Worcestershire NHS
Acute Hospitals NHS Trust

Trust Board

There will be a meeting of the Trust Board on Wednesday 5 July 2017 at 09:30 to 11:30 in Meeting Room 1 and 2, Kidderminster Treatment Centre, Kidderminster

This will be followed by a public question and answer session from 11:45 to 12:00..

Caragh Merrick, Chairman

Agenda		Enclosure
1	**Welcome and apologies for absence**	
2	**Patient Story** Chief Nurse to facilitate	
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*	
4	**Declarations of Interest** *To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.*	
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **3 May 2017** as a true and accurate record of discussions.*	**Enc A**
6	**Action Log**	**Enc B**
7	**Chairman's Business**	**Oral**
8	**Chief Executive's Report** To note	**Enc C1**
9	**Chief Executive's Report and Way Forward** – To note	**Enc C2**
9.1	**Board Development Program** – To approve	**Enc C3**
Quality of Care		
10.1	**Quality Governance Committee report – For assurance** Quality Governance Committee Chairman	**Oral**
10.2	**Quality Improvement Plan** –To approve Chief Nursing Officer	**Enc D1**

10.3	**Executive and Non-Executive Director Walkabouts** – To aprove Chief Nursing Officer	**Enc D2**
Finance and use of Resources		
11.1	**Finance and Performance Committee** – **For assurance** Finance and Performance Committee Chairman	**Enc E1**
11.2	**Financial Performance Report – To note** Chief Finance Officer	**Enc E.2**
Operational Performance		
12.1	**Integrated Performance Report – To note** Acting Director of Performance	**Enc F.1**
Strategic Change		
13	No items to report	
Leadership and Improvement Capability		
14.	No items to report	**Oral**
Stakeholders		
15.1	**Care in the Corridor in Worcestershire Royal Hospital** – To approve Chief Nursing Officer	**Enc G.1**
15.2	**Herefordshire and Worcestershire Sustainability and Transformation Plan** – To approve Chief Nursing Officer	**Enc G.2**
Governance		
16.1	**Audit and Assurance Committee report –** To note Audit and Assurance Committee Chairman	**Oral**
16.2	**Risk Management - Board Assurance Framework and Risk Management Strategy -** To approve Chief Nurse	**Enc H1**
16.3	**Board Business –** To approve Chief Executive Officer	**Enc H2**
16.4	**Freedom to Speak Up Guardian – Update – To approve** Director of Human Resources and Organisational Development	**Enc H3**
16.5	**Fit and proper Persons Test –** To note Chief Executive Officer	**Enc H4**
16.6	**Annual Report –** To approve delegation arangements Chief Executive Officer	**Enc H5**
16.6	**Medical Revalidation Quarterly Report** - To approve Chief Executive Officer	**Enc H6**

Items for information

15 **Any Other Business** *as previously notified*

Date of Next Meeting The next public Trust Board meeting will be held on Tuesday 12 September 2017 in the Board Room at the Alex Hospital, Redditch.

Public Bodies (Admissions to Meetings) Act 1960

The Board is invited to RESOLVE: That under the provisions of Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Worcestershire NHS
Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON

WEDNESDAY 3 MAY 2017 AT 09:30 hours

Present:

Chairman of the Trust:	Caragh Merrick	Chairman
Board members: (voting)	Michelle McKay	Chief Executive
	John Burbeck	Non-Executive Director
	Philip Mayhew	Non-Executive Director
	Bryan McGinity	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Jim O'Connell	Interim Chief Operating Officer
	Jill Robinson	Chief Financial Officer
	Andrew Short	Acting Chief Medical Officer
	Chris Swan	Non-Executive Director
	Bill Tunnicliffe	Non-Executive Director
Board members: (non-voting)	Mark Yates	Associate Director
	Haq Khan	Acting Director of Performance
	Sarah Smith	Director of Planning and Development
	Denise Harnin	Director of HR & Organisational Development
In attendance:	Tim Carter	Head of Executive Office
	Rebecca Bourne	Head of Communications
	Lynn Miles-Price	Minuting Secretary
Public Gallery:	Press	0
	Public	4
Apologies:	Stewart Messer	Chief Operating Officer
	Kimara Sharpe	Company Secretary

01/117 **WELCOME**

Mrs Merrick welcomed members of the public to the Board meeting. She also welcomed the new Chief Executive, Mrs Michelle McKay, to her first meeting.

02/17 **PATIENT STORY**

Mrs Merrick introduced Mrs Vicky Morris, the newly appointed Chief Nursing Officer, to her first meeting. In her position as Chair, she stated that this was a wonderful opportunity to have two permanent appointments in key positions. Mr Jim O'Connell, Interim Chief Operating Officer, also joins the Trust with a

strong track record and she was delighted to welcome him to help with part of the challenges facing the Emergency Department. Mr Mark Yates attends his first meeting as a new Associate Director. He will become a full non-executive Director when Mr Burbeck steps down at the end of his term of office. Mrs Merrick took the opportunity to thank Mr Burbeck for his outstanding contribution to the Trust.

Mrs Merrick explained that the theme for today's meeting revolves around patient safety and a number of items on the agenda will be focusing on this and how the Trust can respond to and mitigate for risks. The Board's Away-Day in June will allow members to consider how they would like to expand coverage of the patient experience and will be working with Mrs Morris on this.

Mrs Morris introduced the patient story by explaining that Ms Lisa Thomson, Director of Communications, had received a letter from the patient's wife. She went on to give the background to the patient's experience and wanted to reiterate Ms Thomson's comments that it was a privilege to meet with this lady during a follow up visit and felt that this family's experience should be shared with the Trust Board and at a later point with the staff.

Mrs Morris stated that the issues in this story resonate across some of our Inpatient Survey results and highlight many failures on our part to communicate with the patient and his wife. Mrs Morris emphasised the importance of placing the patient at the heart of everything we do and that a number of the issues raised will be addressed through the Quality Improvement Strategy and responding to the Inpatient Survey. She advised that she will also be picking this up with the senior nurses and sharing that with them in respect of how we communicate.

The Board thanked Mrs Morris for bringing this heartfelt story to the meeting. Dr Tunnicliffe emphasised the importance of delivering care in the right place, by the right person at the right time. Mr Burbeck commented that from recent ward visits he had spoken to patients who had received good communications from staff but that it was clear, as an organisation, there were inconsistencies. He felt it incumbent on the Trust Board that it knows where this is not happening and to ensure that the appropriate steps are put in place to address the problem.

Mrs McKay agreed with all of the comments made and advised that part of her role was to see each complaint that comes into the organisation and she has received other complaints that touch on this issue. She felt that our view of the patient experience needs to be seen from the other side of the lens.

Mrs Merrick commented that she felt horrified by this lady's experience and found it unacceptable. She added that it was important for us to deal with complaints in a human way. The Chair encouraged the Executive not to habitually defend the organisation, as the Trust needs to respond to the patient's experience and it was clearly very helpful to go and meet with patients. 'Deep dives' into the patient experience will form part of that and as a Board we need to review where the focus needs to be.

Resolved: that
The Board

- Noted the content of the story

03/17 **ANY OTHER BUSINESS**
There were no items of any other business.

04/17 **DECLARATIONS OF INTERESTS**
It was noted that there will be a new director in post and the updated declarations of interest will be posted on the website by the end of this month.

There were no further declarations of interest.

05/17 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 1 MARCH 2017**
Resolved that:-

- The Minutes of the public meeting held on 1 March 2017 be confirmed as a correct record and be signed by the Chair with the amendment of the typographical error noted.

06/17 **MATTERS ARISING/ACTION SCHEDULE**
The Board noted that all the actions had been completed or not yet due.

07/17 **Chairman's Report**
There were no specific items of business to report at this time.

08/17 **Chief Executive's Report**
Mrs McKay briefed the Board on the key areas she and the Executive would be focusing on during the first month of her tenure. The objectives were set out in item two of the report – Staff Engagement and External Engagement.

Mrs McKay would also be requesting that the Board confirms the Chief Executive as Corporate licence holder for the Human Tissue Authority (HTA).

Other headline issues covered within the report included:

- CQC activity;
- Next steps on the NHS Five Year Forward View
- New heart procedure at Worcestershire Royal; and
- General election purdah.

Resolved that:-
The Board

- Approved the Chief Executive as Corporate Licence Holder for the HTA.
- Noted the summary on Next Steps on the NHS Five Year forward view.
- Noted the Government's mandate to NHS England for 2017/18.
- Received the assurance within the report.

09/9 **Chief Executive's Review and Way Forward**
Mrs McKay firstly apologised for the lateness of this paper, which presents the Board with an overview of activities over the next few months, an early view as

to subsequent strategic planning and when proposals will be brought to the Board for consideration and approval. Key issues affecting the Trust are covered in detail within the report under the following headings:

- Investing in Staff
- Delivering better performance and flow
- Improving safety
- Stabilising finances
- Corporate Governance
- Strategic Planning

Mrs Merrick thanked Mrs McKay for her report and felt, notwithstanding the very short time she had been in post, it was a great opportunity to take stock and focus on what we have to look at in the future.

Mr Burbeck commented that he was really pleased to see this so early on in the Chief Executive's tenure, when it was so easy to get absorbed by an organisation. He enquired how engaged were the Executive with this piece of work and if certain aspects had been allocated to specific individuals.

Mrs McKay commented that the paper has been discussed with the Executive and certain responsibilities for certain activities became quite immediately obvious. Once this proposal has been endorsed by the Board responsibilities will become more specific. Dependent on any changes being proposed to the plan at this meeting, work should get underway later today.

Mrs Morris gave her endorsement to this and felt that the Board will see, through the papers it receives, that there will be a move away from being reactive and having a clearer focus moving forward.

Mr O'Connell agreed it was very helpful to have the plan set out like this. He commented that performance and flow will entail working closely with both the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO).

Ms Robinson also agreed this was very encouraging. Whilst recognising that we have managed to get the process piece of finance under control, she commented further steps forward can only be achieved by working with the quality, safety and operational side of the organisation.

Ms Smith welcomed the focus on strategic development and felt that it had been very difficult over the last 18 months to raise our heads above the immediate issues facing the Trust.

Mr Mayhew echoed the comments made by the Executive and emphasised the importance of clearly acknowledging what needs to be done. He felt this to be a helpful, honest assessment and hoped that its simplicity of focus could be retained.

Mr McGinity asked how the Chief Executive planned to engage with staff on the way forward.

Mrs McKay commented that part of the challenge was not to be too process focused. However, she did need a more detailed internal communications process. Mrs McKay advised currently there are a range of mechanisms that she is personally involved in, including drop in visits and the Weekly Messages published on the staff portal. However, these do need to be balanced with a very deliberate communications process.

Mrs Merrick reiterated that everyone welcomed the report and the clarity it provides over the next few months.

Resolved that:-
The Board

- Noted the contents of the report and endorsed the proposed way forward.
- Received the assurance within the report.

10/17 **AQuA – Advancing Quality Assurance – Board programme overview**
Resolved that:-
The Board

- Noted the variety of programmes offered in relation to quality control, improvement and planning.

11/17 **QUALITY OF CARE**

11/17/1 **Quality Governance Committee report**
Mrs Merrick explained the context of the QGC and felt that the meeting held on the 20th April 2017 reflected a point of transition. The Chief Nursing Officer will be the main lead for this Committee.

Dr Tunnicliffe outlined the work of the Committee during March and April 2017 and explained that he had great difficulty in reaching levels of assurance on risks in relation to patient safety and the mitigation of those risks. He welcomed the attendance of the new Executive team at the meeting and hoped this would be a sign of future engagement and a way of driving change forward.

Successes were reported in a number of areas, including pressure ulcers and infection control. However, other areas such as sepsis and mortality reviews remain a challenge. Dr Tunicliffe felt that with the right level of focus it will be possible to improve safety and performance, as exemplified by the NoF Pathway, which has managed to see a seismic change.

