
Previously considered by	Health and Safety Committee Quality Governance Committee

Priorities (√)

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

Related Board Assurance Framework Entries	
Legal Implications or Regulatory requirements	
Glossary	

Key Messages

Date of Meeting: 7 September 2016 **Enc H1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 7 SEPTEMBER 2016

1 Situation

The Trust provides an Annual Health & Safety Report for the Board.

2 Background

This annual report has been produced to inform the Trust Board of the health and safety management activities that have occurred during the period 1st April 2015 – 31st March 2016. These activities were based upon meeting the key objectives within the Health and Strategy 2014. A series of graphs generated by the DATIX Risk Management System have been included to illustrate the numbers of accidents reported during the above period. The report also includes details of the health and safety risks that are currently on the Trust's Risk Register.

3 **Report**

During 2015 the Trust aimed to meet the objectives set out in the revised 2014 Health and Safety Strategy. Progress was closely monitored by the Trust Health and Safety Committee. The following information provides evidence of meeting the respective strategic objectives:

Objective 1

To ensure an effective, co-operative and integrated approach to health and safety management across all three hospital sites.

The Trust Health & Safety Committee is chaired by the Chief Operating Officer and has met on three occasions during 2015. Attendance has been reasonable however on one occasion the Committee failed to be quorate due to a lack of staff side members.

The Committee discussed the following topics:

- Gritting Contract at WRH
- Information Security
- Risk Survey
- Terms of reference (Reviewed)
- Annual Security Report
- Training Needs Analysis
- Employer Liability Claims
- Management of Violence & Aggression
- Security - Self-Review Tool 2015
- RoSPA Health & Safety Audit 2015
- RIDDOR Case Reviews
- National Physical & Non-Physical Assault Report 2014

Objective 2

To ensure effective compliance with health & safety legislation and risk management standards including the 5 Care Quality Commission (CQC)

Domains.

- The H&S policies were not reviewed during 2015 but extended for 1 year until 2016. They are now included as part of the new Clinical Pathways Scheme and will automatically be flagged for review as required.

- The Trust did not submit a CQC return for 2015 as the Standards remain under review. This objective will be reviewed in 2016 and replaced with the need to comply with the requirements set out by the Care Quality Review (CQR).

- The Trust continues to regularly distribute medical device alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA), NHS Improvement and the Department of Health. The information sheets received from the Central Alerting System (CAS) identify particular hazards and risks that may need to be addressed.

- With the exception of the following safety alert the Trust met the deadlines of all Central Alert System (CAS) alerts received during 2015/16:
    - **NHS/PSA/Re/21015/007:** *Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme.*

  This particular alert is currently being managed by the Head of Pharmacy Services.

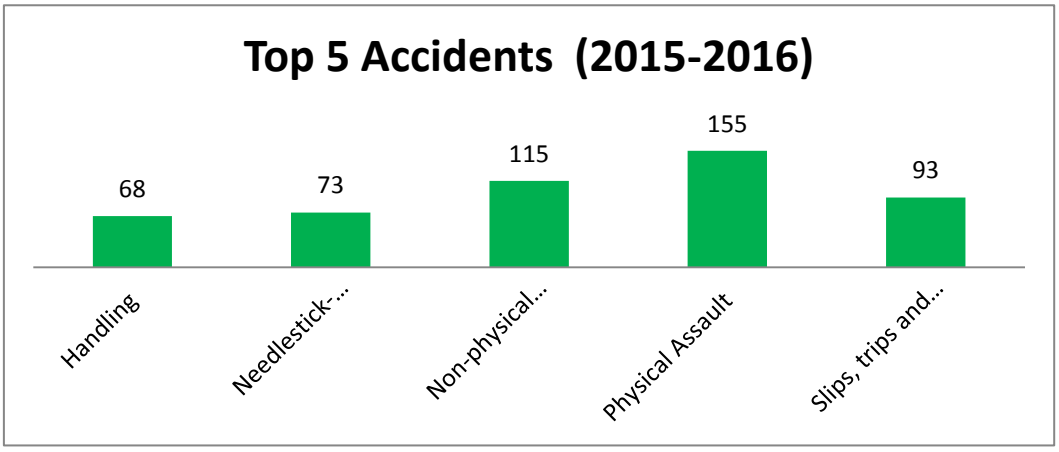
Objective 3

To increase staff involvement in health and safety management by encouraging them to participate in carrying out risk assessments, reporting and investigating accidents and 'near miss' incidents.

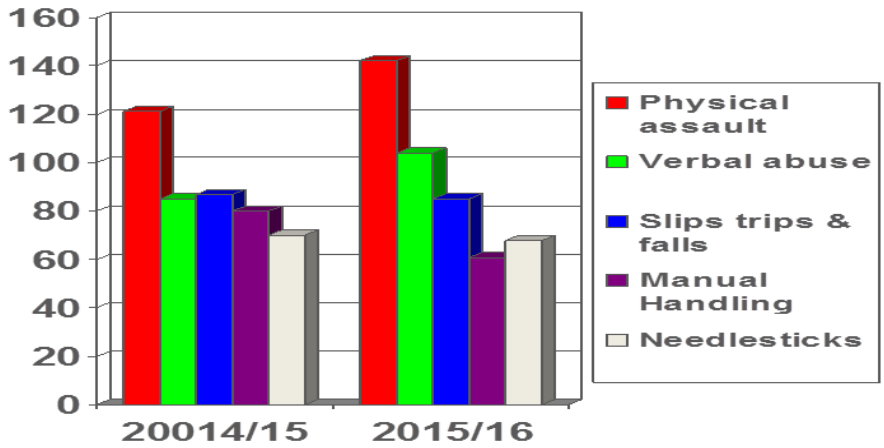
- The Trust continues to make use of the Datix electronic Incident Reporting process which is available to all staff via the intranet. The system currently has 29 non-clinical incidents in the holding area awaiting review and 33 incidents awaiting final approval. This is a vast improvement from last year when there were over 400 incidents outstanding within these two areas of Datix and evidence that managers are now accessing the system and managing incidents in a more timely fashion.

- The Bar chart below indicates the main causes of H&S accidents reported during the last 12 months. The most frequently reported accidents involved violence and aggression. The Trust continues to meet the National Programme of training all staff in Conflict Resolution however a further need has been identified to provide staff at high risk with an additional level of training in therapeutic holding techniques but to date this course has only been attended by 39 members of staff since February 2016. During Mandatory Training session's staff are also reminded of the need to make use of the various tools within the Management of Violence & Aggression

Policy i.e. behavioural agreement, warning and exclusion letters.

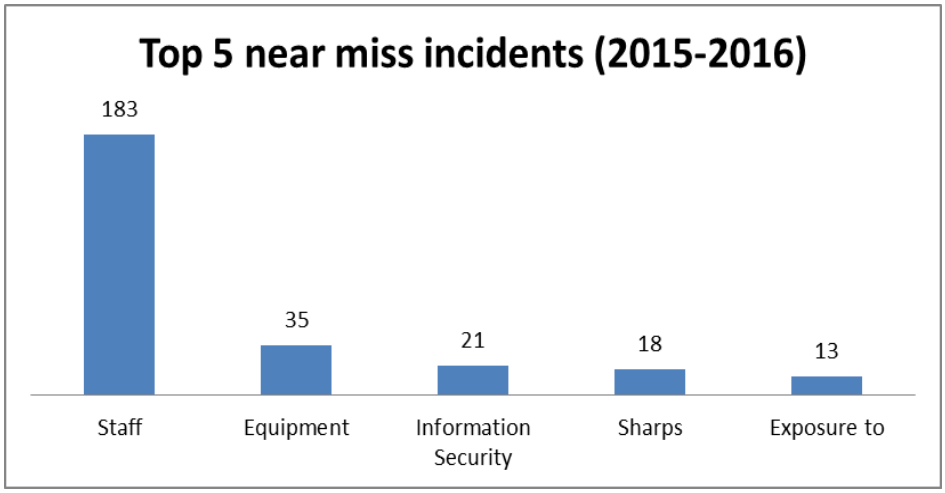


- The graph below compares the numbers of accidents reported in 2014/15 with those reported in 2015/16.



With the exception of the figures associated with violence & aggression the numbers of accidents have all reduced since 2014/15. Investment over the period in improved technology has benefited the Trust in reducing the number of accidents relating to both manual handling and needle-stick injuries.

- The Bar Chart below shows the most frequently occurring near miss incidents that were reported during 2015. During the last 6 months there has been a significant increase in the number of reports relating to staffing levels. The majority of the equipment incidents were categorised under the sub-category failure or broken.



- The Trust also uses the Datix system to record all of its health, safety and security risks. The system currently has 26 open health & safety risks and 3 security risk recorded on the Risk Register. Of these 26 risks, 3 are graded as Moderate (see below), 7 as Low and 16 as Very Low.

- The Moderate risks are as follows:

    - **Design of dirty utility area endoscopy too small leading to potential manual handling risks** – *Progress: The Trust received a JAG visit in June. The Trust is now considering what further work needs to be carried out in order to fully meet their recommendations.*

    - **Holding limbs of anaesthetised patients during skin prepping in Theatres may lead to staff injuries** – *Progress: A working group has been set up to consider all of the risks associated with working in the Theatres environment. A new risk assessment will be developed in due course and added to Datix.*

    - **Risk of exposure to high risk organisms in Pathology Department at WRH**

      Progress: Plans have been drawn up to either enclose or relocated the TB Culture room which is currently situated on the main pathology access corridor.

- The following Moderate risks appeared on the register during 2014/15 but have subsequently been closed due to either re-assessment or the implementation of suitable and effective control measures:

    - Staff physically supporting patients during insertion of epidural/spinal block may be vulnerable to injury
    - Non delivery of fire evacuation training

- The Trust Health & Safety Committee has received Quarterly summary reports of all accidents and risks.

- Regular audits continue to be undertaken by the Infection Control and Manual Handling Teams which contributed to the overall health & safety management programme.

- During 2015 the Divisional Operational Managers were asked to commence a series of H&S Compliance Audits within their respective Divisions. To date the only Divisions to participate in the programme have SCS and Surgery. The Surgical Division have completed visits to 3 work areas using a simple check list audit tool. SCS Division have completed visits to a further 8 work areas. These audits have involved the H&S Manager and have produced very encouraging results indicating an average score of 79%. The main non-compliance issues continue to be related to the lack of evidence of any current risk assessments being carried out and the fact that very few managers have attended any formal H&S training. The DDOps have been tasked to provide a planned audit programme for 2016/17.

Objective 4
To provide appropriate training and guidance for managers and staff that enables them to safely undertake their work activities.

- During 2015 again no specific H&S Management training was undertaken. There is a legal requirement to ensure that we provide further health & safety training to managers and supervisors which would be in addition to them attending the normal Induction and Mandatory training programme. The Trust is meeting in July to decide what level of training it is going to provide for Managers/.Supervisors to offer them the necessary knowledge and skills to be able to manage health & safety within their respective work areas.

- All staff continues to attend a three yearly refresher risk management training day which includes an update on health, safety and security issues.

Attendance figures at mandatory training currently show that the Trust is achieving an 82% level of compliance with Health & Safety and 83% with Violence & Aggression (Conflict Resolution Training). The Health & Safety Manager is currently targeting work areas where the levels of attendance are particularly low.

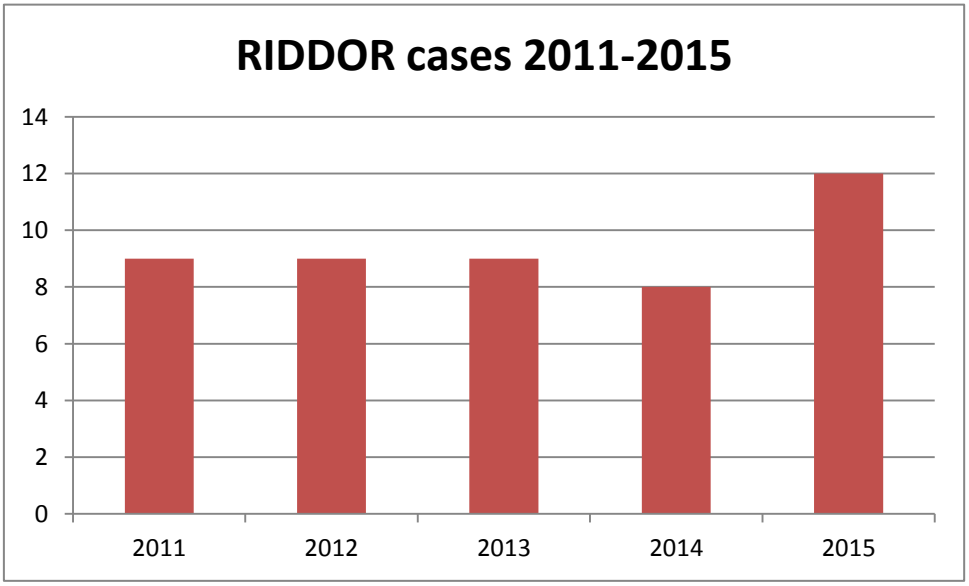
Objective 5
To reduce the number of accidents reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. (RIDDOR).

- Datix has been used to record and regularly report on performance in terms of reducing the numbers of accidents across the Trust. These reports have been provided to various committees and included as part of the Trusts overall performance review.

- The H&S Manager has continued to review each RIDDOR case with the relevant managers and staff-side members in order to help identify the root

causes and determine what lessons can be learnt to prevent any similar reoccurrences. The H&S Committee has received copies of the relevant Case Reviews.

- The overall number of RIDDOR cases (see chart below) has remained relatively unchanged over the past 4 years but has increased slightly during 2015.



- Of the 12 cases reported during 2015:
    - 7 involved slips trips & falls which resulted in fractures. (2 of the injured were members of the public who were visiting one of our hospital sites however following investigations there were no identified causes relating to either Trust property or work activity).
    - 4 involved 'over 7 day' injuries caused by manual handling tasks.
    - 1 involved a sharps injury caused by opening a glass ampoule.

Each case was followed up and fully investigated by the H&S Manager and where appropriate the manager of the work area. The following learning points were identified and shared as part of the investigation process:

- *Where Contractors are undertaking work, the area and in particular any access routes through the area, must be provided with suitable signage to warn of any health & safety hazards and where appropriate the access route should be closed to prevent any unauthorised access.*
- *The Trust must also ensure that a suitable and sufficient risk assessment is undertaken, with input from the Contractor, to ensure adequate control of risks at all times.*

Note: Both learning points were communicated to the Estates Team.

- *There is a device which can be used to cover and protect the top of a glass ampoule as it is broken. This equipment was not in use at the time of the accident however the Trust is now trialling the Ampsnap Vial Opening Device on Laurel 3.*

Note: This safety equipment is due to be rolled out for use across the Trust.

- *Staff must follow the handling assessment either detailed in the patients care plan or following a dynamic assessment of the task to be carried out. If more assistance is required the patient MUST NOT be moved until that assistance is provided even if it means that the patient has longer to wait.*
- *Managers must assess the staffing situations on wards and provide sufficient cover as required.*

Note: These learning points were communicated to the Matrons for further dissemination to all staff.

Objective 6

To effectively manage any security issues that are identified as part of the Trust's risk assessment process.