In terms of the process moving forward, he advised that he had held conversations with both the Chief Executive and Chief Nursing Officer on how the Committee can become more effective and hold those to account. Mrs Merrick commented that the challenge should not be under-estimated as we are progressing from a standing start.

In response to Mr McGinity's comment on Dr Tunicliffe's report to the Quality and Safety Improvement Group, he advised that he would like that to mature in the future. He has yet to see the report as it is still early in its development. This will become a monthly agenda item and will review, reflect and offer assurance to the Board.

Mrs Morris set out the expectations going forward, including very clear levels of assurance based on consistent models; action plans with leads and timescales to ensure traction and milestones. She advised she is currently working to

support staff on evidence and outcomes and hoped that in a short time the papers being presented to the QGC will provide a high level of information and detail being accessible, though not necessarily through volumes of paperwork.

Resolved that:-
The Board:-

- Expectations of items of business to be reviewed by the QGC to be agreed by Dr Tunicliffe and Mrs Morris. Board to be advised on changes made over the next couple of meetings and resulting improvements.
- Transparency and visibility of reporting should be clear to all non-executive directors not just those with clinical knowledge.
- The understandable focus on Section 29a should not distract from the basic things that need to be fixed.
- Noted the report

11/17/2 **Quality Improvement Plan (QIP)**

Mrs Morris presented the plan and a formal brief to the Trust Board on the recent Care Quality inspection. Key messages highlighted were:-

- Quality Improvement Plan performance, which had been presented to the Trust Board in March prior to submission to the CQC.
- There are currently 32 separate action plans grouped into three main themes: urgent care and flow; safe and effective care and governance and risk.
- Delivery of the plan will be governed through the Quality and Safety Improvement Group (QSIG) which meets fortnightly and reports to the Quality Governance Committee (QGC).
- Reporting of the Plan by the QSIG will be by exception and the main discussion on the issues arising there from.
- Unannounced CQC Inspection visit on 11/12th April focused on gaining assurance regarding the section 29a response provided by the Trust.
- CQC overview of preliminary findings is covered later in the minutes.
- Approach to Quality Improvement for 2017/18 set out. A full proposal for that process will be developed and considered in the next Public Board meeting in July 2017.

Mrs Merrick invited questions from those present.

Mr Mayhew commented that he wanted to be assured on the transition between the current reactive plan and the longer term responsiveness plan.

Mrs Morris explained that many of the issues within the plan are fundamental in nature and need to be our top priorities. Those issues very clearly focus on sustained improvement and address core and fundamental standards.

Mrs Morris briefed the Board on the work she is currently undertaking with senior nurses regarding setting out expectations and making improvements. There is a clear nursing voice and during discussions it was agreed that this should be a collective nursing voice. Those discussions have resulted in a statement of intent, which will be signed by the senior nurses and the CNO.

Mrs Merrick stated that the examples given by Mrs Morris are the type of activities that the non-executive directors should be able to observe during their ward visits.

Mr McGinity expressed concern that on a number of ward visits he had been asked what is the latest update regarding the CQC visit and felt that a clear communications process is vital. Mrs Morris agreed and stated that subsequent team briefings need to be considered.

Dr Tunicliffe commented that he had confidence in the newly created SQUID data dashboard and its capacity to provide ward to board information. This should be a key element in supporting the CNO and will have absolute visibility on what is happening at ward level. Mrs Merrick added that it was very easy to use and allows the user to drill down and to see where the issues are.

<u>CQC preliminary findings – full details contained in main report</u>

• Areas of improvement since last inspection include:-
- Pressure area care good across sites visited; and
- Assessment of Paediatric Early Warning Score (PEWS) well managed in ED at the Alexandra Hospital (AH) and had improved at the Worcestershire Royal Hospital (WRH). However, CQC found that at WRH PEWS triggers were not consistently being escalated.

• Areas for improvement include:-
- Initial Venous thromboembolism (VTE) generally completed, although reassessment in line with Trust and national guidance remained poor. Good practice in other areas has been identified and will be rolled out;
- Continues to be lack of awareness and appropriate training of staff in safeguarding children. Trust has an agreement with Health and Care Trust to carry out training. Rapid improvements are required in this area.

Mrs Morris was disappointed that the CQC inspection had found inconsistencies with staff washing their hands, or to have been observed washing their hands and further work needs to be carried out to reduce variations in practice.

Mrs Morris stated that she would like to see the current phase of closures being addressed by the end of May 2017. She added there was a need to be very aspirational in terms of tolerance levels.

Resolved that:-
The Board:-
- **Received the update on the Quality Improvement Plan.**
- **Noted the summary points received from CQC.**
- **Agreed that Quality Governance Committee will provide detailed governance overview and scrutiny to a planned prospective QIP.**
- **Noted the plans for a three year QIP, which will be brought to July Trust Board meeting for approval.**

12/17 FINANCE AND USE OF RESOURCES

12/17/1 Finance and Performance Committee

Mr Burbeck reported on the work of the Committee at its meetings on 29th March and 26th February. He stated that the Trust has now got control of its finances. However, we do go into another challenging year with monthly overspend which needs to be pulled back. He added that he had a high level of confidence that the organisation can achieve the savings needed this year.

He then turned to operational performance, which is struggling in all four key areas. The Interim Chief Operating Officer and Chief Executive gave some reassurance that these issues are being addressed and by the next meeting expect to have more detailed plans and trajectories of what we can realistically expect.

Mr Burbeck advised that representatives from the Surgery Division attended and that the Committee were more assured following this visit that they were giving far greater thought and being realistic and thinking broadly.

In respect of the Workforce Report, Mr Burbeck commented that the Trust is barely treading water. The HR Director explained the Trust's latest approach to recruitment, which included looking at overseas appointments and enhanced advertisement campaigns.

Mr Burbeck updated the Board on the Trust's current capital position and advised that the Board are obliged to make a decision on whether the organisation is a Going Concern and recommended that the Board approval, subject to continued support.

Ms Robinson advised that the Trust has not received any adverse notifications that the DoH will not continue to what they have done in the past.

Resolved that:-
The Board

- Approved that the Trust is a Going Concern, subject to continued support.
- Noted the Trust delivered its control total for 2016/2017 with an overall improvement of £5.83m.
- Noted the approval of the 2017/18 Capital Programme.
- Noted the continued focus for improving the Trust's Operational targets

12/17/2 Financial Performance Report

Mrs Merrick asked that Ms Robinson particularly focus on what the report says about the future and the plan going forward. She commented that the report very clearly sets out the position in terms of numbers, showing a successful year-end close.

Ms Robinson stated that she felt that this was a turning point for the organisation, with focus on financial processes and controls being taken very seriously at divisional level. In reviewing the QIP, Ms Robinson considered the real focus is now on efficiencies and on agency spend. The end of this financial year has seen the divisions reduce agency spend by £10m and, as we go into the next financial year, that should be continued.

Ms Robinson drew the Board's attention to the fact that we have been supported very

well by the national finance funding (STF). The Trust has earned the full amount of the STF related to Financial delivery, but due to not meeting agreed operational performance targets has only earned the performance element for Q1.In addition to the incentive payment, the Trust has received notification from NHSI of a further STF bonus payment of £1.5m paid to providers that exceed their control total and committed to delivering this early. Ms Robinson stated that this will all support the Trust's cash position assurance to the Board.

Mrs Merrick expressed appreciation on behalf of the Board for all of the work undertaken by the Finance team and wanted to acknowledge at this point a job well done in getting a grip on the finances and the divisional impact.

Resolved that:-
The Board

- Noted the Trust's financial performance in month 12 and its financial position for the 2016/2017 financial year.

12/3/3 **Financial Plan**

Ms Robinson presented the report and highlighted two significant issues – operational flow and referral times for treatment.

Whilst acknowledging that we do have additional capacity and do have resources built into the plan, Ms Robinson was concerned that we continue to have additional capacity and all of the cost involved.

She also commented that cancellation of elective activity will result in impact on our plan as we will have to support the resulting additional activity.

Ms Robinson advised that the new Executive team will be re-validating the plans and risks associated with delivery, in particular on the Corporate side and how we can address the back office issues.

Ms Merrick invited questions from the Board.

Mr McGinity commented that £10m repatriation had originally been included in the plan but it now looks like not very confident first year.

Ms Robinson responded that it was not because the opportunities were not there. The organisation needs to look at additional efficiencies.

Mrs Merrick added that recruitment was clearly a big part of this.

Mrs Morris picked up a point on Quality Impact Assessment and advised that she and Ms Robinson were working closely on this process as it was felt it was not as robust as it needs to be. She added that the Board will need to examine that and make sure these are in place and signed off by the Executive.

Mrs Harnin advised that she is currently working on providing the Board with a medical workforce plan which looks across three years. Subsequently, we need to carry out an enhanced piece in terms of recruitment. Mrs Harnin outlined the following activities:-

- the Trust is currently working with overseas recruitment agencies and an overseas recruitment trip to India is planned for the beginning of July;
- the number of consultant appointment panels that are running is being tracked and it is hoped to see the dial start moving and to track movements on a more detailed basis. The tracking piece will go to the Executive meeting weekly until we get assurance; and
- job plans are also being reviewed to align capacity and demand.

Mr Mayhew commented that this was a real opportunity to improve productivity.

Mrs Morris agreed that despite picking up on the negative impacts, it will also identify possible opportunities.

Mrs Merrick emphasised how important it is for the Board to have assurance that the financial team is working with the Executive. As a Trust we need to have a more effective strategy moving forward. Understanding what is the amount we might need to invest in year to deliver some of the productivity and effectiveness objectives, so we can also have the opportunity to generate more internal funding through capital philanthropy. She felt that the opportunities to raise funds for the Trust are currently underutilised.

Mrs Merrick commented that the financial plan is quite complex and felt that it would be of benefit to use the forthcoming Away Day to explore some of the issues.

Resolved that:-
• Noted the Trust's financial position.
• Discussion of the Financial Plan to be included on the Away Day programme.

13/17 **OPERATIONAL PERFORMANCE**

13/17/1 **Integrated Performance Report**

Mr Khan presented the report for month 12 to the Board. He advised that work was currently underway developing the format of the report to create a more forward looking and action focused document. He welcomed feedback from the Board.

Mr Khan outlined following key issues:-

- Performance in respect of the 18 week Referral to Treatment (RTT) target has plateaued at c.84%;
- Some improvements seen in respect of 4 hour emergency access standard (EAS) – although these are not necessarily sustainable. Urgent action required on Care and Flow;

In respect of RTT still need to link back to the physical capacity and the link between what will it take to deliver RTT trajectory in terms of cost. He is currently working on triangulation with financial position.

Mr Khan advised that Jim O'Connell is currently reviewing A & E Care and Flow plan, with key focus on discharges and particularly on long stay patients. A more detailed trajectory is expected by the end of the month, which he felt is a significant step forward. Mr Khan and Mr O'Connell are currently meeting on a weekly basis to work on demand and capacity modelling.

Dr Tunnicliffe queried from the Board's perspective whether we can meet the backlog and achieve targets going forward whilst we have adverse run rate. He also asked if this balanced with the financial position.

Mr O'Connell advised that the Board will be seeing a clear exception report. We have submitted trajectories to NHS and these do not show compliance on RTT. Work currently underway looking at specialities where they are experiencing difficulties. Whilst he was unable to give reassurance at the moment, they were reviewing speciality by speciality – what is driving performance and how this squares with financial performance.

Dr Tunnicliffe emphasised that this has got to be our focus. Some of the issues highlighted have been glowing amber for some time and it is important to give the Chief Finance Officer the support she needs.

Mr O'Connell commented that it is not just in the RTT, Cancer and Diagnostics – the Evergreen Wards are still open far beyond where we want them to be.

Mr Swan raised the issue of the Trust having nearly 300 people on long term sickness absence and queried if it was related to performance. He asked if any analysis has been carried out and what remedial help has been given.

Mrs Harnin confirmed that the Trusts sickness target was c. 4% and would be able to provide the Board with a breakdown of this figure if required. She assured the Board that there is an active management plan for all long term sickness cases. She added that whilst this figure was running slightly above the Trust's target of 3.5% it does benchmark in the middle against the sector, but does need to be constantly managed. She also advised that staff are now able to self-refer to Occupational Health. Mrs Harnin confirmed that further details will be included within the interim report.

Mrs Merrick reflected that she has an over-riding sense that we need greatly, as a team, to have a sense of what we can do in the short term. Otherwise we are struggling to have a sense of improvement we can make, for example the work that has been undertaken with the #NoF. It is important for the new Executive team to recognise that for a long time the non-executives were receiving a lot of assurance about how things are changing in terms of new Executive and Board to take this Trust forward and it is necessary to take this elephant and eat it piece by piece.

Mrs Merrick's personal observation was that she has the confidence in the new Executive team and Board to assess situation quickly and confidently.

Resolved that:-
The Board

- Reviewed the IPR for month 12
- Sought assurance as to whether the risks of under-performance in each area have been suitably mitigated and plans are in place to improve performance.
- Interim report on Workforce Strategy will be presented to the Board at a later date.

14/17	**STRATEGIC CHANGE**
14/17/2	**Trust Management Group**

Resolved that:-
The Board

- Noted the report

14/17/3 **2017 General Election: Purdah Considerations for NHS Trusts**

Resolved that:-
The Board

- Noted the briefing issued by NHS Providers.

Mr McGinity raised a concern from the internal auditors in respect of applying the policy on waiting list initiatives across the organisation.

Mrs McKay advised the report that indicated limited assurance has been discussed.

Mrs Merrick commented that there will be an opportunity at next week's Private Trust Board meeting to take some important steps forward on the STP, led by the Director of Strategy & Planning.

159/16	**LEADERSHIP AND IMPROVEMENT CAPABILITY**
15/16/1	**Pulse Workshop**

Mrs McKay presented an overview of the Pulse Workshop and explained its concept of a clear focus on collective achievement and shared goals. In addition to the Board, the majority of the divisional medical directors and key senior staff were in attendance. The energy on the day was very high and feedback has been positive.

Resolved that:-
The Board

- To consider the proposal for the full roll out of this programme and that Board development to be considered via this process.

16/17	**STAKEHOLDERS**
16/17/1	There were no items to report at this meeting.

Resolved that:-
The Board

- To explore the development of a public engagement strategy as the 'way forward' plan develops.

17/17	**GOVERNANCE**
17/17/1	**Audit and Assurance Committee report**

Mr McGinity informed the Board that the report from the External Auditors showed that the work was on plan and that no issues of concern were raised.

The Director of HR and OD also attended the meeting and the Committee were satisfied with the progress made with the action plan for the expenses audit.

Following concerns noted at the previous meeting, Mr McGinity was pleased to

confirm that the Anti-Fraud officer was now attending induction.

Mrs Merrick expressed her concern at the difficulty in recruiting an associate non-executive director to the Board with a financial qualification. Unfortunately, the recent advertisement failed to deliver any suitable candidates. She asked members of the Board to advise if they knew anyone with suitable expertise who she could contact regarding the role.

Resolved that:-
The Board

- Noted the report from External Audit
- Noted the internal audit reports approved
- Noted the contents of the report

17/17/2 **Remuneration Committee Report**

The Board noted the key messages contained within the report.

Mrs Merrick thanked Mr McGinity for identifying the omission of the number of members constituting a quorum for this committee within the Terms of Reference previously presented. This has now been addressed and a copy of the revised Terms of Reference is included as an appendix to the report.

Resolved that:-
The Board

- Noted the contents of the report.

17/17/3 **Freedom to Speak Up Guardian (FTSUG) Update**

Mrs Harnin presented an update to the Board and requested that the Board endorse continuation of the current model whilst a review is taking place. Best practice models are emerging from and these are being reviewed in terms of finding a replacement for Mr Burbeck, who will be leaving the Trust in June.

Mrs Harnin advised that a paper outlining a review of concerns reported to date from the current Freedom to Speak Up Guardian and a recommendation in terms of a future model within this Trust based on benchmarking will brought to the Board in July 2017.

Mrs Merrick expressed her concern at the number of staff who continue to contact agencies such as the CQC and the importance of strengthening internal options for staff to be heard.

Resolved that:-
The Board

- Noted the contents of the report.

Congratulations to Meadow Birth Centre

Mrs McKay drew the Board's attention to the news that the Meadow Birth Centre has won the national 'Birth Centre of the Year' award at the annual MaMa Awards in Scotland. This was a fantastic achievement for all those involved.

DATE OF NEXT MEETING

The next Trust Board meeting will be held on Wednesday 5 July 2017.

There were no questions from the public gallery.

The meeting closed at 11:50 hours.

Signed _____ Date _____

Caragh Merrick, Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT JUNE 2017

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
3-5-17	Quality of Care	11/17/1	Quality Governance Committee report. Items of business reviewed by QGC to be discussed by Vicky Morris and Bill Tunnicliffe. Board to be kept updated of resulting improvements.	VM				
3-5-17	Quality Improve-ment Plan (QIP)	11/17/2	Plans for three year QIP to be brought back to the Trust Board for approval.	VM	July 2017			
3-5-17	Financial Plan	12/3/3	Discussion of the Financial Plan to be included on the Away Day programme.	JR	June 2017			
3-5-17	Operational Performance	13/17/1	Interim report on Workforce Strategy to be presented to the Board,	DH	Date Tbc		LMP to check with Sandra Berry on current status of report.	
			Interim COO to provide assurance around the risks of the under-performance and actions going forward.	JO'C	July 2017			
3-5-17	Pulse Workshop	15/16/1	Board to consider proposal for full roll-out of this programme.	MMcK	June 2017		Business case approved at Private Trust Board 10-5-17. First meeting of Culture Steering Group held 1-6-17.	

3-5-17	Stakeholders	16/17/1	Explore the development of a Public Engagement Strategy as the 'Way Forward' plan develops.	MMcK				

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 5 July 2017 **Enc C1**

Report to Trust Board

Title	**Chief Executive's Report**
Sponsoring Director	**Michelle McKay, Chief Executive**
Author	**Michelle McKay, Chief Executive**
Action Required	The Board is asked to • Note the contents of this 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	All BAF risks are covered.
Legal Implications or Regulatory requirements	None
Glossary	

Key Messages

Title of report	Chief Executive's Report
Name of director	Michelle McKay

Date of meeting: 5 July 2017 **Enc C1**

WORCESTERSHIRE ACUTE HOSPITAL NHS TRUST

REPORT TO PUBLIC TRUST BOARD – 5 JULY 2017

1 Background

This report aims to brief Board members on various issues.

2 Fire Safety

Following the tragic events at Grenfell Tower, London fire safety has been in sharp focus for both public and private organisation in the past few weeks. I have recently sought additional information and assurance about the fire safety measures in place in the Trust buildings from the Director of Asset Management & ICT and have been assured of the following:

- All of the Trust's buildings currently have in place Regulatory Reform (Fire safety) Order 2005 fire risk assessments completed within the last three months by an Institution of Fire Engineers Accredited Fire Risk Assessor (Life Safety for Complex Buildings)

- The Trust has developed and is implementing a number of programmes of work to eliminate or reduce to as low as reasonably practicable the fire risks identified by the fire risk assessments. The majority of these programmes are to address normal anticipated wear and tear and life cycle replacements of fire safety systems including Fire Compartmentation and Fire Doors

- The Trust has not been subject to any formal enforcement action or to the issue of any letters of improvement by the Fire & Rescue Authority relating to fire safety matters

- Our fire safety adviser carries out monthly walk-through audits of all fire evacuation routes from inpatient areas to ensure no obstructions or combustibles are impacting upon Progressive Horizontal Evacuation capability

- In areas of temporary high fire risk such as A&E during overcrowding periods these walk-through evacuation route audits are increased to weekly together with daily departmental fire warden checks

- Our fire safety advisor, Estates Team and PFI providers have assessed the use of cladding materials and consider there to be no significant external cladding fire risks on any Trust building

- The fire service inspected all three sites on 28 June and identified that, while there were some examples of issues such as fire doors being wedged open, that the situation was improved since the last inspection, particularly at the Worcester site.

Date of meeting: 5 July 2017 **Enc C1**

3 Care Quality Commission (CQC)

Following release of the reports of the November 2016 inspection by the CQC on 20 June 2017, a number of media briefings/interviews were undertaken in addition to staff briefings at all three sites. The staff meetings were generally well attended and staff were positively engaged in their discussion at those meetings. There were many positive comments, particularly, concerning the focus on looking after themselves over this period. It is anticipated that the CQC will release the report into their April unannounced and announced visits during July.

4 Healthwatch annual conference

The Healthwatch annual conference was held on 29 June 2017. I was part of a panel, including other NHS CEOs, to respond to a range of questions from the attendees. Prime areas of discussion during the session included the impact of the STP and mental health. Healthwatch also released their report into the care provided in the ED corridors, which was an action following the risk summits in winter. This document and our response are highlighted further on the agenda.

9 Recommendation

The Board is asked to

- Note the contents of this report

Michelle McKay
Chief Executive

Date of meeting: 5 July 2017 **Enc C1**

Five Year Forward View- Next Steps

EXECUTIVE SUMMARY

1. Next year the NHS turns 70. New treatments for a growing and aging population mean that pressures on the service are greater than they have ever been. But treatment outcomes are far better - and public satisfaction higher - than ten or twenty years ago.

2. With waiting times still low by historical standards but on the rise, and the budget growing - but slowly - it is the right time to take stock and confront some of the choices raised by this challenging context. This plan is not a comprehensive description of everything the NHS will be doing. Instead, it sets out the NHS' main national service improvement priorities over the next two years, within the constraints of what is necessary to achieve financial balance across the health service. (Chapter One)

3. Perhaps most importantly, we all want to know that the NHS will be there for us and our families when we need it the most - to provide **urgent and emergency care** 24 hours a day, 7 days a week. Staff are working with great skill and dedication to do so, and looking after more patients than ever. But some urgent care services are struggling to cope with rising demand. Up to 3 million A&E visits could have been better dealt with elsewhere. There are difficulties in admitting sicker patients into hospital beds and discharging them promptly back home.

4. That's why over the next two years the NHS will take practical action to take the strain off A&E. Working closely with community services and councils, hospitals need to be able to free up 2,000-3,000 hospital beds. In addition, patients with less severe conditions will be offered more convenient alternatives, including a network of newly designated Urgent Treatment Centres, GP appointments, and more nurses, doctors and paramedics handling calls to NHS 111. (Chapter Two)

5. Most NHS care is provided by **general practice**. One of the public's top priorities is to know that they can get a convenient and timely appointment with a GP when they need one. That means having enough GPs, backed up by the resources, support and other professionals required to enable them to deliver the quality of care they want to provide.

6. We have begun to reverse the historic decline in funding for primary care, and over the next two years are on track to deliver 3,250 GP recruits, with an extra 1,300 clinical pharmacists and 1,500 more mental health therapists working alongside them. As well as improved access during the working week, bookable appointments at evenings and weekends will be available covering half the country by next March, and everywhere in two years' time.

7. **Cancer** remains one of the public's most feared illnesses, affecting more than one in three of us in our lifetimes, meaning most of us will face anxiety of ourselves or a loved one receiving this diagnosis at some point. Fortunately cancer survival rates are at record highs, and an estimated 7,000 more people are surviving cancer after NHS treatment than would have three years before. Identifying cancer earlier is critical to saving more lives. So we will speed up and improve diagnosis, increase current capacity and open new Rapid Diagnostic and Assessment Centres. Patients will have access to state of the art new and upgraded

linear accelerators (LINACs) across the country. By taking these actions we expect at least an extra 5,000 people to survive their cancer over the next two years.