- The Trust was required to submit a Security Self Review Tool (SRT) Return for 2015. This document contained the following Sections against which the Trust scored an overall Green Rating for compliance in 27 of the 30 Standards.
    - Strategic Governance
    - Inform and Involve
    - Prevent and Deter
    - Hold to Account

- An Action Plan was developed to improve compliance in the 3 areas where the Trust failed to achieve a Green rating. These included:

    - The Trust should use the SIRS to record and report security incidents to NHS Protect (Currently rated Red) – *this is work in progress and is very reliant upon the co-operation of DATIX*.
    - Development of an Asset Register for items below £5,000 (Currently rated as Amber)
    - Safe and secure facilities for personal property (Currently rated as Amber)

- During 2016 the Health & Safety Committee will be responsible for monitoring progress towards achieving full compliance against all 30 Standards.

Objective 7

To ensure that all food service areas of the Trust including the PFI, that are inspected by their relevant Local Authority Environmental Health Food Safety Inspectors, achieve a minimum Food Hygiene Rating level of 4 Stars.

- The food hygiene and waste management standards and any associated risks continue to be monitored by the Catering and Portering & Transport Manager respectively. No significant risks have been reported through to the Trust H&S Committee.
- In 2015 the Alexandra and Kidderminster Hospital's Catering Departments achieved an excellent 5 Star Food Hygiene Rating.

Objective 8
To achieve an acceptable standard of fire safely in accordance with statutory requirements and Department of Health guidance, thereby minimizing the incidence and impact of fire.

- Please refer to the Trust Annual Fire Safety Report 2015/16 to find details of the Trusts fire risks and the on-going work that is being undertaken to improve control.

4 Recommendation
The Trust Board to approve this report.

Rab McEwan
Interim COO

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7th September, 2016 **Enc H2**

Report to Trust Board (in public)

Title	**Infection Prevention & Control Annual Report 2015-16 and Annual Plan 2016-17**
Sponsoring Director	**Jan Stevens** **Interim Chief Nursing Officer**
Author	**David Shakespeare** **Associate Chief Nurse Infection Prevention & Control**
Action Required	The Board is asked to receive for the purpose of assurance the Annual Infection Prevention & Control Report for 2015-16 and approve the annual plan for 2016-17.
Previously considered by	Quality Governance Committee (21/07/16) and Trust Infection Prevention & Control Committee (30/06/15).

Priorities (√)

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

Related Board Assurance Framework Entries	**2902** – If the Trust does not achieve safety targets, it will fail to reduce avoidable harm & reported mortality rate to expected levels.
Legal Implications or Regulatory requirements	The Trust is required to demonstrate compliance with the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance (The Hygiene Code).
Glossary	TIPCC – Trust Infection Prevention & Control Committee HCAI – Healthcare Associated Infection MRSA – Meticillin Resistant *Staphylococcus Aureus* MSSA – Meticillin Sensitive *Staphylococcus Aureus*

Key Messages

- During 2015-16 the Trust reported 29 cases of hospital attributable *Clostridium difficile* infection against an NHS England set trajectory of no more than 33 cases.
- The trust experienced 1 case of trust attributable MRSA bacteraemia during 2015/16. This means the Trust exceeded the nationally set target of zero tolerance.
- The trust has continued to take steps to improve arrangements for water safety and governance.
- The Trust has revised guidelines for high level personal protective equipment in readiness for high level or new and emerging pathogens.
- The 2016-17 annual plan includes a focus on antimicrobial stewardship, a further strengthening of assurance around water safety and a strengthening of surveillance for surgical site and device related infections.

Date of meeting: 7th September, 2016 **Enc H2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 7th September, 2016

1. Situation

This report summarises and presents the Infection Prevention & Control Annual Report for 2015/16 and Annual Plan 2016/17.

2. Background

Minimising risk from HCAI remains a cornerstone of maintaining patient safety.

3. Assessment

3.1 Key risks

C.difficile: The end of financial year 2015-16 position for *C.difficile* infections is 29 reported cases against a trajectory of no more than 33. This represents an improvement on the 36 cases reported during 2014-15 and the 40 reported during 2013-14.

Clostridium difficile 30 day all-cause mortality is defined as death occurring within 30 days of a specimen testing positive for *C.difficile*. The all cause *C.difficile* mortality for 2015-16 is 4 of 29 cases equating to 13.8%. The *C.difficile* attributable death rate (where *C.difficile* has been cited on part 1a of the death certificate) is 1 of 29 cases equating to 3.4%.

During 2015-16 a total of 5 MRSA bacteraemia (blood stream infections) were reported. One of these cases, reported during February 2016, was attributed on post infection review to the Trust. While disappointing and representing a breach of the national zero tolerance of hospital attributable MRSA bacteraemia; this compares equally with the one case reported during 2015-16.

The Water Safety Group (WSG) has been focused on widening the awareness of water safety issues throughout the Trust and continues to take steps to improve arrangements for water safety and governance.

In response to the threat of Ebola and Middle East Respiratory Syndrome (MERS CoV) the IPC Team have developed a high level personal protective equipment (PPE) protocol alongside Accident and Emergency and Critical Care colleagues. There remains a risk however, with regard to release of staff for attendance at mask fit test training.

3.2 Controls in place

The Trust is required to demonstrate compliance with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (The Hygiene Code). The Trust declares compliance with the Hygiene Code during 2015/16. In order to ensure that compliance with the Hygiene Code is maintained, components of the Hygiene Code are reviewed at TIPCC.

The Trust continues to participate in a Worcestershire health economy approach to minimising risk from HCAI and meets bi-monthly to monitor progress against the agreed health economy strategy.

3.3 Actions

The annual plan for 2016-17 includes a focus on:

- Antimicrobial stewardship to run concurrently with the CQUIN to reduce prescribing / consumption of antibiotics, together with the appointment of a dedicated antimicrobial pharmacist.
- A further strengthening of assurance around water safety including completion and board ratification of a revised water safety plan.
- A focus on achieving a reduction in device related infections including MSSA by means of a revised proforma for monitoring and investigation of MSSA Blood Stream Infections; and the introduction of a health economy wide urinary catheter passport
- A renewed focus on recognition of infection and learning lessons from surgical site infections.
- A re launch of gram negative organism and CPE screening guidance and patient management.

3.4 Success criteria

The Annual Plan will be monitored at TIPCC which is held bi-monthly. Success will be completion of each key work stream of the 2016-17 Annual Plan.

4 Recommendation

The Board is asked to receive for the purpose of assurance the Annual Infection Prevention & Control Report for 2015-16 and approve the annual plan for 2016-17.

Jan Stevens
Interim Chief Nursing Officer

Pull Together to Prevent Infection

Worcestershire Acute Hospitals NHS Trust

Infection Prevention and Control Annual Report 2015/16

And Infection Prevention Plan 2016/17

Jan Stevens CBE
Interim Chief Nursing Officer

David Shakespeare
Associate Chief Nurse – Infection Prevention & Control

Contents Page

Acknowledgements:

Dr H Morton: Antimicrobial Stewardship
Dr T Gee: Tuberculosis
Simon Noon & Dr M Ashcroft: Water governance
Heather Gentry: Audit and training summaries, policy reviews
Vicki Shayler, Data Analyst: HCAI data and graphs

Foreword

I am pleased to present the Infection Prevention & Control Annual Report for 2015/16 and Plan for 2016/17.

Prevention of Healthcare Associated Infection (HCAI) remains a cornerstone of patient safety both in terms of cleanliness of the environment and in clinical practice.

I am particularly pleased that we have again reduced cases of *Clostridium difficile* infection with 29 cases against a trajectory set by NHS England for us of no more than 33 cases; and this also compares favourably with last year's total of 36 cases. However, the Trust unfortunately reports one case of MRSA bacteraemia against a national zero tolerance of this infection.

I am also pleased to report a positive outcome for Infection Prevention from the visit of the Care Quality Commission during July 2015 and I therefore look forward to maintaining both a high profile for infection prevention at Board level and a visible profile of the Infection Prevention & Control Team in our wards and departments during 2016/17.

I am confident that with the support of the Infection Prevention & Control Team we can continue to maintain low rates of Healthcare Associated Infection and a hospital environment that is clean and safe for our patients.

Jan Stevens CBE
Interim Chief Nursing Officer and Director Infection Prevention & Control

1. Executive Summary

- The Trust has reported 29 cases of hospital attributable *Clostridium difficile* infection against an NHS England set trajectory of no more than 33.

- The Trust experienced 1 case of trust attributable MRSA bacteraemia during the year 2015/16. This means the Trust exceeded the nationally set target of zero tolerance.

- The trust has continued to take steps to improve arrangements for water safety and governance.

- The Trust has revised guidelines for high level personal protective equipment in readiness for high level or new and emerging pathogens.

- The Trust continues to participate in a Worcestershire health economy approach to minimising risk from HCAI and meets bi-monthly to monitor progress against the agreed health economy strategy.

2 Introduction

This is the annual report from the Director of Infection Prevention and Control (DIPC) providing information on infection prevention and control (IPC) activity across the organisation. The purpose of this report is to provide detail to our patients, public, staff, Trust Board and Commissioners on the IPC agenda.

This report covers the period from April 2015 to March 2016 and provides information on:

Reporting arrangements for IPC
Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia figures
Clostridium difficile infection rates
A summary of education & training for IPC undertaken in year
A summary of audits undertaken in year
A plan of key objectives for 2016/17

Cases of *C.difficile* infection have further reduced during 2015/16 with 29 cases against a trajectory of no more than 33 cases. These are cases where the sample has been taken beyond day of admission to hospital plus two days. This represents continued improvement on the 36 cases reported during 2014/15 and the 40 reported during 2013/14.

However, a single case of hospital attributable MRSA bacteraemia (blood stream infection) is disappointing given the position of national zero tolerance. This case reflects the position during 2014-15 when one case was also reported.

3. Reporting arrangements

The *Trust Board* recognises and agrees their collective responsibility for minimising the risks of infection and agrees and supports the means by which these risks are controlled. The responsibility for Infection Prevention and Control lies with the Director of Infection Prevention & Control (DIPC) who is the *Chief Nurse*. The Chief Nurse is supported in this respect by an Associate Chief Nurse Infection Control, by the Consultant Microbiologists and the Infection Prevention & Control Nurse Team (IPCT). The *Chief Executive* accepts on behalf of the Trust Board responsibility for all aspects of Infection Prevention & Control within the Trust. This responsibility is delegated to the Chief Nurse as the DIPC. The Chief Nurse reports directly to the Chief Executive and the Board and chairs the Trust Infection Prevention & Control Committee.

The *Consultant Microbiologists* provide expert microbiological and infection prevention advice and provide support for the wider IPCT and fulfil the *Infection Control Doctor* function.

The *Associate Chief Nurse Infection Prevention & Control* provides strategic direction and leadership for the IPCT. The Associate Chief Nurse reports professionally to the Chief Nurse / DIPC and works closely with the Consultant Microbiologists to interpret and incorporate national guidance into local practice. While part of the IPCT, the Associate Chief Nurse works with Divisional leaders to ensure best practice is embedded across the Trust.

The Lead Nurse IPC is a source of expert clinical advice and is operationally responsible for the development of policies, guidance, practice and education and training for infection prevention Trust wide.

The *Trust Infection Prevention & Control Committee* (TIPCC) is the main forum for discussion and monitoring of action around IPC practice at the Trust. The membership of TIPCC includes representation from all Divisions at the Trust, plus the Clinical Commissioning Group IPC Lead Nurse and is chaired by the Chief Nurse. The committee meets bi-monthly. The Chief Nurse takes a report from the committee to the Quality Governance Committee which is a subcommittee of the Trust Board.

Infection Control *Link Practitioners* are a cornerstone of the IPC infrastructure at Worcestershire Acute Hospitals NHS Trust (WAHT) and are the champions of infection prevention in clinical areas. Study days are held at least quarterly to ensure Link Practitioners remain involved in IPC activity and are equipped to follow national best practice guidance. There is also an annual Link Practitioner Study day.

Reporting of HCAI: WAHT continues to participate in mandatory surveillance of Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI), Meticillin Sensitive *Staphylococcus aureus* (MSSA) BSI, *Escherichia coli (ECO)* BSI, Glycopeptide (or Vancomycin) resistant *Enterococci* (GRE/VRE) and *Clostridium difficile* infections. MRSA, MSSA and *E.coli* BSIs and laboratory detected *Clostridium difficile* toxins are reported monthly via the Public Health England HCAI data capture system. This is signed off on behalf of the Chief Executive and reported to TIPCC.

Infection Prevention & Control Team Nurse and administrative (IPCT) establishment

The IPCT whole time equivalent (WTE) establishment is:

1.0 WTE Associate Chief Nurse (Band 8C)
1.0 WTE Lead Nurse (Band 8a)
1.0 WTE Senior IPC Nurse (Band 7)
4.9 WTE IPC Nurse Advisors (Band 6)
1.9 WTE IPC Staff Nurse (Band 5)
1.0 WTE Data Analyst (Band 4)
0.9 WTE Administrative Support Officer (Band 4)
0.8 WTE MRSA Screening Co-ordinator (Band 3)

The team has nurses and administrative staff who are based at and circulate between the Worcestershire Royal and Alexandra Hospital sites. The team also provide a service to Kidderminster Treatment centre and other Acute Trust services based at Evesham Community Hospital and Princess of Wales Community Hospital, Bromsgrove. During the first quarter of 2016-17 the team will be joined by a 1.0 WTE Band 3 Clinical Support Worker.

Members of the IPCT attend and participate in the following groups / committees:

TIPCC
Health Economy HCAI Steering Group
Water Safety Meeting
Medical Devices Committee
Decontamination Committee
Medicines Safety Committee
Senior Nurse Meeting
Procurement Standardisation Group
Patient Environment Operational Group
Winter preparedness Groups
Occupational Health meetings
Estates liaison meetings for environmental cleaning and building planning

The Assurance Framework for IPC

Reporting arrangements for IPC at WAHT are outlined in the policy for 'The Management of Infection Prevention & Control' CG-043.

The Assurance Framework for IPC and reporting arrangements for TIPCC are as follows:

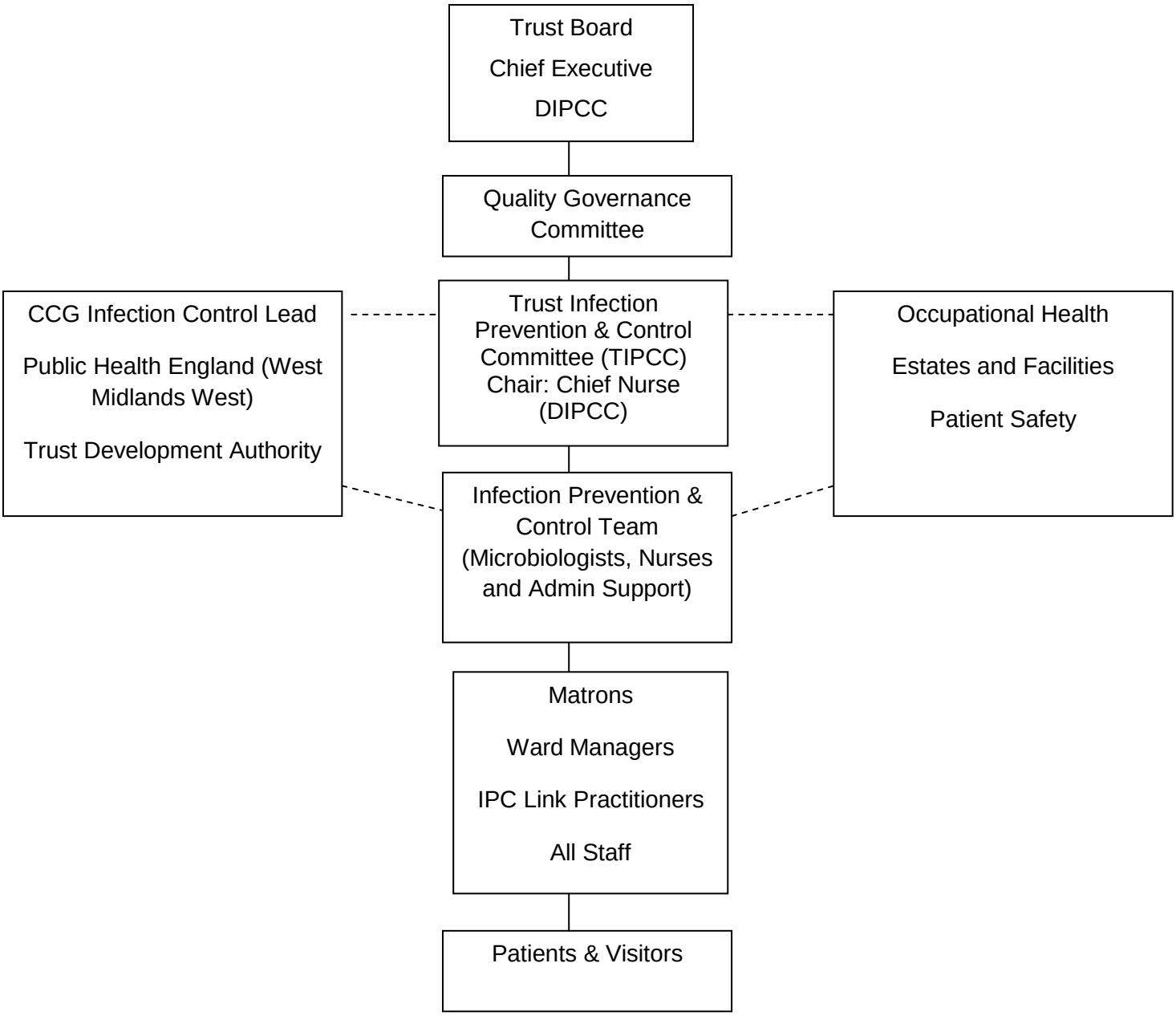


Figure 1: Assurance framework for IPC at WAHT

4. Compliance with the Hygiene Code

The Trust is required to demonstrate compliance with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (The Hygiene Code). The Trust declares compliance with the Hygiene Code during 2015/16. In order to ensure that compliance with the Hygiene Code is maintained, components of the Hygiene Code are regularly reviewed at TIPCC.

5. Clostridium difficile

The end of financial year 2015/16 position for *C.difficile* infections is 29 reported cases against a trajectory of no more than 33. This represents an improvement on the 36 cases reported during 2014/15 and the 40 reported during 2013/14.

Figure 2 below summarises cases of trust attributable *C.difficile* infection against a monthly trajectory agreed with the Trust Development Authority for the financial year 2015/16.

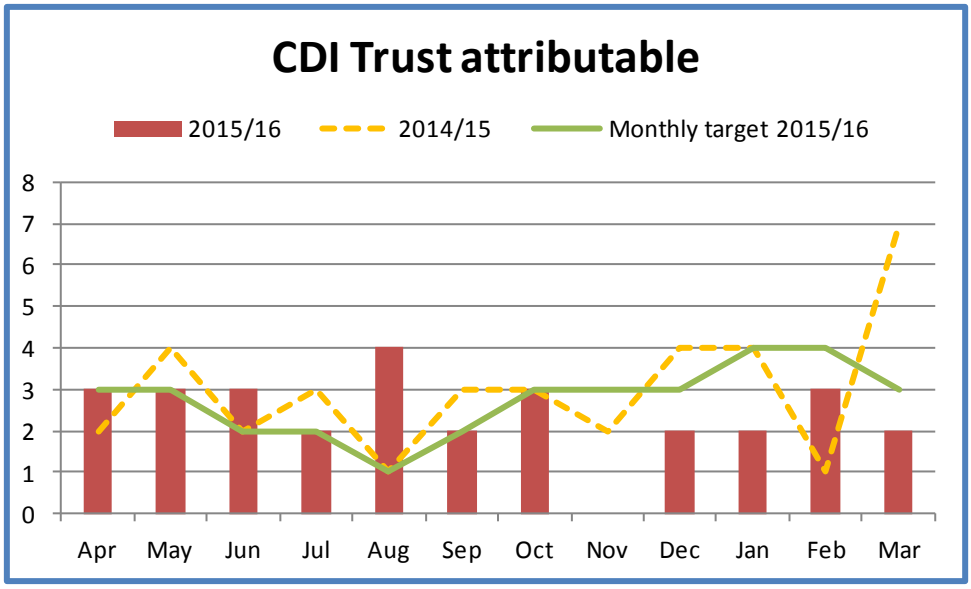


Figure 2: Trust attributable *C.difficile* infections shown monthly for 2015/16 with 2014/15 cases for comparison.

Figure 3 shows cumulative cases against the annual trajectory of no more than 41 cases, showing the end of year within trajectory position.

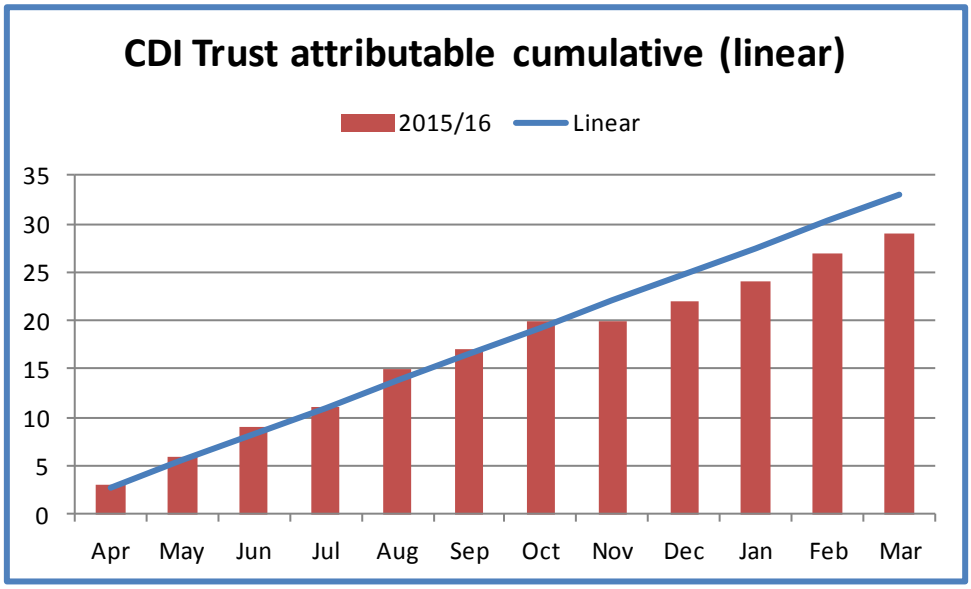


Figure 3: Cumulative trust attributable cases of *C.difficile* infection against linear distribution of trajectory 2015/16.

Figure 4 shows *C.difficile* infections by month and site. Of the 29 reported cases, 18 were from specimens taken at Worcestershire Royal Hospital, 10 at the Alexandra hospital and 1 at Kidderminster Treatment Centre. All cases are investigated to ascertain if there are lessons to apply to future case prevention.

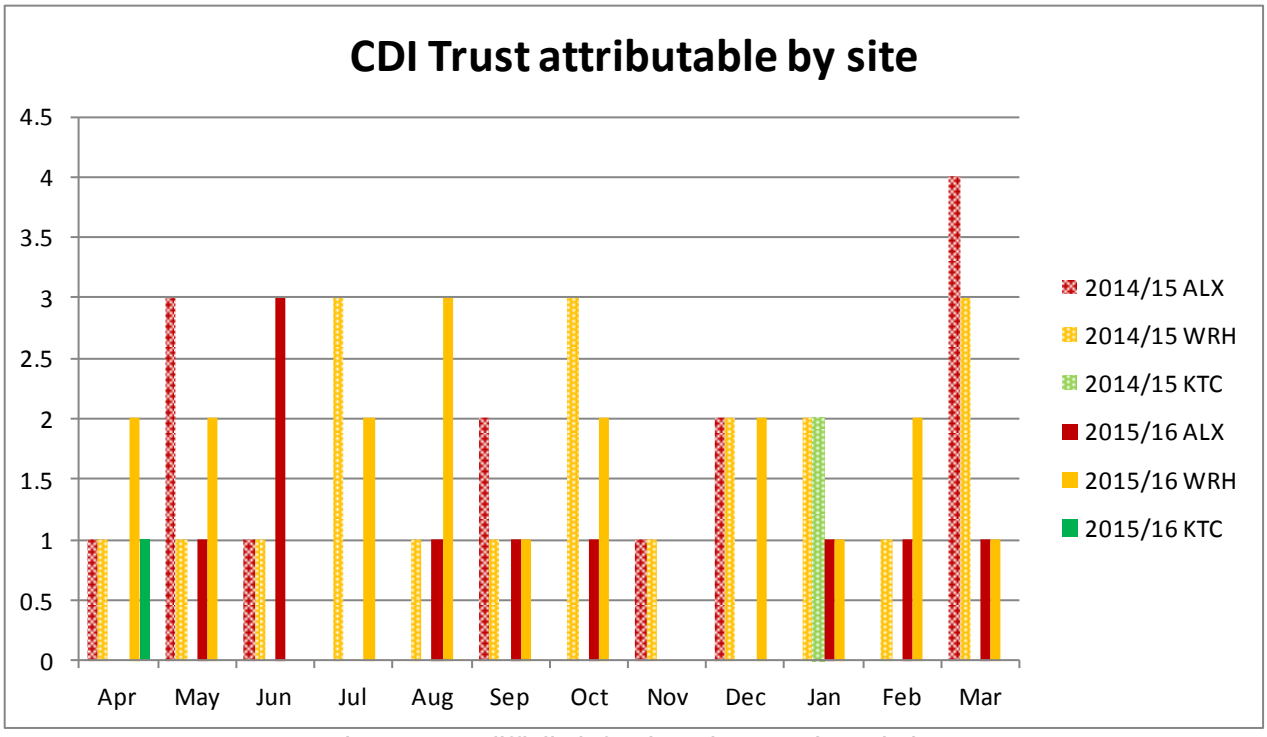


Figure 4: *C.difficile* infections by month and site

Of the 29 cases of *Clostridium difficile* infection during 2015/16

- 20 cases were found to be unavoidable on investigation
- 13 cases had no lapse in care identified
- 9 cases had a non-contributing lapse in care identified
- 7 cases had a contributing lapse in care identified
- 2 cases were found to be avoidable

Key themes identified from investigation of cases are broadly in the categories of antimicrobial prescribing, documentation, and communication.

- 12 cases included issues around prescribing
- In 8 cases a delay in sampling was noted, however, this can be due to no provision of a sample by a patient following initial symptoms
- In 10 cases there were issues around the completion of the diarrhoea and vomiting risk assessment
- In 4 cases there was a delay in isolation, usually due to high bed and side room capacity at the Trust

Revised definitions are to be used in the coming year primarily to support clinical case reviews being based on harm reduction and prevention and cases will be assigned a Red/Amber/Green rating:

Lapse in care contributing to acquisition of CDI	Lapse in care not contributing to acquisition	No lapse in care

Clostridium difficile infection 30 day all-cause mortality

Clostridium difficile 30 day all-cause mortality is defined as death occurring within 30 days of a specimen testing positive for *C.difficile*. It is important to remember that this is 'all-cause' mortality where a death may have occurred due to a range of co-morbidities and does not mean that *C.difficile* is the cause of death. In addition, these figures are calculated from trust attributable cases only and reflect only when a sample has been taken beyond day of admission plus two.

A separate calculation is also made for deaths where *C.difficile* is cited as the cause of death on part 1a of a death certificate (the *C.difficile* attributable death rate). Where this happens, such cases are recorded and investigated as serious incidents.

Figure 5 below shows the Trust's *C.difficile* 30 day all-cause mortality for 2015/16. The all cause *C.difficile* mortality for 2015/16 is 4 of 29 cases equating to 13.8%. The *C.difficile* attributable death rate (where *C.difficile* has been cited on part 1a of the death certificate) is 1 of 29 cases equating to 3.4%.

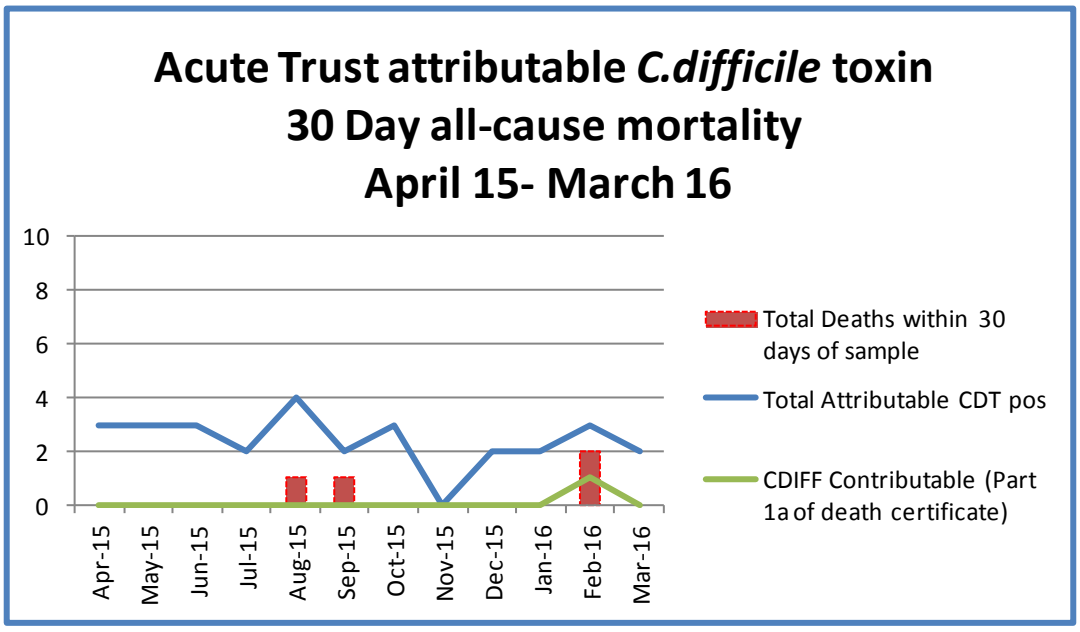


Figure 5: *C.difficile* all-cause mortality 2014/15.

Clostridium difficile infection trajectory for 2016/17

The trajectory for 2016/17 for the Trust has been set by NHS England, at no more than 32 trust attributable cases.

C.difficile PCR

C.difficile PCR is also monitored in accordance with the three step algorithm. The Trust follows Department of Health 2012) guidance on diagnosis and reporting of *C.difficile and* uses a three step process of glutamate dehydrogenase (GDH), toxin enzyme immunoassays (EIA) and toxin gene (PCR) testing.