8. Increasingly, the public also understand that many of our lives will at some point be touched by **mental health** problems. Historically, treatment options for mental health compare unfavourably with those for physical conditions, particularly for children and young people. The public now rightly expect us to urgently address these service gaps.

9. Substantially increased investment will enable 60,000 more people to access psychological, or 'talking' therapies, for common mental health conditions over the coming year, rising to 200,000 more people in 2018/19—an increase of over 20%. We will also address physical health needs by providing an extra 280,000 health checks in 2018/19 for people with severe mental illness. New mothers will get better care. Four new Mother and Baby Units across the country, more specialist beds and 20 new specialist perinatal mental health teams will provide help to 9000 more women by 2018/19. An extra 49,000 more children and young people will be treated by community services. Both children and adults will benefit from reduced travel distances when they need inpatient care through an expansion and rebalancing of specialist beds around the country. 24-hour mental health liaison teams in A&Es, investing in crisis response and home treatment teams and placing 1,500 therapists in primary care will ensure more people get appropriate care when they need it.

10. As people live longer lives the NHS needs to adapt to their needs, **helping frail and older people stay healthy and independent**, avoiding hospital stays where possible. To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. Early results from parts of the country that have started doing this – our 'vanguard' areas – are seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country. The difference has been particularly noticeable for people over 75, who often face a revolving door of emergency admission, delayed discharge and then hospital re-admission.

11. We now want to accelerate this way of working to more of the country, through partnerships of care providers and commissioners in an area (Sustainability and Transformation Partnerships). Some areas are now ready to go further and more fully **integrate their services and funding**, and we will back them in doing so (Accountable Care Systems). Working together with patients and the public, NHS commissioners and providers, as well as local authorities and other providers of health and care services, they will gain new powers and freedoms to plan how best to provide care, while taking on new responsibilities for improving the health and wellbeing of the population they cover.

12. Mirroring this local action, we will also be taking further action nationally to ensure that the NHS can deliver more benefit for patients from every pound of its budget. While the NHS is already one of the leanest publicly-funded health services in the industrialised world, there are still opportunities to do better, as set out in the **NHS' 10 Point Efficiency Plan.**

13. None of this is possible without the outstanding **staff** of the NHS. Although we have 3,000 more doctors and 5,000 more nurses than 3 years ago, and productivity continues to

improve, frontline staff face great personal and organisational pressures from rising demand. As a crucial part of delivering the next steps of the Five Year Forward View, we therefore set out in this document how we will continue to support the NHS frontline over the next two years, with Health Education England expanding current routes to the frontline, and opening innovative new ones to attract the best people into the health service, whatever stage of their career they are at.

14. In doing so, the NHS is on a journey to becoming one of the **safest** and most transparent health systems in the world. Chapter Nine describes next steps on this agenda. As well as harnessing people power, the NHS also needs to leverage the potential of **technology and innovation,** enabling patients to take a more active role in their own health and care while also enabling NHS staff and their care colleagues to do their jobs - whether that is giving them instant access to patient records from wherever they are, or to remote advice from specialists.

15. There are considerable risks to delivery of this stretching but realistic agenda, but taken together the measures set out in this plan will deliver a better, more joined-up and more responsive NHS in England. One that is focussed on the issues which matter most to the public. That collaborates to ensure that services are designed around patients. And that is on a more sustainable footing, so that it can continue to deliver **health and high quality care - now and for future generations**.

Worcestershire NHS
Acute Hospitals NHS Trust

Enc C2

Report to Trust Board

Title	**Chief Executive Review and Way Forward Update**
Sponsoring Director	**Michelle McKay, Chief Executive Officer**
Author	**Michelle McKay, Chief Executive Officer**
Action Required	The Board is asked to: **note** the contents of this report
Previously considered by	Trust Leadership Group

Priorities (√)

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

Related Board Assurance Framework Entries	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels 2790 As a result of high occupancy levels, patient care may be compromised 2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity and missed opportunities 2904 If there is inadequate culture and staff development for improvement, the Trust will not be able to continuously improve 3038 If the Trust fails to improve performance, strengthen governance and patient safety it will not address CQC inspection concerns 3291 Deficit is worse than planned and threatens the Trust's long term financial sustainability
Legal Implications or Regulatory requirements	
Glossary	

Worcestershire NHS
Acute Hospitals NHS Trust

Enc C2

UPDATE 'WAY FORWARD PLAN'
29 JUNE 2017

1. Situation

Following endorsement of the 'Way Forward' plan by the Trust Board on 3 May 2017, this paper provides an update on progress to date against the strategies and timelines identified in the original plan and incorporates additional actions determined against the key areas identified.

Many of the areas of focus that were identified for action over this three months are progressing as planned and approaching finalisation. The development of a three year plan is complete which will replace this initial way forward process.

2. Background

The situation that the Trust is in currently sees challenges across the spectrum of quality service provision, performance against KPIs, financial sustainability and culture. The 'Way Forward' plan was endorsed by the Board on 3 May 2017, with the request for monthly updates on progress. It was also recognised that the plan was a living document and would have other initiatives added as time progressed. It is important to note that the plan does not incorporate all activity underway in the Trust's priority areas but instead focusses attention on those that are necessary for the Trust to succeed.

3. 'Way Forward' Plan components

Investing in Staff

Recruitment

- Recruitment plan completed – May
- Workforce workshop with NHS Improvement – May
- Additional recruitment strategies implemented – June
- Comprehensive Workforce strategy approved - July
- Measure of success – decreasing vacancy rate from July

Finalisation of the recruitment plan has been delayed due to the absence of the HR Director. Additional resource has been identified from a neighbouring Trust to complete the recruitment plan. This is scheduled for completion by 7 July. However a number of actions are being progressed including Facebook 'Work for us Wednesday' campaign commenced, filming of a recruitment video, Skype interviews

and preparation for overseas recruitment trip in July, as previously approved by the Board.

The workshop with NHS Improvement (NHSi) has also been delayed due to availability of key staff, but occurred on 21 June which produced advice about a number of key contacts and focus areas to be incorporated into the plan.

Data for medical vacancy rates in May shows a current rate of 160 with 70 doctors appointed but starting over the next three months. Projected vacancy rate is 88 for July and 84 for August.

Additional resource from a neighbouring Trust has agreed to develop the Workforce Strategy with the intention that this is completed by end August.

Staff engagement and culture change

- Initial workshop held – April
- Proposal for culture change program approved – May
- Signature behaviours agreed – June
- Board and Exec Pulse survey process commenced – July
- All staff Pulse survey process commenced – August
- Measure of success – demonstrable increase in staff engagement and safety focus from July

Verbal approval was obtained from NHSi to proceed with the preparation work for the culture change program. Two workshops have been held with Board and senior leaders and the signature behaviours have been agreed. The culture committee has had its first meeting.

The Board and Exec survey process began on 19 June. Debrief, both team and individual, will commence on 24 July. Staff engagement groups have occurred across the three sites to finalise the detailed planning necessary for the program. It is anticipated that the planning for the full program, including internal and external communications, will be considered by the culture committee in July. Discussion continues with NHSi on the business case for the balance of the program.

Delivering better performance and flow

SAFER

- Plan for intensive Red-2-Green week approved – May
- Intensive Red-2-Green week – June
- Measure of success – attainment of (KPIs) as per trajectory

The stranded patient daily review process has been in place for four weeks. The intensive Red-2-Green week at the Worcester site is

underway, following the six week lead-in process. Throughout May, this has resulted in a decrease by 60 in the number of stranded patients, occupancy dropped 3%, ambulance handovers >60 minutes halved and use of escalation beds dropped by 24. The Alex EAS has regularly hit 90%. Many learnings are coming from the intensive Red-2-Green week and it has been determined that we will continue with the intensive process at Worcester, rather than move to the Alex site.

Capacity and Demand

- Proposal approved – May
- Analysis of capacity and demand – June
- Implementation of new scheduling and job planning – July
- Measure of success – attainment of KPIs as per trajectory

Contract for this work has been awarded with the work commenced in June, as scheduled.

Capital works in Emergency Department

- Proposal approved by Trust Leadership Group – June
- Measure of success – enhancement of ED streaming post construction and subsequent attainment of KPIs as per trajectory

The preferred capital option has been agreed with design and costing underway. A three phase service development plan has been developed starting with primary care streaming in ED, full primary care and MAU streaming and finally co-location of GP out of hours service into ED.

Improving safety

Board Development

- 12 month board development program, with a focus on safety, determined – June
- Board development program commenced – June
- Measure of success – Board members have shared knowledge of safety, patient experience, risk etc

On 6 June, AQuA conducted a 'Defining Excellence – the Board's role in driving safety and quality' session for the Board. Finalisation of the full 12 month Board program is underway and will be considered by the Board on 5 July.

Risk Management

- Risk management strategy approved by Board – June

- Board review of strategic risks – June
- Training program for senior staff – June/July
- Refresh of divisional risk registers – July
- Measure of success – demonstrated use of risk management process informing organisational decisions

The corporate risk register has been reviewed and a revised risk management strategy has been developed and endorsed by the Trust Leadership Group. The Board have undertaken a strategic risks review, facilitated by Grant Thornton on 6 June. Training is underway with divisional risk register review occurring. The BAF and risk management strategy will be considered by the Board on 5 July.

Quality Improvement Strategy

- Meeting with NHS Improvement (NHSI) patient experience lead – May
- Quality Improvement Strategy approved – July
- Measure of success – approach to quality aligned to 'normal business'

The prime area of focus concerning quality has been in progressing the actions arising from the s29A notice and moving away from task based processes to embedding quality in 'business as usual'. Themes have been developed, statement of intent, quality assurance for fundamental standards and quality improvement with a schedule of work over the next three months developed. The Quality Improvement Plan for the next year, encompassing the findings of the CQC report from the inspection in November 2016 will be considered by the Board on 5 July.

Stabilising our finances

- Analysis of Model Hospital benchmarking data – May
- Identification of areas of opportunity – June
- Detailed plans approved – July
- Financial sustainability strategy approved - September
- Measure of success – attainment of 2017/18 financial plan

This work is on track with identification of opportunities underway.

Corporate governance

- Review and amendment of committee structure – June
- Measure of success – reduction in number of meetings and increase in meeting effectiveness and decision making

The Director of Governance UHCW, has commenced a review of corporate governance arrangements. Planning has also started to

enable a self-assessment against the well-led framework in July leading to an independent review against the framework in September.

Strategic planning

- Clinical service strategy, incorporating technology and estate planning – September
- Measure of success – clarity regarding future service configuration and cost for implementation.

Acute medicine strategy currently being considered by Division of Medicine. Frailty strategy development underway. Clinical Commissioning Groups announcing decision on 'Future of Acute Hospital Services in Worcestershire' in July, following public consultation on the proposed model.

4 Recommendation

The Board is asked to note the contents of this report.

Michelle McKay
Chief Executive Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Enc C3

Report to Trust Board

Title	**Board Development Program**
Sponsoring Director	**Michelle McKay, Chief Executive Officer**
Author	**Michelle McKay, Chief Executive Officer**
Action Required	The Board is asked to: **approve** the contents of this report
Previously considered by	

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	

Worcestershire NHS
Acute Hospitals NHS Trust

Enc C3

BOARD DEVELOPMENT PROGRAM

1. Situation

A component of the 'Way Forward' plan is a Board development program. This paper proposes an approach for the Board's consideration.

2. Background

The membership of the Trust Board is largely new, with a number of the newly appointed Non-Executive Directors not having experience in the health system. The proposed development program is designed to provide opportunity for a more detailed understanding of components of the health system, in addition to a personal development program which is a component of the Trust wide cultural change program. Further, the well led framework assessment process will also be utilised to support Board development.