In addition to externally reportable toxin positive cases as described above, PCR testing is also undertaken. This testing is able to identify toxin negative patients but PCR positive, where a patient is carrying *C.difficile* with the potential capability of making toxin. It is therefore important to monitor these patients and assess risk e.g. if symptomatic to ensure isolation precautions ensue and treatment is instigated.

Figure 6 shows PCR by location and Figure 7 shows PCR and toxin by location. The IPCT monitors these to ascertain if there is any action that could be taken to prevent further toxin positive cases.

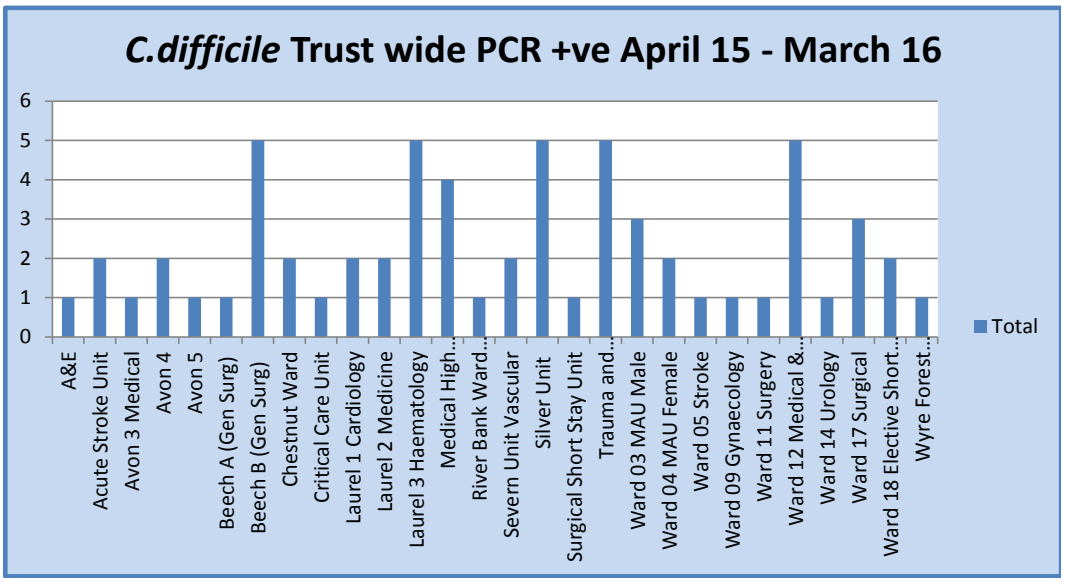


Figure 6: *Clostridium difficile* PCR by location 2015/16 (Total 63, WRH 42, Alex 20, KTC 1)

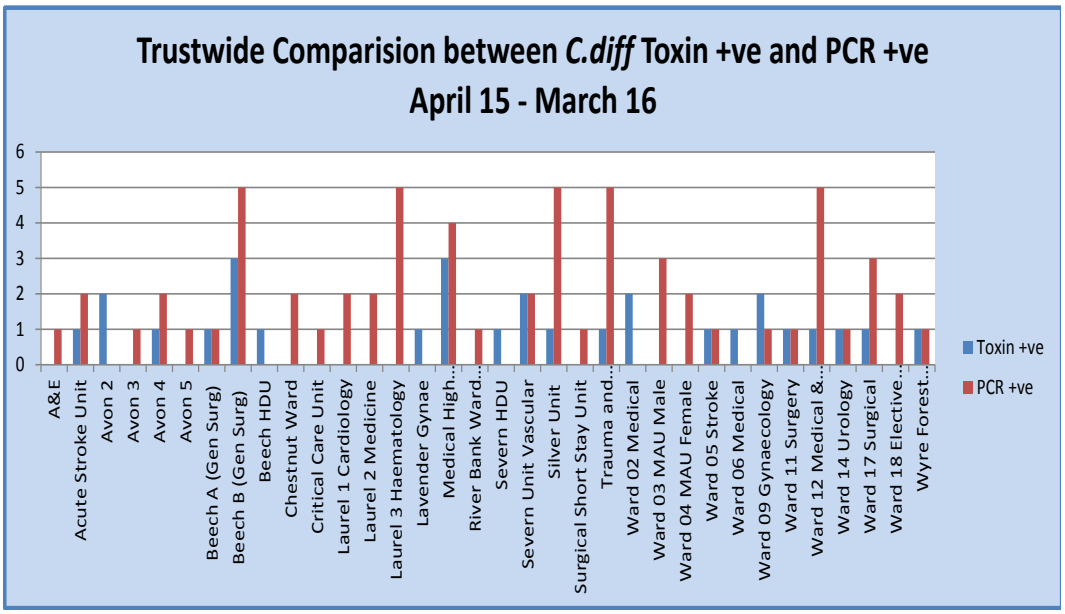


Figure 7: *Clostridium difficile* toxin and PCR by location 2015/16

6. Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia

During 2015/16 a total of 5 MRSA bacteraemia (blood stream infections) were reported. One of these cases, reported during February 2016, was attributed on post infection review to the Trust. While disappointing and representing a breach of the national zero tolerance of hospital attributable MRSA bacteraemia; this compares equally with the one case reported during 2015/16. The 2015/16 case is reflected in Figure 8 below.

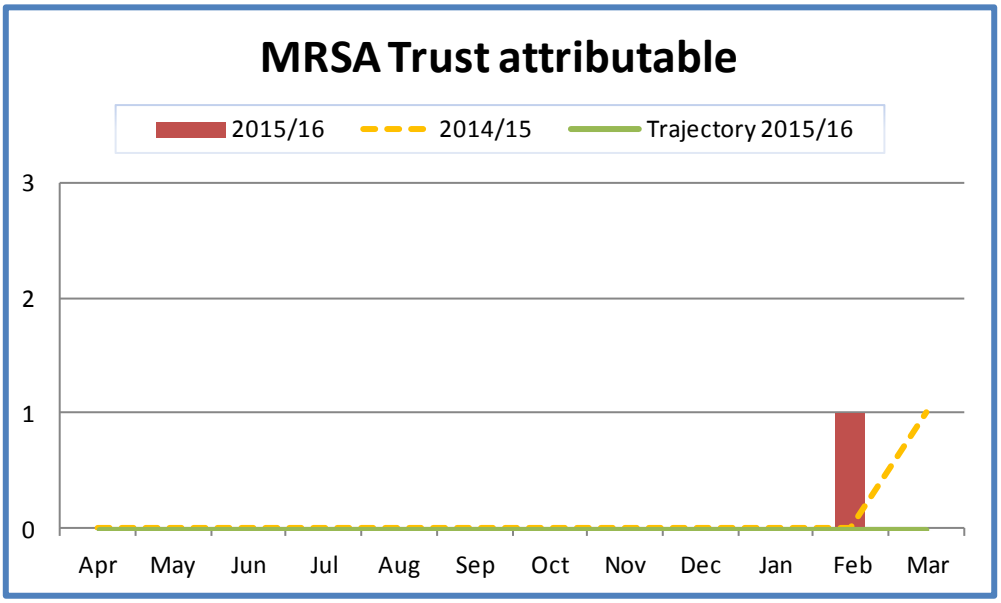


Figure 8: Trust attributable MRSA BSI 2015/16; also showing 2014/15 case

The hospital attributable case occurred in February 2016 in a patient on Acute Stroke Unit at Worcestershire Royal Hospital.

The four cases not apportioned to the Trust included one case in each of April and June; and two cases in September 2015. In the April case (specimen date 14/4/15), the patient was admitted to the Alexandra Hospital but had undergone surgery at another Trust; the case was attributed to South Warwickshire CCG. In the second case, with a specimen date of 22/6/15, while also admitted to the Alexandra Hospital, there had been no previous recent admissions and the case was attributed to third party. The first September case was reported in a patient admitted to the Alexandra Hospital, with a specimen date of 12/9/15 and has been attributed by South Worcestershire Clinical Commissioning Group based on a typing result that indicates a link between this case and another patient who attends the same GP surgery. The second September case was in a patient admitted from a Nursing Home to Worcestershire Royal Hospital WRH with a specimen date of 28/9/15 and was reported in a patient who was previously positive, had skin breaks to lower legs and was nearing the end of life.

The figures for the previous full year 2014/15 were 10 non attributable cases and 1 attributable case.

For purposes of comparison, published figures by Public Health England indicate that for the financial year 2015-16, of 18 acute trusts covered by Public Health England in the West Midlands area, there has been one Trust with 8 hospital attributable MRSA bacteraemia; one Trust with 6 cases; one trust with 5 cases; one Trust with 3 cases; two Trusts with 2 cases and 4 other Trusts with 1 case.

Ten year context for MRSA bacteraemia

The overall number of MRSA bacteraemia has continued on a general downward trajectory at the Trust, with a small increase noted during 2013/14 and 2014/15 in line with national trends. However, the number of trust attributable cases, shown in green in figure 9, continues to decline with one case in each of 2014/15 and 2015/16.

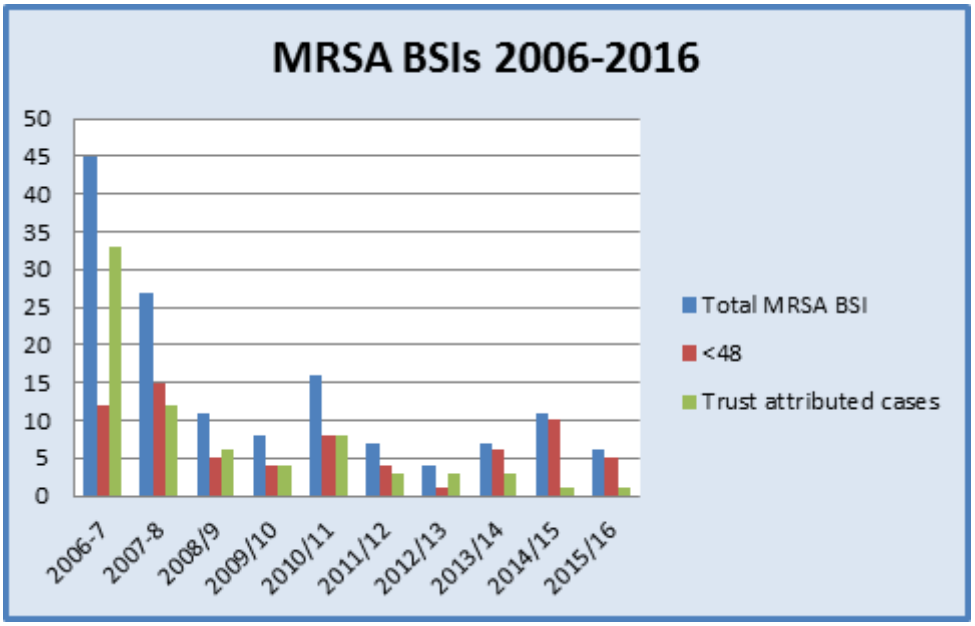


Figure 9: MRSA BSI reported by WAHT 2001/2015.

MRSA screening

During 2015/16 the Information Team and IPCT have worked closely to review data quality issues around MRSA screening compliance figures, leading to improvements that now more accurately reflect the vigilance placed on MRSA screening by the Pre-operative Assessment Team.

A definition of high risk has been taken from Department of Health (2014) modified MRSA screening guidance. This includes: Vascular, renal/dialysis, neurosurgery, cardiothoracic surgery, haematology/oncology/bone marrow transplant, orthopaedics/trauma, all intensive care units (Adult/paediatric/Neonatal), High Dependency Units, Coronary Care Units and the Neonatal Unit at Worcester Royal Hospital.

Figure 10 shows MRSA screening compliance of high risk elective patients against a target of 95%.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
High Risk Admissions	200	208	234	209	211	233	221	256	197	192	220	181
% Compliant	97.0%	97.6%	97.0%	96.7%	96.7%	99.1%	91.9%	95.7%	98.0%	95.3%	98.6%	95.6%

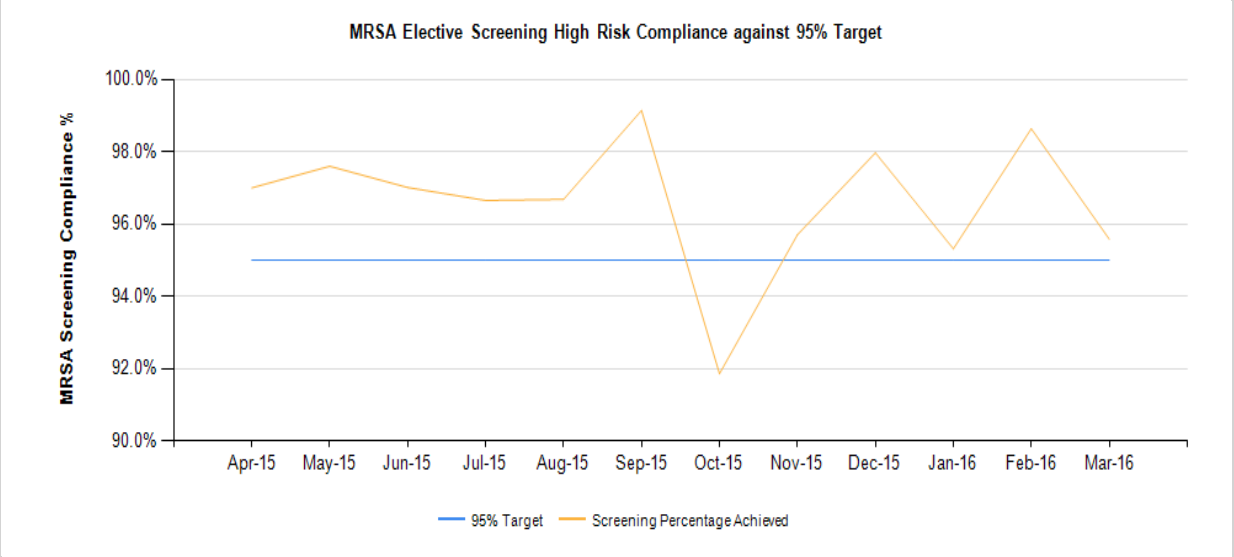


Figure 10: MRSA high risk Elective screening compliance against 95% target

Work to improve data quality has included a review of elective patients Herefordshire who may have had their screen done in Hereford, a review of ward attenders who may have been logged as full admissions and therefore don't have a corresponding MRSA screen and waiting list initiative patients where the screen and procedure are undertaken in a private hospital but they are listed on the Trust's OASIS patient management system. This work around improving data quality for elective admissions will continue into 2016/17 and will proceed to a review of data quality on MRSA screening for emergency admissions.

Re –screening for longer term in-patients is undertaken one month post admission. Compliance with this has remained at 100% in year (Figure 11).

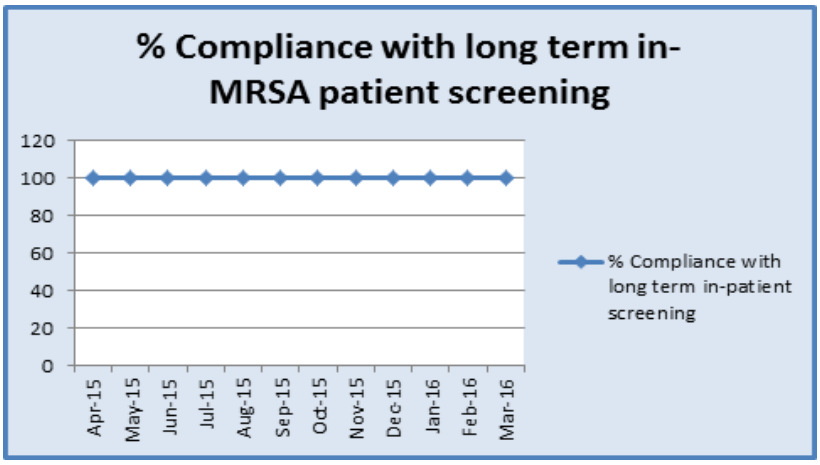


Figure 11: Long term inpatient MRSA re- screening 2015/16

7. Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Bloodstream infections due to Meticillin sensitive *Staphylococcus aureus* became subject to mandatory reporting in April 2011. During 2015/16 the trust has recorded 69 MSSA BSI, of which 19 occurred in patients beyond the first post-admission day and were therefore classified as hospital attributable.

Figure 12 below shows the 19 trust attributable MSSA BSI reported during 2015/16 and comparison with the 9 cases reported during 2014/15. Of the 19 cases reported 2015/16, 12 were reported in blood cultures from Worcestershire Royal Hospital and 7 from the Alexandra Hospital. At least 4 cases during the year were likely to have been line associated and therefore 2016-17 will see the Infection Control Team more closely reviewing each case to ascertain if any modifications in practice could lead to prevention of this infection.

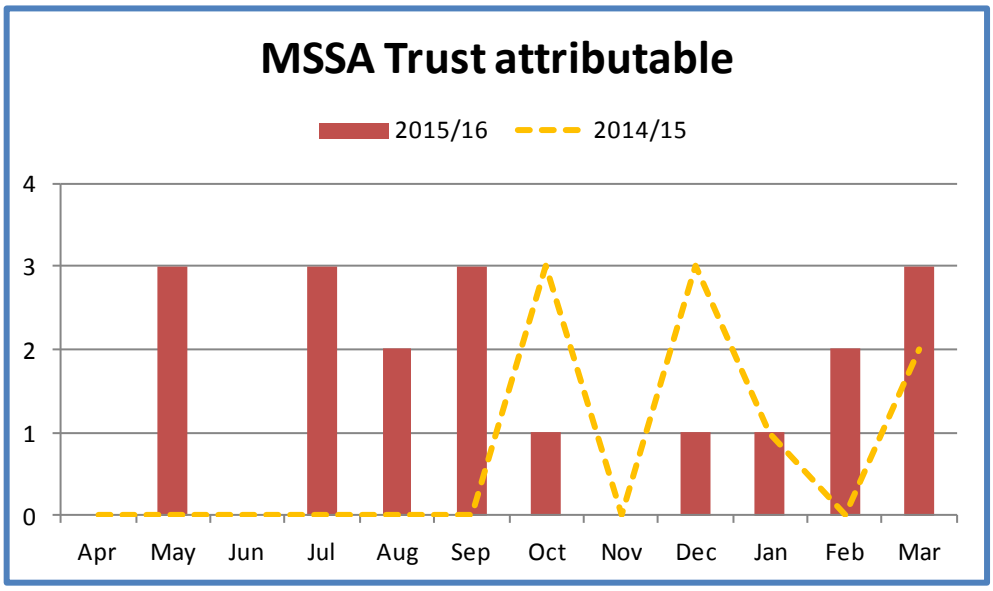


Figure 12: Trust attributable Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI 2015/16.

There continues to be no local or national mandatory reporting trajectories for MSSA. It is not anticipated that there will be any national trajectories introduced during 2016/17.

8. *E.coli bacteraemia*

During 2015/16 the Trust recorded 316 *E.coli* bacteraemia of which 49 were classified as trust attributable, having been detected in patients beyond the first post admission day. This compares with 61 trust attributable cases during 2014/15 and 69 during 2013/14. Of the 49 cases, 31 were reported in blood cultures from Worcestershire Royal Hospital, 17 from the Alexandra Hospital and 1 from Kidderminster Treatment Centre. The most significant cause group appears to be urosepsis.

Figure 13 shows trust attributable *E.coli* bacteraemia during 2015/16 with 2014/15 for comparison. *E.coli* bacteraemia has been included in the mandatory reporting process since June 2011. There are no national or local trajectories set for *E.coli* bacteraemia.

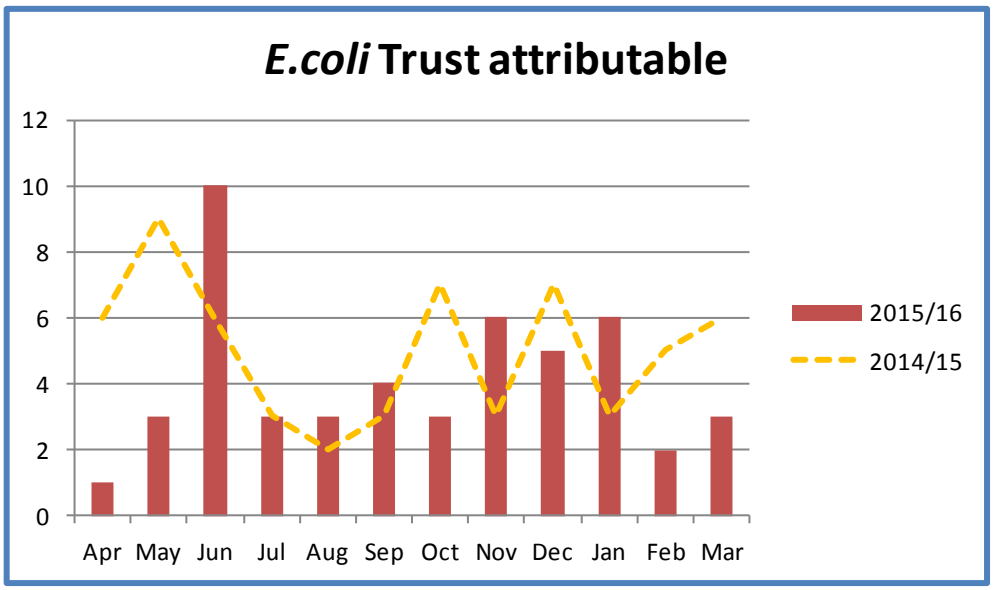


Figure 13: trust attributable *E.coli* bacteraemia 2015/16.

A breakdown by site is as follows for 2015/16 with 2014/15 for comparison (Figure 14)

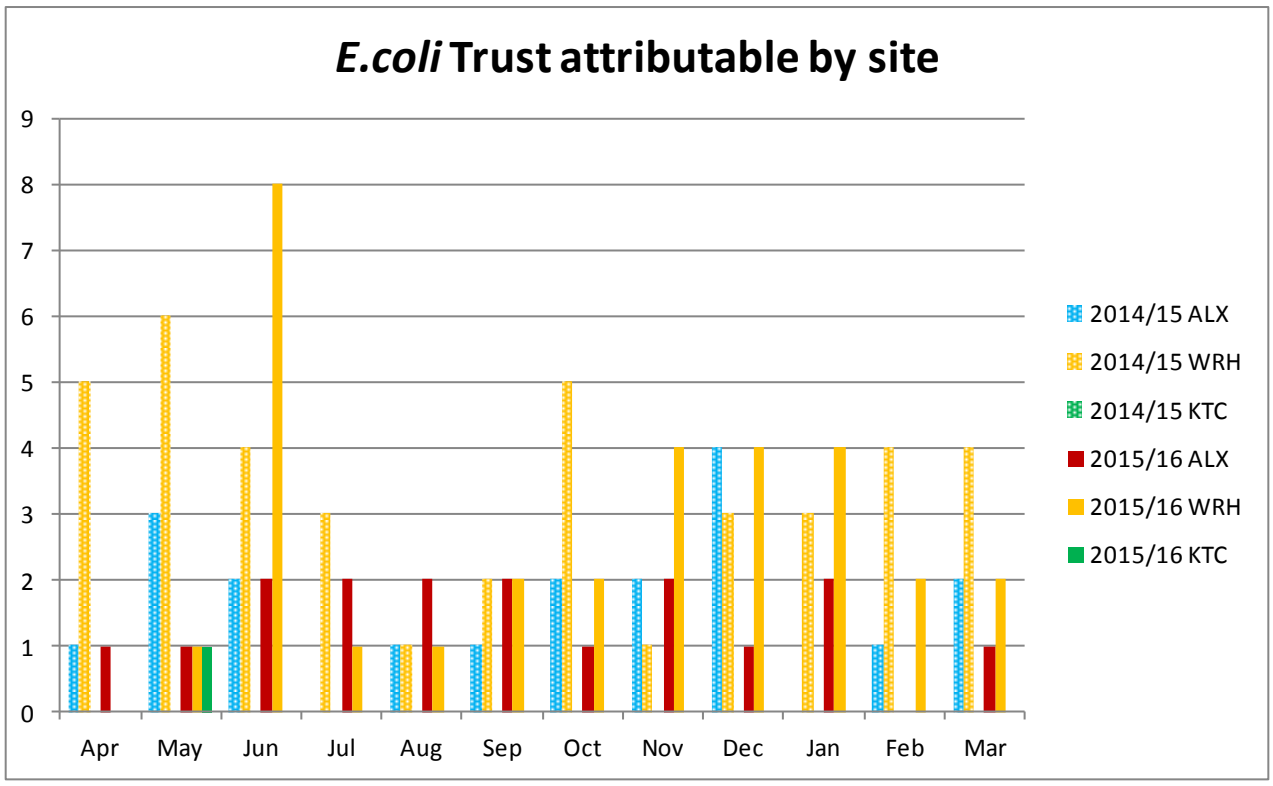


Figure 14: *E.coli* Trust attributable bacteraemia by site at WAHT 2014/16.

9. Antimicrobial Stewardship

Antimicrobial stewardship

Antimicrobial stewardship is a systematic effort to stem the overuse of antimicrobials and retard the development of antimicrobial resistance in micro-organisms.

The departments of microbiology and Infection Prevention and Control continued to implement the recommendations of the “Start Smart then Focus” national campaign for the financial year 2015-2016. Existing antimicrobial stewardship activities such as trust antimicrobial prescribing guidelines, *C. difficile* post-infection review meetings, daily intensive care unit ward rounds, weekly *C. difficile* ward rounds and selective reporting of antimicrobial susceptibilities were maintained through the year. Antimicrobial stewardship is taught to both senior and junior colleagues as part of their mandatory training sessions.

A new development in the second half of the year was setting up two generic e-mail accounts for the Alexandria and Worcestershire Royal Hospital sites to be used by ward pharmacists to refer patients who were on piptazobactam or meropenem for longer than 10 days. A referral triggered a bedside visit by a microbiologist within 48 hours. Over a five month period, eight referrals were made and all were seen; in seven cases, the antibiotic was stopped outright.

Overall antibiotic consumption for the trust was 6293 grams / 1000 admissions for the financial year. This was similar to consumption in 2014-2015 (6392 grams / 1000 admissions) but significantly more than in 2013/2014 (5881 grams / 1000 admissions). Further work is required to explain this significant increase in consumption.

Details of antimicrobial consumption by agent are detailed below.

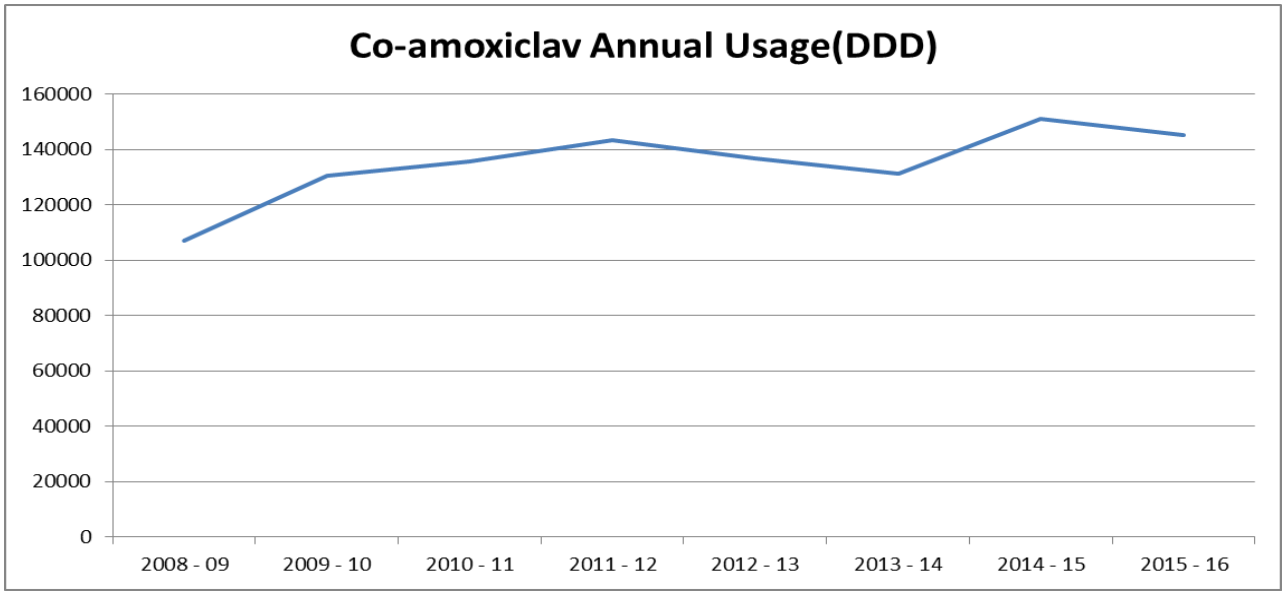


Figure 15: Annual co-amoxiclav use since 2008

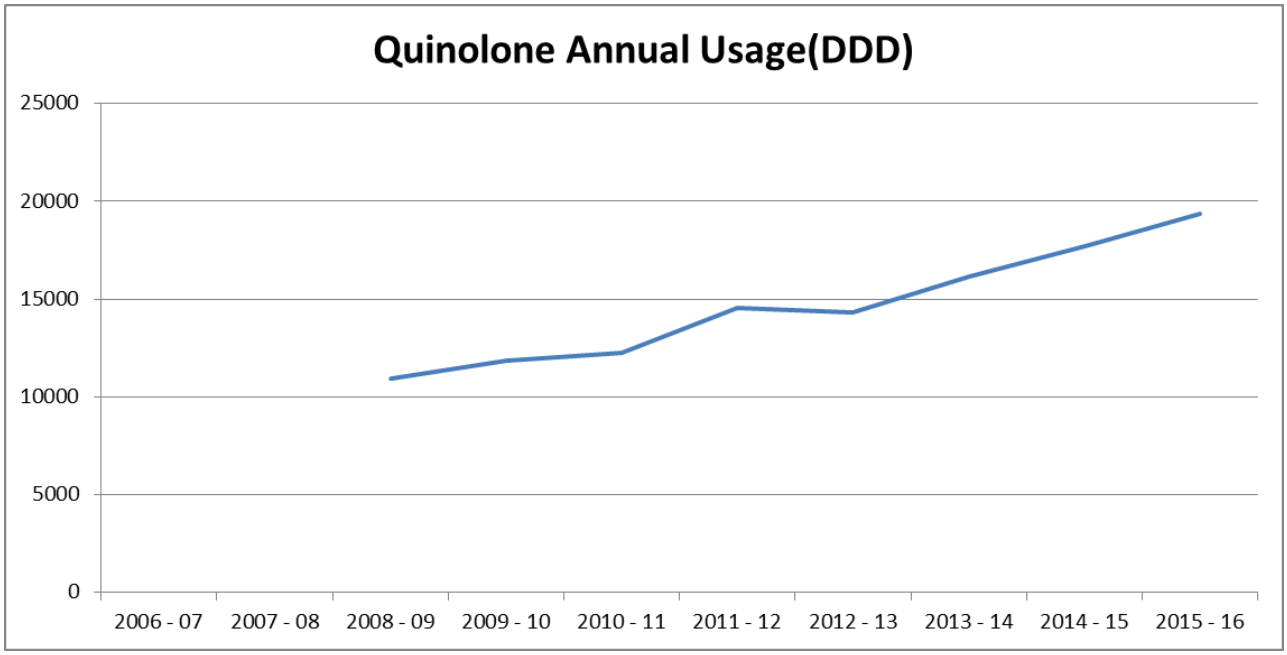


Figure 16: Annual quinolone use since 2008; by far the most Commonly used quinolone is ciprofloxacin.