3. Assessment

Cultural Change program

The Board and Exec survey process began on 19 June. A Board wide debrief has been scheduled for 2 August to discuss the results. This process will also provide a 'Net Leadership Score' for the Board. This process will continue over the next three years and enable the Board to monitor the collective leadership capability. Individual Board members will have one-to-one debrief and mentoring sessions which will commence on 24 July.

Quarterly program

It is proposed that a quarterly program be instituted for the Board to enable a more detailed focus on aspects that are relevant to the Board's responsibilities and understanding of the health system. This program began at the first 'away day' on 6 June with the first component being a focus on safety, quality and strategic risk. AQuA conducted a session entitled 'Defining Excellence – the Board's role in driving safety and quality' and Grant Thompson conducted a session on strategic risk which enabled the Board to then consider organisational risks and risk appetite.

A further three such sessions are proposed over the remainder of the financial year. Those sessions would cover frailty, urgent care and patient experience. It is envisaged that each session would include

involvement of experts in the field and the Board then considering the impact on the Trust. These sessions would, therefore, provide both a developmental opportunity for the Board in the context of deeper understanding of the relevant issue, as well as the opportunity for the Board to work together to review how the Trust is, or should be, responding to the particular topic.

Well led Framework

The 'Way Forward' plan articulated a self-assessment against the CQC well led Framework followed by an external assessment. It is proposed that the self-assessment consist of three phases:

- A documentation review to be conducted by the Deputy Company Secretary and the Improvement Director
- A review of the Board and Board committee processes to be conducted by NHSi
- A self-assessment to be completed, separately, by the Non-Executive Directors and by the Trust Leadership Group, culminating in a collective Board agreement on self-assessment

It is anticipated that these components will be conducted through July and August with an external assessment occurring in October.

4 Recommendation

The Board is asked to consider and approve the proposal.

Michelle McKay
Chief Executive Officer

Worcestershire NHS
Acute Hospitals NHS Trust

"Improve, Inspire, Innovate"

Quality Improvement Plan

Worcestershire NHS
Acute Hospitals NHS Trust

Contents

Background & Summary

CQC Inspection July 2015

The Chief Inspector of Hospitals visited the Trust in July 2015 and published the findings in December 2015. The Trust was rated overall as *'Inadequate'*. The Trust had had a previous unannounced and focussed inspection of ED in March 2015 which resulted in a number of Section 29 Warning notices and weekly monitoring returns to the CQC of ED triage times.

CQC Unannounced Inspection July 2016

Following concerns raised directly to the CQC by a whistle-blower the CQC carried out an unannounced inspection of radiology services. This resulted in a section 31 notice and the trust has remained on weekly monitoring since that time.

Overall rating Nov 2016	Inadequate	
Are Services Safe?	Inadequate	
Are Services Effective?	Requires Improvement	
Are Services Caring?	Good	
Are Services Responsive?	Inadequate	
Are Services Well-led?	Inadequate	

CQC Re- Inspection November 2016

The Trust had its scheduled re-inspection 22 – 25 Nov 2016 followed by a number of unannounced visits. Following this inspection, the level of concern was such that a Risk summit was called by NHSI on the 22 Dec 2016. Whilst the focus of this summit was on the safe care of patients in Urgent Care the CQC raised a number of other areas of concern which included safe medicines management, care of patients on CPAP in paediatrics and safe staffing and monitoring of escalation areas. A follow up risk summit was held on 18 Jan 2017. The Trust then received a section 29A Warning Notice from the CQC outlining concerns at all three sites. The final report from this visit was published on 20 June 2017. This showed a decline in the overall Responsive domain rating from Requires improvement to Inadequate.

CQC Unannounced Inspection April 2017

The CQC undertook an unannounced inspection to review progress against the Section 29A Warning Notice in April 2017 followed up by interviews with the Executive Team and staff focus groups. On this inspection they did not find sufficient evidence to demonstrate that the requirements of the Warning Notice had been met. The report from this visit is due to be published in July 2017

Following on from receipt of the Section 29A Warning Notice a Quality Improvement Plan (QIP) was developed and an internal monitoring group (the Quality & Safety Improvement Group) was established chaired by the Chief Executive. Any outstanding actions from that QIP have either been moved into this updated QIP presented below or into business as usual.

Who is Responsible?

- Our initial actions (focusing on the 'Must' and 'Should Do's') to address the Section 29A Warning notice of January 2017 were agreed by the Trust Board in March 2017
- Trust leaders have developed this Quality Improvement Plan which was ratified by the Trust Board on 5 July 2017, provided to the CQC on 6 July and reviewed at the Quality Oversight Group meeting on 10 July.
- The Chief Executive is ultimately responsible for implementing actions in this document. The Chief Medical Officer, Dr Suneil Kapadia provides the executive leadership for safety and clinical effectiveness and the Chief Nurse, Vicky Morris provides the executive leadership for Quality, CQC regulation and compliance.
- The Trust works closely with NHS Improvement, specifically the Improvement Director allocated to the Trust, Cathy Geddes and the Regional Team, who ensure delivery of the improvements and oversee the implementation of the Quality Improvement Plan.
- Ultimately the success in implementing the recommendations of the Quality Improvement Plan will be assessed by the Chief Inspector of Hospital upon re-inspection of our Trust
- If you have any questions about progress on implementation, contact Vicky Morris at: Vicky.morris@nhs.net

How we will communicate our progress to you

We will update this progress report every month while we are in Special Measures and the Quality Improvement Plan will be available for access following approval by the Quality Oversight Group and the Trust Board.

Chair / Chief Executive Approval (on behalf of the Board):

Chair Name: Caragh Merrick	Signature:	Date:
Chief Executive Name: Michelle Mckay	Signature:	Date:

The CQC findings – A summary

This section provides a summary of the CQC's findings about services at Worcestershire Acute Hospitals NHS Trust. Summary report and full CQC report can be found on the Worcestershire Acute Hospitals Web Site www.worcsacute.nhs.uk or the CQC website: www.cqc.org.uk

General

There had been deterioration in the quality of services provided since the previous inspection in 2015 with a decline in the Responsive domain from "Requires Improvement" to "Inadequate". The trust was rated as Inadequate overall and across all three hospital sites. It was rated as Inadequate for being safe, responsive and well-led, Requires Improvement for being effective and Good for being caring. End of Life Care was rated as Good on both the Alexandra Hospital and Worcestershire Royal Hospital sites and Critical Care services were rated as Good at the Alexandra Hospital site.

1. Ensuring Services are safe

The CQC rated the safety of our services as '*inadequate'*. They found a culture of reporting, investigating and learning from incidents but inconsistencies in external reporting for serious incidents. Staffing within the Emergency Department at the Worcestershire Royal site was not in line with national guidance; however, most other areas had adequate staff to ensure patients received safe care and treatment. Management and storage of medicines was poor with a lack of a robust process being in place for monitoring and reporting fridge temperatures. Too many patients were receiving care in the corridors of our Emergency Departments, particularly at the Worcester site, sometimes being placed near exit doors and out of the line of staff's sight.

2. Ensuring Services are effective

The CQC rated the effectiveness of our services as '*requires improvement'*. The Trust mortality indicators (HSMR and SHMI) at the time were both above the national average. Our performance in national audits was poor with some areas performing significantly worse than the England average. Robust action plans were not in place to ensure improvement and there was no standardised approach to local audits. Mandatory training for staff was below the Trust standard in most areas and not all staff understood their obligations under the MCA and DOLS, meaning our most vulnerable patients were potentially at a higher risk of not receiving all the care they need.

3. Ensuring Services are caring

The CQC rated the caring of all our services as '*good'*. They observed staff delivering compassionate care, involving patients in decision making, whilst providing good emotional support to patients and people close to them. However, the privacy and dignity of patients being cared for in corridors within the ED departments was often compromised.

4. Ensuring services are responsive

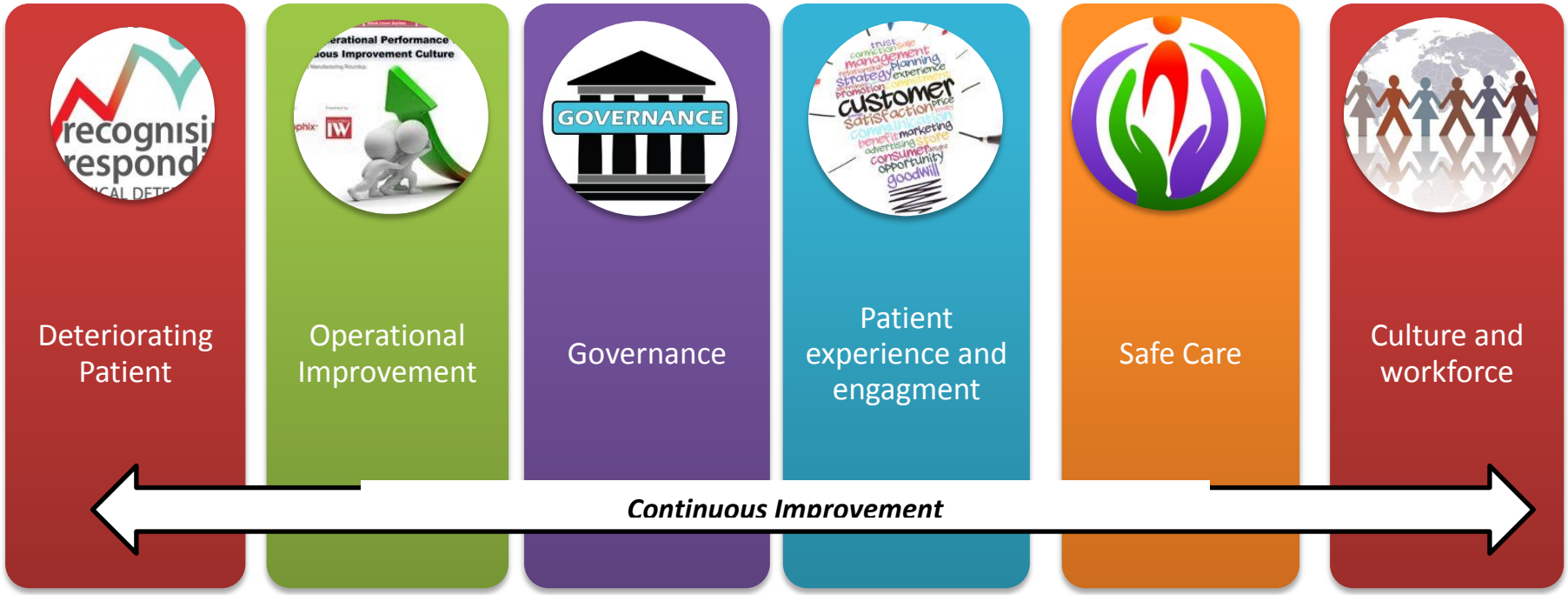
The CQC rated the responsiveness of our services as '*inadequate'.* The Trust was consistently failing to meet the national performance standards (Emergency Access; Cancer; Referral to Treatment and Diagnostics) with the flow of patients through the hospital being poorly managed. However, the Trust did have systems in place to ensure that patients living with dementia had safe care that was tailored to their needs. Staff could also demonstrate good examples of where they had altered care to ensure patients beliefs and diverse needs were met.

5. Ensuring services are well led

The CQC rated the Well Led aspect of the Trust as '*inadequate'.* They had significant concerns about the interim nature of the Board at the time and felt that the executive team did not have effective processes to ensure communication was embedded from ward to board. A revised framework for governance and assurance had been put in place but the CQC felt that it was not operating effectively and so the board did not have clear oversight of the risks affecting the quality and safety of care for patients. The CQC also raised concerns about reported high rates of bullying of staff from patients, relatives and other staff. In addition they noted the lack of BME staff employed in senior posts within the Trust.

Developing our Improvement Plan

The six themes within our plan are:



Each section of our improvement plan outlines the CQC findings, the improvement projects identified and how we intend to measure success.

Quality Improvement Plan Governance

It is important that we ensure robust governance arrangements through which the quality improvement plan (QIP) will be managed. Immediately following the publication of the Section 29A Warning Notice in January 2017, regular Quality and Safety Improvement Group (QSIG) meetings were established with Divisional representation to monitor delivery against that Improvement Plan. This meeting is chaired by the CEO. The Trust will build on that meeting and will now become the Quality Improvement Board (QIB) which over time will develop into the group that monitors delivery of all Improvement Programmes across the Trust.

The QIB reports into the Quality Governance Committee which is a Board Committee.

Responsibilities of: Divisional Leads/ Trust Leads/ Staff with Actions

- The Divisional triumvirates / Trust Leads are responsible for ensuring that the QIP actions are achieved and the plan is updated on a regular basis, and any issues escalated appropriately and within a timely manner.
- The QIP must be monitored on a regular basis by the Divisions/Trust Leads to ensure it remains on track, pro-actively identifying slippage and mitigating actions to rectify as soon as possible.

Responsibilities of: Executive Leads

- The Lead Executive for each 'concern' identified is responsible for ensuring that the identified outcome, KPI (and associated trajectories) and action are appropriate. They are responsible for signing off their relevant parts of the QIP.
- A Lead Executive will be allocated responsibility for overseeing the implementation and impact of each of the 6 work streams (Deteriorating Patient, Operational Improvement, Governance, Patient Experience and Engagement, Safe Care, Culture & Workforce)
- The Executive leads will provide both support and challenge to the Divisions/ Trust leads at the relevant governance meeting if concerns are identified, or the delivery of actions are delayed to meet the stated outcomes. Divisions/Trust leads will be requested to identify mitigating actions to bring the delivery back on track.

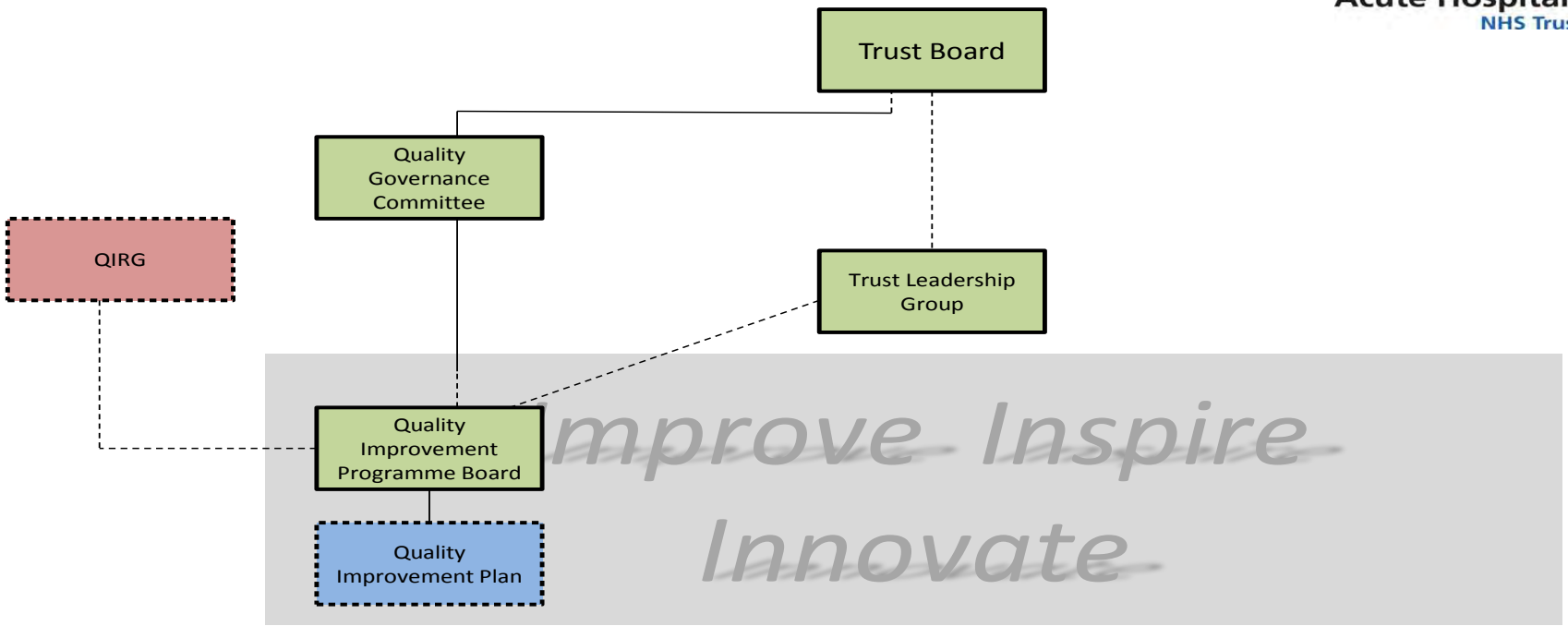
Responsibilities of: Programme Management Office

- Will provide support to the Divisions / Trust Leads to ensure that the QIP is co-ordinated appropriately working closely with the Deputy Chief Nurse (Quality) who has operational oversight of the plan.

Worcestershire NHS
Acute Hospitals NHS Trust

NHS
Worcestershire
Acute Hospitals
NHS Trust

Corporate Governance Structure (Quality and Safety Focus)



How we will implement this plan

The governance section above outlines the committee structure responsible for ensuring delivery and assurance against the QIP. This section identifies how the trust is going to operationalise the delivery of the plan.

The Trust has identified one of its substantive Executive Directors to take on the lead responsibility for Quality Improvement across the organisation. This is the Chief Nurse. The Deputy Chief Nurse (Quality) will be accountable to the Chief Nurse and will oversee the delivery of the Improvement Plan, utilising a programme management approach.

Each of the 6 themes identified within the programme (Deteriorating Patient, Operational Improvement, Governance, Patient Experience and Engagement, Safe Care, Culture and Workforce) has been allocated an executive lead that will be accountable for the successful delivery of the desired outcomes documented within their section of this plan to the Quality Improvement Board. This Group will be chaired by the Chief Executive Officer and supported by the Chief Nurse. This group currently meets fortnightly and it is the aim of the Trust that this Group will be a long-standing group which will be responsible for monitoring the continuous quality improvement across the organisation beyond the next CQC inspection.

Supporting the implementation of the improvement plan with be the development of a three year strategy within the Trust which will be delivered to support and educate staff in utilising improvement science to implement and monitor small and large scale change; to utilise staff's expertise (such as that of consultants and other staff who have a special interest in improvement and who have skills in mapping, implementing lean methodology etc.) to support staff implement change in practice and to utilise staff's knowledge of particular topics, such as aspects of functional management, leadership, change management etc. as well as offering facilitation, coaching and mentoring skills to all levels of staff within our organisation.

The Plan – Deteriorating Patient. Executive Lead, Chief Medical Officer

What the CQC found

Patient risk assessments were not fully completed on admission and generally not reviewed at regular intervals throughout the patient's stay in hospital.	The risk of patients deteriorating was not always appropriately managed particularly for those patients moved to outlying wards.
Lack of clear oversight of the deterioration of patients and the inaccuracies in completion of National Early Warning Score	The ED at the Alexandra Hospital could not ensure that there was always a senior doctor available who was qualified to resuscitate children. Staff had not been trained to use a new system to help staff recognise when a child's condition was deteriorating.
Inaccuracies in completion of the Paediatric early Warning Scores and failure to escalate appropriately	Robust and appropriate systems were not in place for carrying out VTE assessments which contravened NICE guidance.
The Trust was performing worse than expected for two mortality indicators (SHMI and HSMR)	The critical care team were able to ensure safety across the county wide service by transferring skilled staff to assist with the management of patient care according to need.
Patients were cared for in environments that did not always have the equipment to safely care for a deteriorating patient.	Not all equipment had been safety tested and the emergency neonatal trolley in the delivery suite was not always checked properly.

Our plans to improve

1. ***Improve the morbidity and mortality processes across the Trust to enhance shared learning and to reduce unnecessary harm to patients.*** We will achieve this through the successful implementation of the following:

- Introduce standardised primary & secondary mortality reviews across the Trust based on The Learning from Deaths Guidance (NHSE 2017), reporting to the Board as per guidance.
- Enhanced shared learning from morbidity & mortality reviews, by reviewing the current Trust process to ensure that every death is reviewed by the appropriate clinical teams (not just those patients at the end of their life, or from the DNACPR audits) and through the appointment of an additional clinical lead responsible for leading on mortality reviews.
- Reviewing and strengthening the Trust-wide Mortality Review Group.
- Review the existing VTE project plan and strengthen this based on best practice learned from elsewhere.

2. ***Improve the accurate recording of NEWS and PEWS and ensure appropriate escalation happens when needed.***
   We will achieve this through the successful implementation of the following:

   - Strengthen the programme of audits to monitor compliance with the NEWS and PEWS policies, supported by an on-going training programme.
   - Roll out the use of SBAR as the communication tool between clinicians for requesting support for deteriorating patients and handover.
   - Standardise and implement Safety Huddles across all wards.
   - Develop the business case for procuring a mobile clinical system to enable real time patient monitoring and escalation.

3. ***Improve the early detection and timely treatment for patients admitted with Sepsis.*** We will achieve this through the successful implementation of the following:

   - Review of the work programme of current Sepsis Improvement Group, ensuring all actions are going to deliver the improvements required.
   - Development of a business case to support the additional resource required to deliver improvements.
   - Embed a systematic approach towards the prompt identification and appropriate treatment of life-threatening infections, while at the same time reducing the chance of the development of strains of bacteria that are resistant to antibiotics.
   - Timely identification of sepsis in emergency departments and acute inpatient settings.

4. ***Ensure robust individual patient and environmental risk assessment processes are in place that will ensure patients are cared for in the right place, by the right person who has the right equipment to support care delivery.***
   This will be monitored at daily bed meetings and audited quarterly.

We will know when we have succeeded when we have demonstrated:

Outcomes	***Theme Achievement Date**
HSMR and SHMI rates are in line or better than the national average	**31/08/18**
Compliance with the Sepsis 6 bundle is in line or better than national average	
There will be a reduction in unexpected Cardiac arrests from the 16/17 baseline	
There will be a reduction in unplanned admissions to our ITU's from the 16/17 baseline	

***Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Operational Improvement. Executive Lead – Chief Operating Officer

What the CQC found

Lack of privacy and confidentiality for patients being cared for on trolleys on the corridors of the emergency department at Worcestershire Royal Hospital and the Alexandra Hospital.	The flow of patients into and through the hospital was not well managed across the Trust
Medical patients on non- medical wards were not always effectively managed.	The Trust was not meeting the cancer 62 day standard of 85%
Patients who were moved were not always reviewed to check the move was appropriate.	There was a high volume of patients moving between wards overnight.
The amount of time patients spent in ED waiting for treatment was consistently worse than expected standards.	Only 50% of ambulance patients were handed over to ED staff within 15 minutes.
Patients are waiting too long from the decision to admit until being admitted so patients are not accessing care in a timely way.	The admitted referral to treatment time was consistently below the Trust standard of 90%

Our plans to improve

1. ***Implementation of the Trust wide Flow project.*** We will achieve this through the successful implementation of the following:

- Implementation of Red 2 Green 7 days No Delay project to speed up flow through the hospitals.
- Robust daily reviews of “stranded” patients to ensure the right care delivered in the right place.
- Length of stay review & Implementation of the 6A ‘s of managing emergency admissions project with the support of ECIP
- Bed management review
- Establishment of a Frailty Unit including a Frailty model across the health economy
- Increase the number of ambulatory care pathways.
- New capital build aligned to current Emergency Department increasing capacity and improve streaming.
- Review of the Paediatric Assessment Unit and urgent care pathways to ensure there is sufficient capacity.
- Review of SOPs for placing patients into escalation areas, ensuring they cover off risk assessments, staffing and equipment checks.