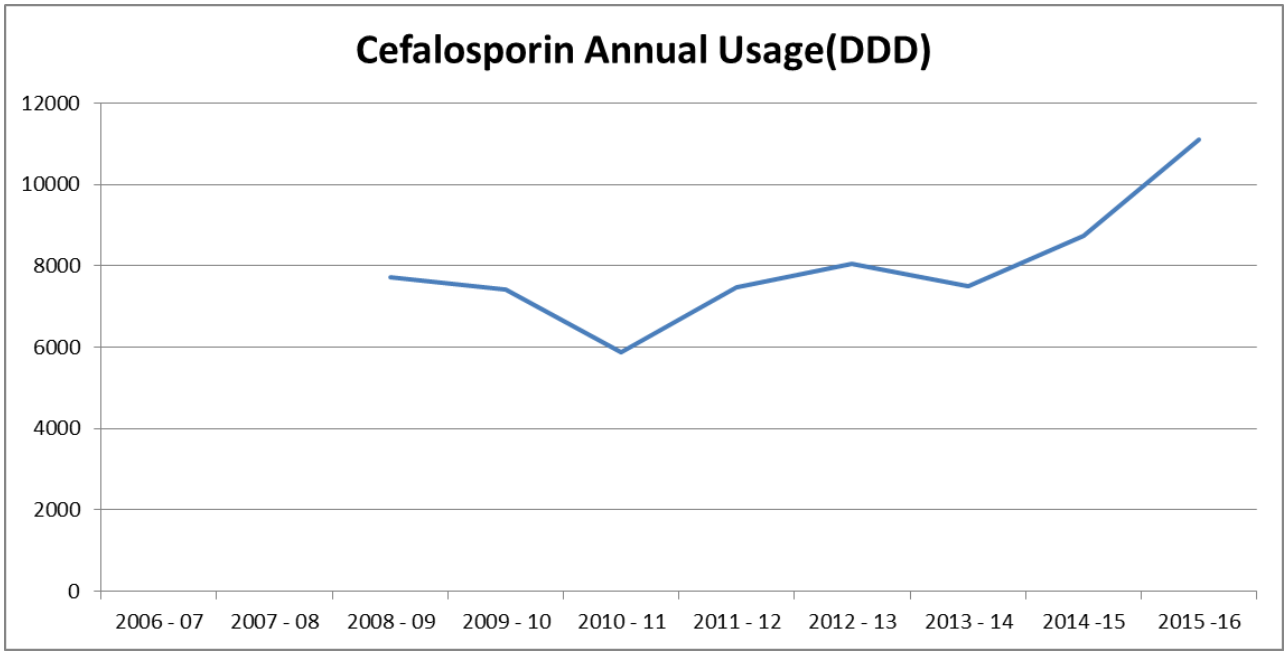


Figure 17: Annual cefalosporin use since 2008

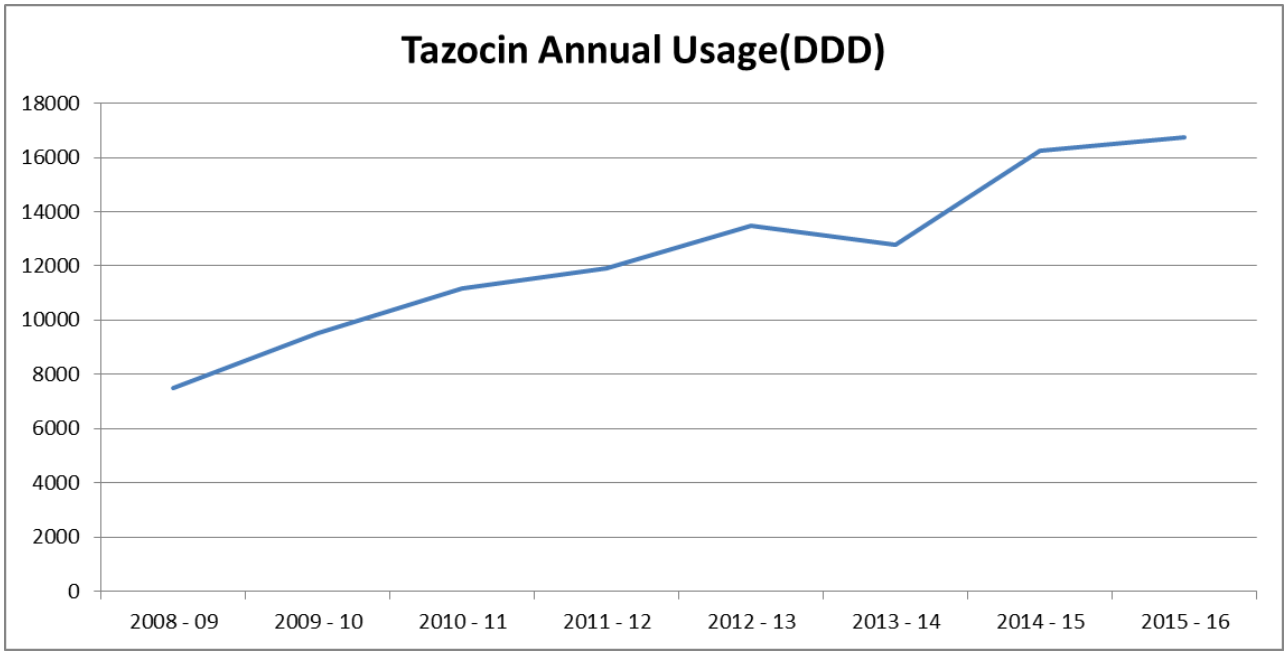


Figure 18: Annual Tazocin (piperacillin-tazobactam) use since 2008

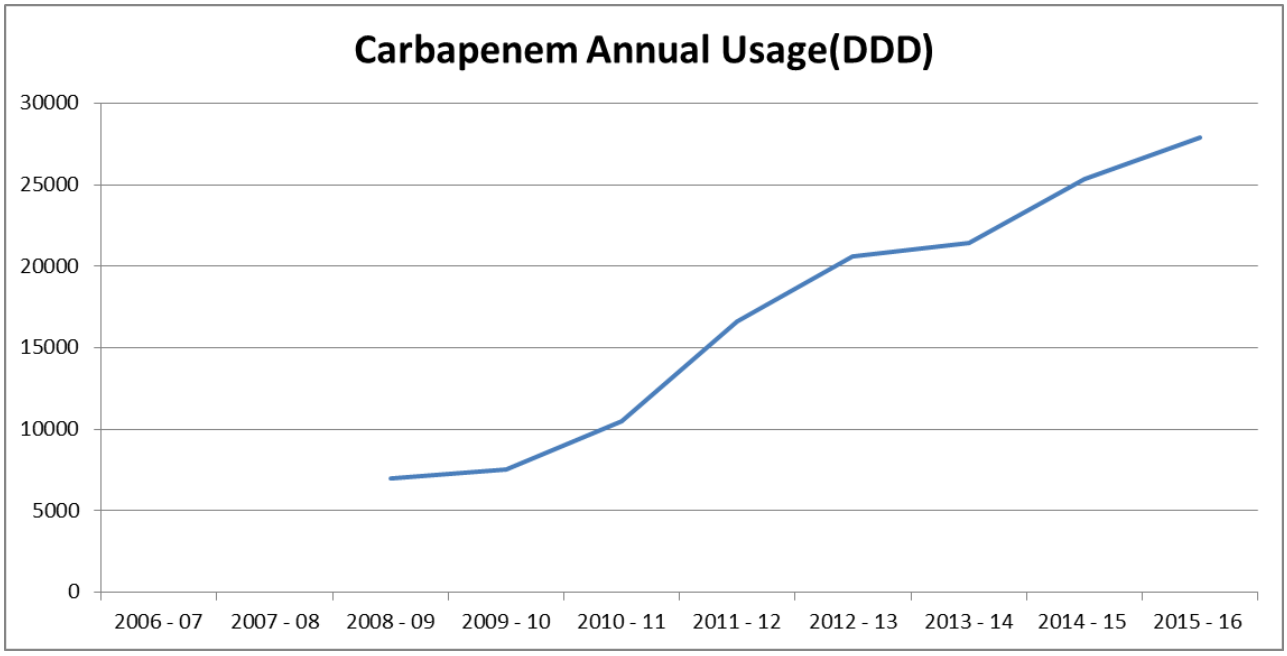


Figure 19: Annual carbapenem (meropenem and ertapenem) use since 2008

It appears that the large and significant increase in consumption of antibiotics from 2013/14 to 2015/16 was driven by an increase in the consumption of carbapenems, piperacillin-tazobactam and quinolones. The cephalosporin rise is likely to be due to increase outpatient IV prescribing (OPAT) to facilitate more rapid discharge from hospital and is less concerning. The reasons for the rise in of carbapenem, piperacillin-tazobactam and quinolone consumption are not apparent from the data and are highly likely to be multifactorial.

It may be in response to the following factors:

- An increasingly frail, elderly population with multiple co-morbid conditions and high susceptibility to bacterial infection.
- An increasing rate of infection with multi-drug resistant Gram-negative pathogens (an increased laboratory isolation rate of ESBL-producing Enterobacteriaceae has been noted from surveillance).
- Increasing awareness of sepsis, due to high-profile national campaigns and a lower threshold to prescribe broad-spectrum antimicrobials in response.
- Inadequate time, confidence or training of medical practitioners resulting in inadequate initial assessment of a patient to determine the likely focus of infection and hence over-reliance on broad spectrum agents to manage sepsis rather than narrow spectrum "site-specific" therapy.
- Failure to de-escalate to a narrower spectrum agent upon receipt of culture and sensitivity data.
- Continuation of antimicrobial therapy post-operatively as 'extended prophylaxis', in opposition to the trust's guidelines (demonstrated from an audit of surgical patients).
- Lack of a dedicated, full-time antimicrobial pharmacist or whole-time equivalent to support stewardship activity
- Increasing numbers of oncology patients being cared for in Worcestershire and hence increased numbers of patients with febrile neutropenia presenting to hospital. First-line agents for febrile neutropenia are piperacillin-tazobactam or if penicillin-allergic or a haemato-oncology patient, meropenem.

Commissioning for Quality and Innovation (CQUIN) – Antimicrobial Stewardship

There was no antimicrobial stewardship CQUIN for the financial year 2015/2016.

There is a CQUIN for the 2016/2017 financial year. The trust will be required to reduce the consumption of total antimicrobials, piperacillin-tazobactam and carbapenems (i.e. ertapenem and meropenem) by 1% each of the baseline value, which is consumption in the financial year 2013-14, the indicator weighting is 0.20%. This means the trust will need to reduce total antimicrobial consumption to 5822 grams / 1000 admissions, a 7.5% reduction on current consumption. The other part of the CQUIN (indicator weighting 0.05%) will require evidence showing up to 90% of prescriptions have been reviewed within 72-hours of initiation of antimicrobial therapy.

Achieving the objectives for the CQUIN will require a substantial increase in resources provided by the Trust. However, a business case for a dedicated antimicrobial pharmacist has now been approved. Other suggested measures to meet the CQUIN objectives include a review of the trust's antimicrobial prescribing guidelines and the implementation of an antimicrobial audit schedule to be devolved to the divisions to implement and benchmark against. Poorly compliant departments will be invited to discuss reasons for this with the medical director. It is also recommended the review signature box on the antimicrobial section of the Trust's prescription chart is moved from its current position at 5-days post initiation of therapy to 3 days, in order to meet the requirements for the second part of the CQUIN.

10. Infection Prevention & Control Serious Incidents

Outbreaks of infection due to Norovirus or other agents, or periods of increased incidence or outbreaks of *Clostridium difficile* infection are classified as serious incidents and reported on the serious incident reporting system STEIS in accordance with the Serious Incident Management Policy and Procedure. Figure 20 below lists the 13 HCAI related serious incidents reported during 2014/15.

Incident date	Site	Summary
09/06/15	Alex	Period of increased incidence *C.difficile*, Ward 9
18/09/15	Alex	Contamination of EBUS scope
20/01/16	WRH	Flu outbreak Riverbank Unit
26/01/16	WRH	Outbreak of Norovirus Silver Unit
16/02/16	WRH	*C.difficile* recorded on part 1a of death certificate, Severn Suite
29/02/16	WRH	MRSA bacteraemia, Acute Stroke Unit

Figure 20: HCAI serious incidents reported 2015/16

Period of increased incidence *C.difficile*, Ward 9

A period of increased incidence of *Clostridium difficile* toxin is declared when two hospital attributable cases occur on the same ward within 28 days.

A period of increased incidence was detected on 09/06/15 when a second toxin positive case was confirmed on a patient on Ward 9 within a 28 day period, following a first case on 07/06/15.

The investigation had two elements; firstly to establish for the toxin positive cases if there was an act or omission in the management of the patients that could constitute a lapse in care meaning that the *C.difficile* infection could have been avoided; and secondly to establish if there are any links between the cases.

Typing of the two cases confirmed differing strains and therefore there was no direct evidence of cross infection between the cases.

It is likely that antimicrobial therapy required as part of clinical treatment in both cases was the trigger cause of *C.difficile*. Both patients had a range of co-morbidities for which antimicrobials were indicated; in both cases this required treatment / prophylaxis was most likely to have resulted in the toxin positive cases independently of each other.

A key focus of the work of the IPCT during 2016/17 will be around education and policy for antimicrobial stewardship.

Contamination of EBUS scope

Between March and November 2015 an investigation took place into the possible internal contamination of the EBUS (Endobronchial ultrasound) scope with a variety of organisms. This matter was referred to the manufacturer of the scope who believe the issue was with the decontamination of the scope but referred the design to the Medicines and Healthcare Products Regulatory Agency for further investigation. There has been no evidence that patients have suffered infections as a consequence of this concern and patient safety has not been compromised. The Trust also requested an independent review of decontamination practices for flexible endoscopes and some recommendations were enacted.

Flu outbreak Riverbank Unit

Three children on Riverbank Ward were found to be positive to Influenza A between 18th and 20th January 2016. The cases were deemed to be hospital attributable based on the onset of symptoms beyond 72 hours of admission to hospital. An outbreak was declared and Public Health England informed. Infection prevention precautions were instigated including use of personal protective equipment and enhanced cleaning. An increase in staff sickness with flu like symptoms was seen during this period with staff illness peaking between 14th and 30th January 2016. Virology testing showed that 6 members of staff were positive to Influenza A, of which 4 had received their flu vaccination. However, further investigation noted limited uptake of the flu vaccine and the Occupational Health Department arranged additional sessions to offer the vaccination. However, there was still only a staff uptake of 37% for the flu vaccine and the lesson for 2016/17 will be to achieve 70% or above for this area.

Norovirus outbreaks

The Trust has a standard response to Norovirus. This includes daily review of affected patients and an increase in the frequency of environmental cleaning using a chlorine releasing product. Outbreak meetings are also held which receive an overview of the wider community prevalence of Norovirus. This means that where Care Homes are affected, this information is relayed to admitting areas at the Trust to ensure that patients from affected locations in the community can be placed in isolation on admission.

During 2015/16 there was just one outbreak reported as a serious incident on Silver Unit at Worcestershire Royal Hospital.

A Norovirus debrief following the 2014/15 outbreaks was held during August 2015. Key actions included a reminder for staff to use the diarrhoea and vomiting risk assessment tool to help ascertain the likely infection cause and for staff, to use the side room risk assessment tool especially at times of high capacity to identify patients who may not need isolation so that symptomatic patients can be placed in side rooms.

Outbreak of Norovirus Silver Unit

On 26/01/2016 Silver Unit, was closed due to eight patients having symptoms suggestive of Norovirus. Pooled testing was carried out from 2 patients and Norovirus was confirmed. In accordance with current Trust policy for pooled testing, all other symptomatic patients were also treated as Norovirus positive.

There were two further temporary ward closures on 12/03/16 and 11/04/16 also due to patients symptomatic of Norovirus.

There was compliance to the Norovirus policy during these outbreaks and therefore there are no new important lessons to learn.

However, an end of season debrief will be held during the summer of 2016 to ascertain of further actions can be undertaken in preparation for and during the winter season of 2016/17.

***C.difficile* recorded on part 1a of death certificate, Severn Suite**

An 81 year old patient was admitted to Severn unit during January 2016 with acute limb ischaemia and underwent a below knee amputation on 05/02/16. The patient sadly died on 16/02/16 and *Clostridium difficile* was cited in part 1a of the death certificate. An investigation agreed that *C.difficile* was a primary cause of death but that the patient's death could not have been prevented and no lapses of medical or nursing care were identified.

MRSA bacteraemia, Acute Stroke Unit

An MRSA bacteraemia was confirmed in a patient on Acute Stroke Unit (ASU) at the Worcestershire Royal Hospital with a blood culture specimen date of 29/02/16. The date of admission was 23/02/16 and the patient screened negative to MRSA (nose and groin swabs) on admission to MAU. However on transfer to ASU on the same date a repeat screen was taken which was positive. The patient had a previous history of MRSA dating back to 2008.

Due to the time lapse between admission and the blood culture being taken, the post infection review meeting held on 22/03/06 confirmed that the case would be classified as hospital attributable. The source of the MRSA bacteraemia was felt to be the patient's chest infection.

A key lesson has been to investigate with the Informatics Team the possibility of ensuring the MRSA alert flag on the OASIS patient management system must be viewed before moving onto next step in admission. This would ensure staff are alerted to previous MRSA history and enable decolonisation to commence at the earliest opportunity possible following admission.

11. Tuberculosis (TB)

Worcestershire continues to be a low incidence area for tuberculosis with an incidence below the national average. Most cases of TB are community based but occasionally admission to hospital is required. Cases are managed by the TB lead physicians, predominantly on an outpatient basis, and supported by the county wide TB nursing team who also screen contacts of each case. If admission to hospital is required, cases of suspected or confirmed pulmonary tuberculosis are admitted to isolation rooms, preferably with negative pressure ventilation.

Occasionally patients are admitted to hospital and a diagnosis of pulmonary TB comes to light after a few days into an admission. In this scenario contacts of such a case are identified and offered advice and screening where appropriate. One such case presented to the Alexandra hospital in February 2016. The diagnosis of suspected pulmonary TB was made the day after admission. At this point the patient was promptly moved into a side room for isolation and infection prevention precautions instigated. Pulmonary TB was later confirmed by laboratory and radiological testing. Four patients were identified as potential contacts of the case and were contacted in writing to inform them and offer further advice and screening as necessary. No secondary cases of TB have been identified.

Since last year the microbiology and IPCT have worked closely with the TB nursing team and Trust communications team to raise awareness of TB. Teaching sessions on tuberculosis and how to prevent transmission of the infection were delivered to Trust link professionals in February 2016. World TB day on 24th March 2016 was used as an opportunity to inform staff and patients of the condition and how to prevent it, by means of screen savers and information stands at each hospital site. This is an annual event and will be developed year on year to improve awareness of the condition.

12. Vancomycin-resistant Enterococci (VRE)

Cases of Vancomycin Resistant *Enterococci* (VRE) colonisation were noted during the year, which led to enhanced cleaning and use of Hydrogen peroxide environmental decontamination on both of the Trusts Critical Care Units to eradicate the bacteria from medical devices and the environment.

Enterococci are bacteria that are normally present in the human gut and female genital tract and are also often found in the environment and on animals. In some instances, *Enterococci* are resistant to some antibiotics used to treat infection caused by these bacteria and are therefore termed Vancomycin Resistant *Enterococci* (VRE). Most VRE colonisations or infections occur in hospital and are often found in patients who have previously been treated with prolonged courses of antibiotics, have weakened immunity, have had recent surgery or have long term indwelling medical devices, especially in high / critical care units. Patients who are colonised only with VRE do not need further antibiotic treatment. However, there is a risk that these resistant organisms could spread to other patients where infections could subsequently be caused. Therefore, the presence of VRE prompts a programme of enhanced cleaning and environmental decontamination, where possible using hydrogen peroxide vapour, in order to eradicate their presence from the clinical environment.

During October 2015 three patients screened positive for VRE on the Critical Care Unit at Worcestershire Royal Hospital. This prompted a programme of enhanced environmental and medical device cleaning and patients were moved to side rooms where possible. During February 2016 a total of 6 patients were found to be colonised with VRE on the Critical Care Unit at the Alexandra Hospital. A review of patients identified as VRE positive on the Worcester site since January 2015, who were cared for in the Critical Care Unit during their stay at the Worcestershire Royal Hospital, led to 10 samples being sent for typing from the site. Five samples were also sent for typing from the Alexandra site from patients cared for in the Critical Care unit. Sending specimens for typing is a method used to identify whether or not the samples are the same and potentially linked to each other, or are different and unrelated. The typing results identified a variety of strains. However, 2 of the 5 samples sent from the Alexandra site were reported to be the same. Of the 10 samples sent from the WRH site, 2 were also reported as the same. Of the other samples a variety of strains were identified.

VRE can be passed from person to person by the contaminated hands of care givers and also following contact with a contaminated surface or piece of equipment. During March and April 2016, 50 environmental swabs were taken on each Critical Care Unit on commonly used equipment and bed space fittings including bed frames and mattresses, pumps, dispensers, and at locations in the clinical environment. Following enhanced cleaning and hydrogen peroxide decontamination at both locations, all but one environmental sample tested negative. Periodic environmental testing will continue into

2016-17 in order to ensure the burden of VRE is kept to a minimum at both locations and any single case of VRE colonisation or infection is flagged to the Infection Prevention & Control Team who will advise on a recommended course of action in each case.

13. Surgical Site Surveillance

In 2004 it became a mandatory requirement for all trusts undertaking orthopaedic surgery to conduct surveillance of surgical site infections, using the Surgical Site Infection (SSI) Surveillance Service of Public Health England (PHE). The data set collected as part of the surveillance is forwarded to PHE for analysis and reporting. Surveillance is divided into quarters (Jan-Mar, Apr-Jun, July-Sept and Oct-Dec) and each Trust site is required to participate in at least one surveillance period every 12 Months in at least one orthopaedic category.

The data collection is overseen by the IPCT on the Alexandra site with trained surveillance nurses collecting and inputting data on ward 1 at Kidderminster Treatment Centre, T&O ward at Worcester Royal Hospital and wards 16 & 17 at the Alexandra Hospital. During the surveillance period, all patients undergoing total hip replacements, total knee replacement or repair of fracture neck of femur must be included and the appropriate data set gathered, including post discharge surveillance, which extends for 30 days. Infections are defined according to a robust case definition. Any infections that are reported using the SSISS data base are investigated by the Orthopaedic team, surveillance nurses, ward manager and infection prevention and control team to identify any issues / practices for improvement.

Surveillance for wound infection is continued for 30 days in the immediate post-operative phase and is required for up to one year post procedure for joint prosthesis surgery. Cases of surgical site infection identified are considered at review meetings to ascertain if any lessons can be learned for future practice.

During 2016/17 a business case will be prepared to update the ICNet system used by IPCT – this would enable more extensive surveillance of other categories of surgery and facilitate 1 year follow up / review.

Key themes from investigations to date suggest no single reason for the increase in infection rates. However, early change of dressing due to wound exudate may be a factor. An action for 2016/17 will be to improve data capture for mandatory orthopaedic surveillance to improve accuracy of data and ensure all cases are promptly identified, reviewed and reported. A case is being prepared for support for a proposal to improve data capture and facilitate a wider range of surgical site surveillance to be undertaken. During 2016/17 there will be a further work stream established with a view to reviewing skin disinfection products used and to rationalise their use at the Trust.

A multi-disciplinary steering group to monitor surveillance outcomes and to plan surgical site surveillance has met. To improve the effectiveness of this group monthly clinical case reviews are being instigated for 2016/17 to ensure a timely robust review of cases and improve the ability to share learning more widely throughout the organisation. The group also aspires to develop a wider surgical site infection surveillance agenda to include other surgical procedures such as large bowel, caesarean section and other relevant surgical procedures outside the mandatory requirements, though this would be resource dependant.

Figure 21 shows the wound infection rates recorded at the Alexandra Hospital, Kidderminster Treatment Centre and Worcestershire Royal Hospital in 3 procedures: hip replacement, knee replacement and repair of fractured neck of femur over the last 7 years.

Year	Procedure	WRH	ALX	KGH
2009	THR			2 in 55
	TKR	0 in 46	0 in 78	
	NOF		1 in 47	
2010	THR	0 in 63	1 in 119	0 in 58
	TKR		0 in 83	4 in 32
	NOF		0 in 50	
2011	THR	1 in 113	0 in 53	0 in 97
	TKR	1 in 35	3 in 79	2 in 89
	NOF		0 in 58	
2012	THR	0 in 149	1 in 145	0 in 65
	TKR	1 in 117	0 in 66	1 in 76
	NOF	4 in 165	0 in 54	
2013	THR	0 in 164	2 in 233	1 in 105
	TKR	0 in 148	2in 242	1 in 105
	NOF	0 in 415	0 in 247	
2014	THR	0 in 205	2 in 297	0 in 112
	TKR	0 in 130	11 in 305	2 in 117
	NOF	4 in 452	2 in 242	
2015	THR	0 in 126	5 in 331	0 in 60
	TKR	0 in 37	4 in 373	0 in 89
	NOF	3 in 409	2 in 245	

Figure 21: Wound infection rates in hip and knee replacement and fractured neck of femur repair (calendar year).

14. Water governance

The Water Safety Group (WSG) has been very focused on widening the awareness of water safety issues throughout the Trust and continues to take steps to improve arrangements for water safety and governance:

Monthly Water Safety Group (WSG) meetings are on-going. Prior to each meeting a monthly water report to a standard format is circulated to all members of the WSG and other stakeholders, which with the agenda forms the basis of meeting discussions.

The WSG now includes new builds and projects on the agenda and at every WSG meeting, Project Managers report on future projects and any implications for water safety. This approach ensures that future building projects at the Trust have safe water, supplied by systems which have been designed appropriately and which do not present a risk to the Trust's patients.

Whilst the remit and agenda for the WSG have expanded in the last year a recent audit by the Trust's Authorising Engineer identified a shortfall of the Trust's water management system. The Report found weaknesses in governance and has recommended that the Trust appoint more people into roles of responsibility for water safety and that water safety group is better attended by clinical and other operational teams. The latest WSG invite has requested the Divisional Directors of Nursing to attend the meeting, or send a deputy, ensuring that we have adequate clinical representation.

There is now a flushing programme on all three Trust sites and flushing log books have been issued countywide to a standard format. Flushing is taking place and log books are audited by Estates. Water management training for clinical staff is on-going.

A Water Safety Plan has been produced, in line with the requirements of HTM04-01 addendum. The plan covers all existing buildings currently occupied by Trust and also covers new builds, with clear direction on design, build, commissioning and hand over.

The Authorised Engineer, Trust Microbiologist and Principal Engineer have agreed a new water testing protocol which will go live during 2016/17. The enhanced testing will provide additional assurance that the controls in place are working and water quality continues to be safe.

Over the year 2015/16 the Trust has seen issues with *Pseudomonas aeruginosa* being detected in the new Radiotherapy building along with a historical issue of *Pseudomonas* in Laurel 3 ward. Patients were protected by fitting point of use PALL bacterial filters to the taps. After considerable work by the PFI hard Facilities Management service provider, the amount of positive results has decreased dramatically and we are now discussing the removal of these filters.

15. New and emerging pathogens – High Level Personal Protective Equipment

During the summer of 2014 we saw the advent of concerns regarding preparedness to deal with isolation of potential viral haemorrhagic fever type cases in the form of Ebola in West Africa. In response to this threat the IPC Team developed a detailed protocol for the use of high level personal protective equipment (PPE) with our Accident and Emergency and Critical Care colleagues. In June 2015 we saw an additional threat in the form of Carbapenemase-producing Enterobacteriaceae (CPE), more latterly Middle East respiratory syndrome coronavirus **(**MERS-CoV**)** and changes in the guidance issued by Public Health England on the use of masks and other respiratory PPE for aerosol generating procedures.

In response the Lead Infection Prevention Nurse developed guidance for staff on the range of PPE required to effectively manage each of these situations using a task and finish working group approach.

Measures introduced to support developments include:

- Guidance documents, quick guide posters and training
- Purchase of a loose fitting hood system for respiratory protection of staff unable to be fit tested with the tight fitting face mask routinely used
- Provision of out of hours availability of relevant PPE for all eventualities
- A comprehensive training programme for staff to be fit tested to wear required face mask protection
- Use of the electronic staff record (ESR) to capture all staff trained to wear FFP3 respirator masks and staff trained to fit test others in their use, this will facilitate staff recall for re-training at the desired time interval and move with staff between locations within the Trust

16. Education and training

Education continues to be a core element of the work of the IPCT, which delivers a wide range of training and educational sessions. These include Trust Induction and Mandatory update programmes for both clinical and non-clinical staff. Educational sessions are also provided for housekeepers, porters and external contractors. Antimicrobial prescribing updates are provided by the consultant microbiologists to medical and non-medical prescribers and via mandatory training for senior trust staff. The IPCT also contribute to doctors induction workshops and provide infection prevention guidance and training for maintaining asepsis, peripheral cannulation, central vascular device management, blood culture sampling and phlebotomy.