2 ***Capacity and Demand analysis and job planning to ensure we right size capacity and match resources required.*** We will achieve this through the successful implementation of the following projects:

- Capacity and Demand analysis June 2017
- Review of job plans for all Consultants July 2017
- Bed and theatres right sizing once Capacity and Demand analysis complete
- Review of Clinical Nurse Specialist roles and job plans September 2017
- Medical bed modelling supported by Intensive Support Team
- Review of Paediatric Urgent care pathway and staff.

3 ***Increase capacity to ensure delivery of Cancer and RTT improvement trajectories.*** We will achieve this through the successful implementation of the following:

- Approval of 7 business cases to increase the clinical workforce; outsource where required and run additional sessions internally.
- Review of Waiting List processes ensuring strong Divisional oversight

We will know when we have succeeded when we have demonstrated:

Outcomes	***Theme Achievement Date**
Achievement of the improvement trajectory for the Emergency Care Access standard	**31/03/18**
Achievement of the improvement trajectory for Cancer waiting standards.	
Achievement of the improvement trajectory for Diagnostic wait standard	
Achievement of the improvement trajectory for 18weeks RTT standard	
25% of discharges before midday	
Established Estimated Date of Discharge (EDD) for all patients	
Red 2 green actions standardised in all wards	
All patients streamed from front door into the most clinically appropriate setting – Right Patient, Right Ward, 1st Time	
A consistent reduction in the Delayed Transfers of Care (DTOC) to 3.5%	
Ambulance handovers consistently complete handovers within 15mins	
Ensure maximum theatre utilisation, in order that the number of cancelled operations reduces in line with the England average	
A consistent improvement in A&E FFT results	

***Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Governance. Executive Lead- Chief Nurse

What the CQC found

Nursing documentation was poorly completed.	Performance in national audits was in some areas significantly worse than the England average with limited evidence of action plans to address all areas for improvement.
There was a culture of reporting, investigating and learning from incidents throughout the Trust. However, not all incidents that were required to be reported externally as "serious" were correctly classified and externally reported.	There was no standardised approach to completion of audit.
The Executive Team did not have effective processes to ensure communication was embedded from Ward to Board	Although a revised framework for governance and assurance was in place, it was not operating effectively and the board did not have clear oversight of the risks affecting quality and safety of care for patients.
There was not an appropriate system in place to support the fit and proper person's requirements.	Risk registers were not fully populated with risks at Divisional level.

Our plans to improve

1. Enhance our Quality and Corporate Governance, so there no longer exists a gap between the clinical areas and the board.
We will achieve this through the successful implementation of the following:

- Implement the outstanding recommendations from the Buddy Trust Governance Review
- Review the Divisional Governance meetings and implement changes required in order to ensure a consistent approach.
- Commission external expert advice on Corporate Governance and implement recommendations.
- Ensure a robust process is in place for meeting the Fit and Proper Person guidance.
- Undertake the NHSI Well Led Governance Review.

2. Strengthen our Risk Management processes, so there no longer exists a gap between the clinical areas and the board.
We will achieve this through the successful implementation of the following:

- Implement the outstanding recommendations from the Buddy Trust Governance Review
- Roll out a programme of training on risk management both to the Board and operational teams.

- Review and update the BAF and Risk Management Strategy.
- Review Risk Registers via the Trust Risk Management Group.

3. Strengthen the Trusts ability to transform the safety and quality culture across the organisation. We will achieve this through the successful implementation of the following:

- Undertake a Trust wide Safety Culture questionnaire.
- Introduce a Trust-wide transformation and PMO team who will support the delivery of this overarching piece of work, focusing on long term continuous improvement
- Work with the West Midlands Academic Health Science Network (WMAHSN) to support an improvement in staffs understanding of improvement methodologies.
- Review the Trusts Incident reporting Policy and training programme to ensure increased awareness and knowledge amongst staff.

4 Strengthen the outcomes from local & national audits, demonstrating learning by continuously improving compliance. We will achieve this through the successful implementation of the following:

- Establishment of a system to co-ordinate results from audits, the resulting action plans and evidence of implementation and compliance which will be monitored via the Trust Clinical Governance Group.

We will know when we have succeeded when we have demonstrated:

Outcomes	***Theme Achievement Date**
Our quality & Corporate governance systems are robust and can demonstrate a dynamic flexible process which moves seamlessly from ward /department to board and back again	**31/03/18**
Our risk management systems are robust, and can demonstrate a dynamic responsive oversight and approach to risks identified at all levels within the organisation, strengthening board oversight of risk.	
An enhanced safety and improvement culture which reaches all levels of staff across the organisation and focuses on: learning, sharing the learning, continuous quality improvement and the use of appropriate information to evidence performance against agreed success metrics (Clinical effectiveness)	
100% compliance with the Fit and Proper Persons Process (FPP) by 30/06/17	

***Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Patient Experience and Engagement. Executive Lead- Chief Nurse

What the CQC found

Feedback from patients and those who were close to them was positive about the way staff treated them. Patients were observed being treated with dignity, respect and kindness.	Close working between the specialist palliative care team and ED staff was observed at the end of life
Relatives of patients in critical care had access to facilities to enhance their stay on the unit including overnight accommodation.	The need for emotional support was recognised and specialist and spiritual support was provided.
Managers did not have clear oversight of mixed sex breaches or the need to report them in line with national guidance.	Pain in children attending the MIU was not always managed effectively.
The NHS FFT had been suspended in children's clinics (KTC) since the service reconfiguration. Patient's feedback could not be used to monitor and improve services.	Patient's privacy and dignity was often compromised for patients being cared for in the Emergency Department corridors.

Our plans to improve

1. ***Reduce the number of mixed sex breaches and ensure robust reporting mechanisms are in place.*** We will achieve this through the successful implementation of the following:
   - Development of a Standard Operating Procedure (SOP) for monitoring and reporting mixed sex breaches.
   - *See Section 2 on Operational Improvement for linked actions that will reduce MSA breaches*

2. ***Ensure all Divisions have robust processes in place to capture patient feedback in a meaningful way and involve patients more in our improvement journey.*** We will achieve this through the successful implementation of the following:
   - Development and implementation of a Patient Engagement Strategy that focusses on actions to increase real time patient feedback, strengthens the patient voice at the Board and engages Patients and carers in the Trust's improvement journey.
   - Review of the current Complaints policy ensuring Divisions become more responsive to concerns raised and learn from the patient feedback.
   - Improve the reporting of complaints to the Board ensuring more in depth analysis of complaints and compliments received.
   - Review of current patient feedback mechanisms, exploring options to improve.

3. ***Ensure all staff that care for children are appropriately trained to identify and manage their pain.*** We will achieve this through the successful implementation of the following:
   - Undertake a training needs analysis and roll out of competency based training.
   - Audit effectiveness of training including Parent and Child feedback.

4. ***Improve flow and streaming in order to reduce the number of patients cared for in the ED corridor at Worcestershire Royal Hospital and ensure appropriate facilities are in place to provide privacy for patients within the department.*** We will achieve this through the successful implementation of the following:
   - *See Section 2 on Operational Improvement for actions that will support this*.
   - Deliver on the planned capital build for the Emergency Department at Worcester Royal site, thereby increasing capacity within the department and improving the ability to provide care in appropriate settings.

We will know when we have succeeded when we have demonstrated:

Outcomes	*** Theme Achievement Date**
Achievement of Trust standards in complaint response times	31/03/18
FFT results that are in line or better than the national average	
An improvement in the 17/18 patient survey results against the 16/17 results	
Active engagement of patients in a range of groups and improvement projects	
Patients are not routinely cared for in the corridors of the Emergency Departments	
Audits show children's pain is being appropriately managed	
Patients are not cared for in a mixed sex environment	

*** Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Safe Care. Executive Lead – Chief Medical Officer

What the CQC found

The level of safeguarding children's training was low and not compliant with national guidance.	Staff were unaware of FGM and child sex abuse. There was a risk staff would not recognise when a child was being abused or exploited.
Medicines management was poor with medicines that required cool storage being stored in fridges which were either below or above the manufacturers recommended temperature.	There was inadequate review and document control of protocols for standard x-ray examinations.
Emergency medicines were not protected from tampering and poor practice was observed relating to staff signing for controlled drugs in the Endoscopy dept. at KTC.	Not all staff had undertaken relevant mandatory training. This included safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
Wards and clinical areas were visibly clean, however, some poor adherence to the trusts infection, prevention and control procedures was observed.	Patient's records were not always stored securely.
Aging and unsafe equipment was used in radiology departments across the trust that was being inadequately risk rated.	Assessments for paediatric patients' requirement of 1:1 care from a mental health nurse were not always undertaken and care was not consistently provided by a member of staff with appropriate training.
Patients with mental health needs were not always cared for in an appropriate environment within ED.	There was not a robust, consistent process in place for Harm Reviews

Our plans to improve

1. ***Improve the management and security of medicines*.** We will achieve this through the successful implementation of the following projects:

- Improving the way that the Trust learns from medication errors by: a) ensuring that all Divisions include monthly reviews of all medication errors reported from Medicines Optimisation and Divisional Governance processes through to the Clinical Governance Group on a quarterly basis and b) distribution of a regular medicines management newsletter
- Enhanced staff knowledge regarding medication issues, as a result of implementation of '5-minute pharmacy alerts' as screen savers which outline medication issues and learning
- Applying the principles of the 'Hospital pharmacy transformation plan' as part of the Carter Efficiency Programme
- Conduct a review of all medicines and fluid storage areas ensuring safe and secure storage is provided.
- Review the medicines policy to ensure it reflects a risk based approach to safe and secure handling in line with national guidance (Duthie report)

2. ***Ensure equipment is well maintained, stored and safety checked, focusing particularly on:*** *Radiology equipment, Resuscitation Trolleys & Fridge Temperatures.* We will achieve this through the successful implementation of the following:
   - Regular audits of Resuscitation trolley checks and fridge temperatures as part of the Nursing SNAP audits triangulated by Pharmacy audit for the safe and secure handling of medicines
   - Development of a SOP for temperature checks, escalation and subsequent action.
   - Development of an equipment replacement programme and identification of a minor equipment budget.
   - Review and update the Asset Register within Radiology
   - Audit of all electrical equipment safety checks.

3. ***Ensure our Healthcare Records are stored securely.*** We will do this through the successful implementation of the following:
   - Conduct a review of all areas where health records are stored ensuring safe and secure storage is provided.

4. ***Improve our compliance with Infection prevention and control procedures.*** We will do this through the successful implementation of the following:
   - A follow up peer review visit to take place within 3 months, to include NHSI and NICE colleagues- implement recommendations following review.
   - Re-establishment of the Anti-microbial Stewardship Group
   - Monthly monitoring of all relevant statutory requirements (e.g. water and ventilation requirements) via the Trust Infection Prevention and Control Group.

5. ***Improve our staff knowledge in caring for all vulnerable patient groups and ensure provision of an appropriate environment at all times.*** We will do this through the successful implementation of the following:
   - Training needs analysis and review of current training packages provided
   - Divisions to set and deliver improvement trajectories on mandatory training specifically in relation to Safeguarding, FGM, Domestic Violence, MCA and DOLS. This will be monitored via Performance Reviews.
   - Review of mental health rooms within ED, undertaking a ligature risk assessment.
   - Establish a standardised process for conducting Harm Reviews and establish a group to oversee outcomes of reviews.
   - Review of procedures for implementing the “5 Steps to Safe Surgery” guidance.