The IPCT also provide educational sessions which are Division specific including education sessions whenever a specific need arises, as outlined above plus waste management, hand hygiene competency checks and FFP3 mask fit test training.

Link Staff Study days

During 2015/16 there were also 9 IPC Link Staff study days including the Link Staff Annual Study Day (Figure 22).

Date	Site	Number attended
Annual Study Day 23/04/15	Alex	119
17/07/15	WRH	22
21/07/15	Alex	30
18/09/15	WRH	22
21/09/15	Alex	23
03/11/15	Alex	28
06/11/15	WRH	30
09/02/16	WRH	27
11/02/16	Alex	23

Figure 22: Link staff study days 2015/16

Topics for study days 2015/16 included:

Infection Prevention Teams in the 21st century
Personal experiences of working with Ebola patients
Health economy wide urinary catheter passport development and best practice
Update on the use of Flexi-seal faecal management system
Winter preparedness – HCAI including Norovirus, Staff Stool Sampling Kits
Personal Protective Equipment and development of the High Level PPE Protocol
Influenza recognition, management and reducing the risk
Online PHE Training module for influenza and Flu champions
The range of Clinell Wipes for patient and environmental or equipment cleansing including correct uses and disposal

Clinell range of support materials including a tablet based teaching system and commode audit tool
Water Flushing Compliance and documentation
Waste hierarchy and waste disposal incidents
Clinisafe Waste Container product launch for disposal of soft hazardous waste e.g. medicinally contaminated non-sharp items (nebulizer masks, gloves and aprons)
Cruetzfeldt-Jacob Disease update following two case diagnoses
Tuberculosis update following change to national guidance
Sarstedt-Urine Monovette Training (for urine sample collection) and update on general principles of microbiological sampling
Developments of Documentation updates – including changes to D&V Risk Assessment
Gojo® Hand Hygiene Technology and Hand Hygiene Compliance Project Update
Mattress Audits & Policy Update

Attendance at IPC mandatory training

Figure 23 below demonstrates the number of staff who attended infection prevention training either at an induction or mandatory annual risk update session between 1st May 2015 and 30th May 2016. Training content is currently under review to introduce use of other media to assist in reducing the physical attendance at taught sessions. Attendance is to be reduced to three yearly for non-clinical staff in line with the West Midlands Streamlining Programme aimed at developing a regional approach to refresher periods when delivering statutory and mandatory training for all subjects that are listed within the Core Skills Training Framework.

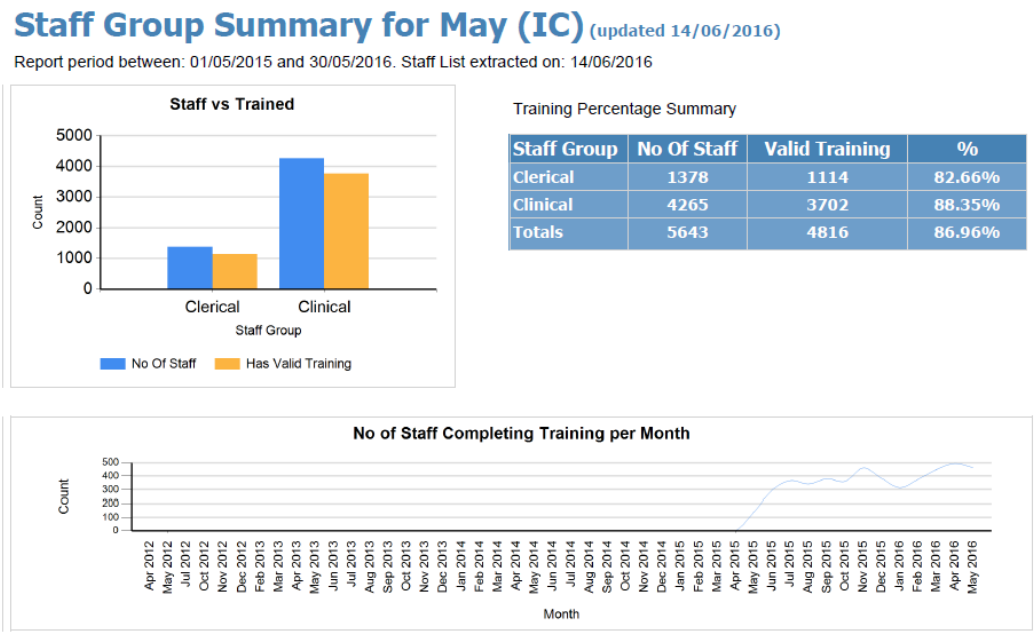


Figure 23: Attendance of IPC induction or mandatory training in year

Compliance with hand hygiene competency

Figure 24 below demonstrates the number of staff who received either theory or competency assessment training for hand hygiene in the last 2 years. This will have been delivered during attendance at induction, mandatory risk updates or directly from the infection prevention team or link practitioners who are all trained to check hand hygiene competency for staff every two years. From 1st April 2016 data will reflect only those staff who have undertaken a competency check test in the last two years so it is anticipated compliance will appear to drop initially as those staff who have only received the theory of hand hygiene will be excluded. Theoretical hand hygiene training is reflected in attendance at infection prevention mandatory updates when this is delivered.

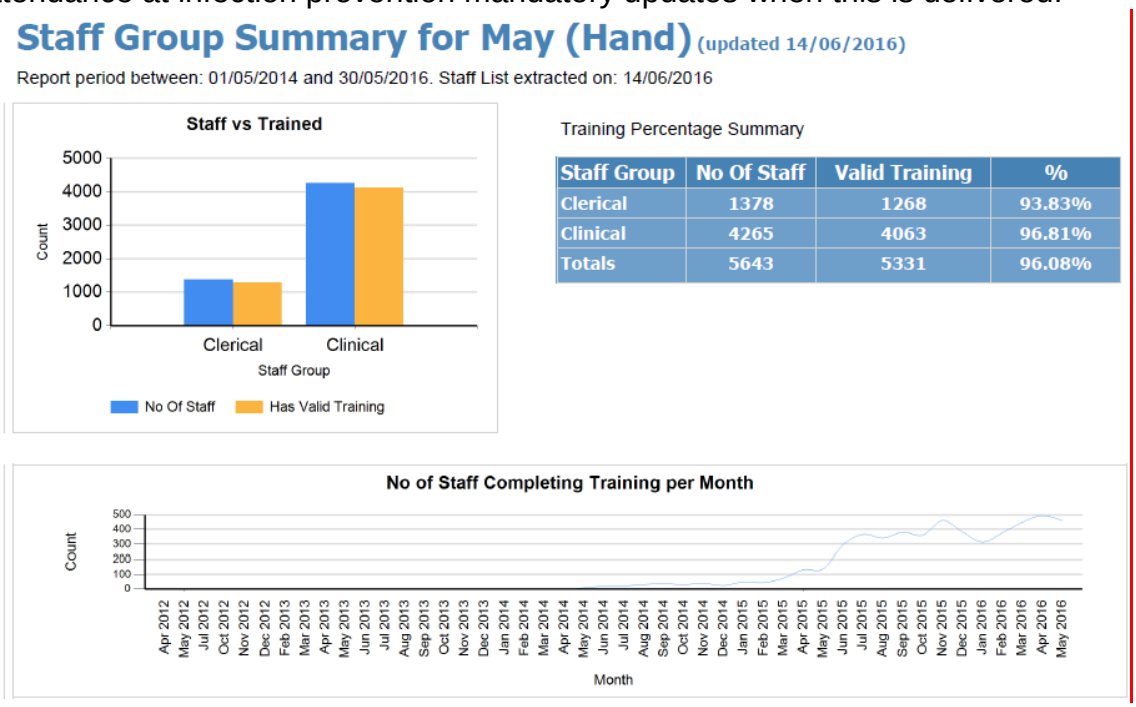


Figure 24: Compliance with hand hygiene training/competency

Further training

In addition to mandatory and link staff training, the IPCT also provide reactive training based on request or following audit findings, plus other bespoke training. This has included sessions for Housekeeping, Health Care Assistants, medical students, student nurses and midwives, staff being trained in venepuncture, central vascular device management, cleaning 'monit' audit skills, balance score card audits and database completion, training around the surgical site infection prevention self-directed learning pack, commode cleaning competency, hand hygiene competency and contractors induction training.

In addition, a workshop is held for all FY1 and FY2 medical staff commencing in the Trust to ensure they are skilled in the use of equipment provided to facilitate IPC practices. This includes blood culture collection technique, safety medical devices, faecal management system insertion, use of peripheral vascular device insertion packs and needle free devices, intravenous dressing application and removal, skin disinfection and basic IPC practices/ use of PPE.

17. Infection Control audits and key findings

The Infection Prevention ward audit tool was updated during the year in response to external visits by the Trust Development Authority and now has an increased focus on environmental cleanliness, in particular to check for dust in a range of locations and on medical devices. This has led to improved and closer working with the Facilities teams and Housekeepers across the Worcestershire Royal and Alexandra Hospital sites where regular joint Housekeeping and Infection Control Team walk rounds and spot checks are undertaken.

Some key audit findings earlier in the year included high dust evident in some areas including on fixtures and fittings hence the renewed focus to check this to ensure a clean patient environment. It has also been clarified Trust wide that computers, computers on wheels and electronic whiteboards are the responsibility of ward staff to keep clean and dust free. Medical devices used by nurses are required to have the green 'I am clean' tape and to be checked again before going back into use. Anti-ligature light and patient call pull cords are in a process of being replaced Trust wide as the replacement plastic pull cords can be easily cleaned. Lime scale build up on taps is also regularly checked and removed by Housekeepers where a build-up is noted. Sanitising gel dispensers are checked and cleaned daily to ensure they are refilled and that there is no sticky residue build up from regular use. Any damage noted to walls or floors is escalated to the Estates Team for rectification.

All infection control audits undertaken for any specific area are fed back to the manager of the area and the matron and to the relevant Housekeeping lead for their attention and action. The Infection Prevention nurses also follow up any unexpected results to ensure rectification of issues raised by audit.

In addition the audit schedule has been revised to reflect Divisional allocations of Infection Prevention nurses and to ensure appropriate frequency of audit dependent on patient risk factors and the level of invasive care required. In general the following audit frequency is in place:

- Wards and inpatient areas are audited 4 monthly
- Priority Departments e.g. theatres are audited 3 - 6 monthly dependent on findings
- Departments e.g. outpatients are audited 6 monthly
- Annual duty of care audits of waste, laundry and catering areas are scheduled
- The Facilities team also undertake regular patient environment audits and public areas are covered under mini PLACE audit programmes

18. Policy reviews

Infection Prevention Policies reviewed during the year 2015-16

WAHT-INF-025 Aseptic non-touch and clean technique
WAHT-INF-016 Protocol for the Management of *Clostridium difficile* and Prevention of Spread
WAHT-CG-507 Food and Fluid Hygiene Policy
WAHT-INF-002 Hand Hygiene Policy
WAHT-INF-033 Protocol for Seasonal Influenza
WAHT-INF-033 Influenza Clinical Quick Guide
WAHT-CG-088 Policy for the Decontamination and Storage of Mattresses
WAHT-INF-003 Protocol for the Management of Methicillin Resistant Staphylococcus aureus (MRSA)
WAHT-INF-006 Pre-admission screening protocol for Methicillin Resistant Staphylococcus aureus (MRSA)
WAHT-INF-010 Parasite Policy
WAHT-CG-495 Pest Control Policy
WAHT-INF-035 Protocol for the Insertion, Management and Removal of Peripheral Vascular Devices
WAHT-INF-036 Protocol for the Performance of Venepuncture
WAHT-INF-013 Protocol for the Management of Presumed Outbreaks of Viral Diarrhoea and Vomiting
WAHT-CG-481 Waste Management Policy
WAHT-INF-030 Guidelines for the Prevention, Identification and Management of Wound Infections

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H.P. Loveday J.A. Wilson, R.J. Pratt, M. Golsorkhi, A. Tingle, a. Bak, J. Browne, J. Priesto, M. Wilcox (2013) National evidence-based guidelines for preventing hospital-acquired infections in NHS Hospitals in England.(Epic 3)

21: Annual Plan 2016-17 (To be monitored at Infection Prevention & Control Committee)

Key work streams 2016-17	Lead Officers
Antimicrobial prescribing compliance	
Achieving compliance and providing assurance around antimicrobial prescribing • Dedicated antimicrobial pharmacist to be appointed • Achievement of 2016-17 antimicrobial prescribing CQUIN including reduction in overall Antimicrobial prescribing • Timely IV to oral switch and monitoring	**Director of Pharmacy** **Consultant Microbiologist**
Device related infections	
Achieving a reduction in device related infections including MSSA • A revised proforma for monitoring and investigation MSSA Blood Stream Infections • Introduction of urinary catheter passport • A focus on monitoring and improving best practice in IV care	**Associate Chief Nurse Infection Control and Lead Nurse Infection Control**
Surgical Site Infection – strengthening surveillance	
Achieving improved assurance of recognition of infection and learning lessons from cases • Reviewing the process of data collection and investigation of infection • Demonstrable learning of lessons from SSI surveillance	**Associate Chief Nurse Infection Control**
Water Safety – strengthening assurance	
Achieving improved assurance of water quality and safety for the Trust • Completion of revised Trust water safety plan • Improving the outlet flushing regime to improve assurance of compliance to water safety plan	**Principal Engineer Water Safety**
Waste management – new ways of working	
Achieving improved assurance of waste management • Introduction of tiger waste stream • Improving surveillance of waste segregation and management	**Head of Facilities and Contracts**
Gram negative organisms – improving management	
Achieving improved assurance on management of gram negative organisms including CPE • Re launch of CPE screening guidance and patient management	**Consultant Microbiologist** **Lead Nurse Infection Control**

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 7 September 2016 **Enc H3**

Report to Trust Board (in public)

Title	**Use of the Common Seal**
Sponsoring Director	**Kimara Sharpe** **Company Secretary**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Board is requested to note the activity of the Common Seal for the 12 months ending 31 August 2016.
Previously considered by	Not applicable

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	None applicable.
Legal Implications or Regulatory requirements	
Glossary	

Key Messages

This paper details the use of the Common Seal from 1 September 2015 to 31 August 2016. The Trust's Standing Orders determine that a report is taken to the Trust Board on the activity of the Seal.

Date of meeting: 7 September 2016 **Enc H3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Use of the Trust Common Seal

Number	Date of Sealing	Description of document sealed	Names of persons sealing	Titles
175	29-10-15	Lease as part of King's Court Estate: King's Court EMC Ltd and Worcestershire Acute Hospitals NHS Trust	Andrew Phillips Kimara Sharpe	Interim CMO Company Secretary
176	4-3-16	Land Registry – repeat of 172 seal: Transfer of land HW137677 to the Berkley 2002 settlement (mistake made by Land Registry necessitated a repeat of the seal)	Andrew Phillips Chris Tidman	Interim CMO Interim CEO
177	23-6-16	Land Registry (reference 174 and 177) – Land registry require two separate documents to match those held by Spetchley Estates	Rab McEwan Kimara Sharpe	Interim COO Company Secretary
Signature only	23-6-16	Land Registry (reference 174 and 177) – Land registry require two separate documents to match those held by Spetchley Estates	Rab McEwan Kimara Sharpe	Interim COO Company Secretary

Kimara Sharpe
Company Secretary
September 2016

Title of report	Use of the Common Seal
Name of director	Kimara Sharpe