We will know when we have succeeded when we have demonstrated

Outcomes	***Theme Achievement Date**
Compliance with mandatory training standards	**31/03/18**
Positive audit results relating to healthcare records storage, medicines administration and storage, fridge temperature checks and ligature assessments.	
Full compliance with mandatory training with staff able to describe the care needed for vulnerable patient groups.	
All divisions have up to date asset registers and an equipment replacement programme	
A reduction in incidents relating to incorrect storage of medicines	
Regular communication of lessons learnt from incidents relating to medicines	
Patients get the care required through early identification of risk as part of the Harm review process.	
SNAP and Observational audits demonstrate robust hand hygiene and compliance with PPE	
Outbreak RCA's demonstrating effective isolation management.	
Decreasing C.Diff cases and achievement of improvement trajectory	

*** Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

The Plan – Culture and Workforce.	Executive Lead – Chief Executive Officer

What the CQC found

The Executive team at the time were made up of mainly interim executive directors who were not recognisable or visible to staff through the Trust.	Staffing levels within the emergency department were not planned and reviewed in line with national guidance. There were not enough consultants to meet the RCEM recommendations. However, most other areas had adequate staff to ensure patients received safe care and treatment.
There were not effective processes in place to ensure communication was embedded from ward to Board.	Staff did not feel valued or listened to by divisional and executive teams
The trust has poor performance in the NHS Staff survey	Nursing staff competency records in some departments were out of date.
The rates of bullying for both black and minority ethnic and white staff from patients, relatives and the public along with other staff were high and represented a significant risk to patient care.	There was not a Freedom to Speak up Guardian in place.
The Trust staff appraisal rate was below the Trust standard of 90%	

Our plans to improve

1. ***Implement a cultural change programme that embeds signature behaviours and creates a greater sense of accountability within the Trust.*** We will do this through the successful implementation of the following:

- Identification of signature behaviours
- Roll out of the Pulse cultural change programme with surveys of all staff three times a year
- Measurement of net leadership score for Board and Executive three times a year

2 ***Improve the recruitment and retention of our staff.*** We will do this through the successful implementation of the following:

- Development and implementation of a comprehensive recruitment strategy with a particular focus on medical staff recruitment.
- Undertake an overseas recruitment trip to India for medical staff in July.
- Development of a workforce strategy that focusses on retention, leadership development and development of new roles.
- Taking part in the NHSI supported programme for developing the role of Advanced Care Practitioners
- Explore reward and recognition schemes as part of the Pulse programme.

- Undertake 6 monthly staffing reviews in order to ensure the correct skill mix and staffing numbers.
- Working with STP partners in exploring development of roles to work across boundaries and organisations.
- Strengthen the Trust links with Health Education England.
- Strengthen the appraisal process, enhancing the quality of that process, whilst improving compliance across the Trust
- Implement a robust process for clinical supervision; ensuring staff have time to participate.
- Learn from best practice e.g. the Retention Programme at UCLH.
- Divisions to ensure all staff are up to date with their competency frameworks, monitored via Divisional Boards.

3 ***Improve how we engage with our staff to help us to deliver the best possible care to the local population.*** We will do this through the successful implementation of the following:

- Hold staff discussion forums to better understand how we can improve our communications from ward to board.
- Sustain the Senior Nurse profile in all clinical areas to ensure support to frontline staff (in line with Statement of Intent)
- Increase the use of social media to engage with staff.
- Increase Board visibility through leadership walk-abouts
- Employ an independent Freedom to Speak Up champion and ensure systems are embedded that encourage and support staff to raise concerns.
- Review and re-launch the trust Equality and Diversity Group.
- Establish a Workforce Board Committee.

We will know when we have succeeded when we have demonstrated:

Outcomes	***Theme Achievement Date**
Reduction in vacancy rates against 16/17 rates	**31/03/18**
Improvement in turnover rates to bring them in line with the national average	
Improvement in staff FFT and the national staff survey against the 16/17 rates.	
Improvement in net leadership score	

*** Each project will have rolling milestones and Key Performance Indicators (KPI's) that will reported on monthly**

Appendix 1 Example of the reporting format

Progress report					Worcestershire NHS Acute Hospitals NHS Trust
Project Name:		Division or programme:			
Project Manager:		Senior Responsible Owner:			
Report Date:		Reporting month:			
Project purpose and objectives					
[The high level aim/purpose of the project]					
Progress Summary					
Forecast end date:		Status this period:	Green - On plan		
Progress statement this period		Future activity information to highlight			
[High level progress statement for this reporting period, aligning to deliverables]		*[Information of note relating to the following reporting period]*			
Milestones / Deliverables					
Milestone or deliverable	Target date	Revised completion date	Status	Comment	
			Blue - Fully Complete		
			Blue - Complete but monitoring		
			Green - On plan		
			Amber - At risk		
			Red - Overdue		

Key Risks & Issues		
Risk or Issue	Severity	Mitigation
	High - Entire project at risk	
	Med - Deliverable at risk	
	Low - Minimal impact to project	
Support or decisions to escalate		
[Escalations for support requests or decisions to be made]		
A metric dashboard with relevant run charts will accompany this for reporting.		

Appendix 2 –Initial KPIs

Theme	KPI's						
Deteriorating Patient	HSMR, SHMI, Primary and secondary mortality review compliance	VTE compliance (Oasis only)	Sepsis 6 compliance	Unplanned ITU admission	Unexpected cardiac arrests	NEWS / PEWS compliance, NEWS / PEWS escalation (SNAP)	Escalation of deteriorating patient
Operational Improvement	RTT 18 week, RTT 52 week waiters	Cancer 62 day, Cancer 2ww, Cancer 104 day breaches	Diagnostics	EAS Ambulance Handovers within 30 minutes/1 hour	12 hour breaches	Harm review completion	EDD compliance within 24 hrs.
Governance	Documentation audit questions (TBC by DCNO when review complete)	National audit compliance	Outstanding audit action	Overdue risks, Risks with overdue actions, High / moderate risks with no actions	Overdue policies	Compliance with Fit and Proper Persons Guidance	
Patient Experience & Engagement	Mixed sex breaches	Bed moves between 22:00 - 07:00	Complaints responded within 25 days, Complaints open over 6 months	Inpatient survey (key questions)	Friends and family test score & participation (inpatient, A&E and Maternity)	Compliments	
Safe Care	MRSA Cdiff (SNAP audit) hand hygiene compliance Missed medication	Grade 2, 3 and 4 avoidable pressure ulcers	Medication incidents per 1000 bed days	Falls with serious harm per 10000 bed days	Children safeguarding training,	Adult safeguarding training,	MCA training, DOLs training
Culture & Workforce	Staff turnover (all) Staff turnover (nurses and doctors)	Mandatory training	Net Leadership score (Pulse)	Staff FFT	Length of time from application to appointment	Vacancy Rates	

Date of meeting: 5 July 2017 **Enc D1**

Report to : Trust Board

Title	**Quality Improvement Plan**
Sponsoring Director	**Vicky Morris, Chief Nurse**
Author	**Cathy Geddes, Improvement Director**
Action Required	The board is asked to: • Approve the Quality Improvement Plan and the proposed QIP governance structure. • Approve the QIP submission to the CQC
Previously considered by	N/A

Priorities (√)

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

Related Board Assurance Framework Entries	R1.1 If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions. R1.2 If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.
Legal Implications or Regulatory requirements	The Trust is required to comply with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Under these regulations, the Trust has a number of Section 31 and Section 29A warning notices that it is required to comply with.
Glossary	CIH – Chief Inspector of Hospitals CQC- Care Quality Commission QIP – Quality Improvement Plan QGC – Quality Governance Group KPI's – Key performance indicators

Key Messages

Title of report	
Name of director	

Worcestershire Acute Hospitals NHS Trust

Date of meeting: 5 July 2017 **Enc D1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 5 June 2017

1. Situation

The attached Quality Improvement Plan has been written following publication of the CQC Inspection Reports relating to the November 2016 Trust wide planned CIH inspection. This plan will now replace the previous QIP written as a response to the Section 29A Warning Notice issued on the Trust in January 2017.

This plan will form part of the overall 3 year Trust wide Improvement Strategy going forward.

2. Background

The Trust had its scheduled re-inspection 22 – 25 Nov 2016 followed by a number of unannounced visits. Following this inspection, the level of concern was such that a Risk summit was called by NHSI on the 22 Dec 2016. Whilst the focus of this summit was on the safe care of patients in Urgent Care the CQC raised a number of other areas of concern which included safe medicines management, safe staffing and monitoring of escalation areas. A follow up risk summit was held on 18 Jan 2017. The Trust then received a section 29A Warning Notice from the CQC outlining concerns at all three sites. The final report from this visit was published on 20 June 2017. This showed a decline in the overall Responsive domain rating from Requires improvement to Inadequate

The CQC undertook an unannounced inspection to review progress against the Section 29A Warning Notice in April 2017 followed up by interviews with the Executive Team and staff focus groups. On this inspection they did not find sufficient evidence to demonstrate that the requirements of the Warning Notice had been met. The report from this visit is due to be published in July 2017.

Following on from receipt of the Section 29A Warning Notice a Quality Improvement Plan (QIP) was developed and an internal monitoring group (the Quality & Safety Improvement Group) was established chaired by the Chief Executive. Any outstanding actions from that QIP have either been moved into this updated QIP presented below or into business as usual.

Title of report	
Name of director	

Date of meeting: 5 July 2017 **Enc D1**

3. Assessment

The revised QIP is a response to the published CQC reports (June 2017) and has incorporated any outstanding actions from the previous QIP written as a response to the Section 29A Warning Notice.

This plan is set a high level with 6 key themes, each of which has an Executive Lead.

Delivery of the plan will be monitored at the Quality Improvement Board, chaired by the Chief Executive and will report externally to the Quality Oversight Group and internally to QGC.

Each theme will have detailed project plans, rolling milestones and KPI's underpinning them.

4 Recommendation

The board is asked to:
Consider and approve the Quality Improvement Plan and the proposed QIP governance structure.
Approve submission of the QIP to the CQC.

Name of Director- Cathy Geddes
Title: Improvement Director

Title of report	
Name of director	

Our sites are completely SMOKEFREE

NHS Worcestershire Acute Hospitals NHS Trust

Executive and Non-Executive Director Walkarounds

Information Guide

Patients Respect Improve and Innovate Dependable Empower

Summary

Healthcare is a people business. For Worcestershire Acute Hospitals Trust (WAHT) it is now the right time to revise and renew the Executive and Non-Executive Director Walkaround programme. The aim is to promote safety and quality and, most importantly, to engage with our staff and patients/service users.

This information guide will describe to you the Executive and Non-Executive Directors Walkarounds programme. We anticipate these Walkarounds facilitating the improved accessibility and visibility of our Executive and Non-Executive Directors across the WAHT.

Both the Francis enquiry and the Keogh report make reference of the need for healthcare organisations to foster a culture of improvement, but of equal importance, a listening and transparent culture.

These Walkarounds will support WAHT to enhance the relationship between frontline staff and the Executive and Non-Executive Directors. They will also provide the Executive and Non-Executive Directors with real time feedback and evidence to further focus on safety, leadership, Quality and listening to and valuing staff.

The future aim of the Walkarounds will include the triangulation of all visit actions and feedback with data supplied by the Healthcare Standards Team. This data will be used to inform future visit discussions and most importantly, to celebrate success on the frontline teams.

Mrs Vicky Morris
Chief Nursing Officer, Worcestershire Acute Hospitals NHS Trust

Introduction

The Walkarounds are a way for the Executive and Non-Executive Directors to engage with staff in a safe, informal and non-judgemental way. They provide the opportunity for staff to speak to the Executive and Non-Executive Directors about their thoughts, ideas, innovations and/or concerns first hand – this will help WAHT to foster an open and fair culture by encouraging staff to discuss things openly.

The Walkarounds will increase engagement and visibility from ward to board and continue to build on these relationships as they continue in the future.

The programme of Walkarounds is defined in Appendix A, and split into 3 types as follows:

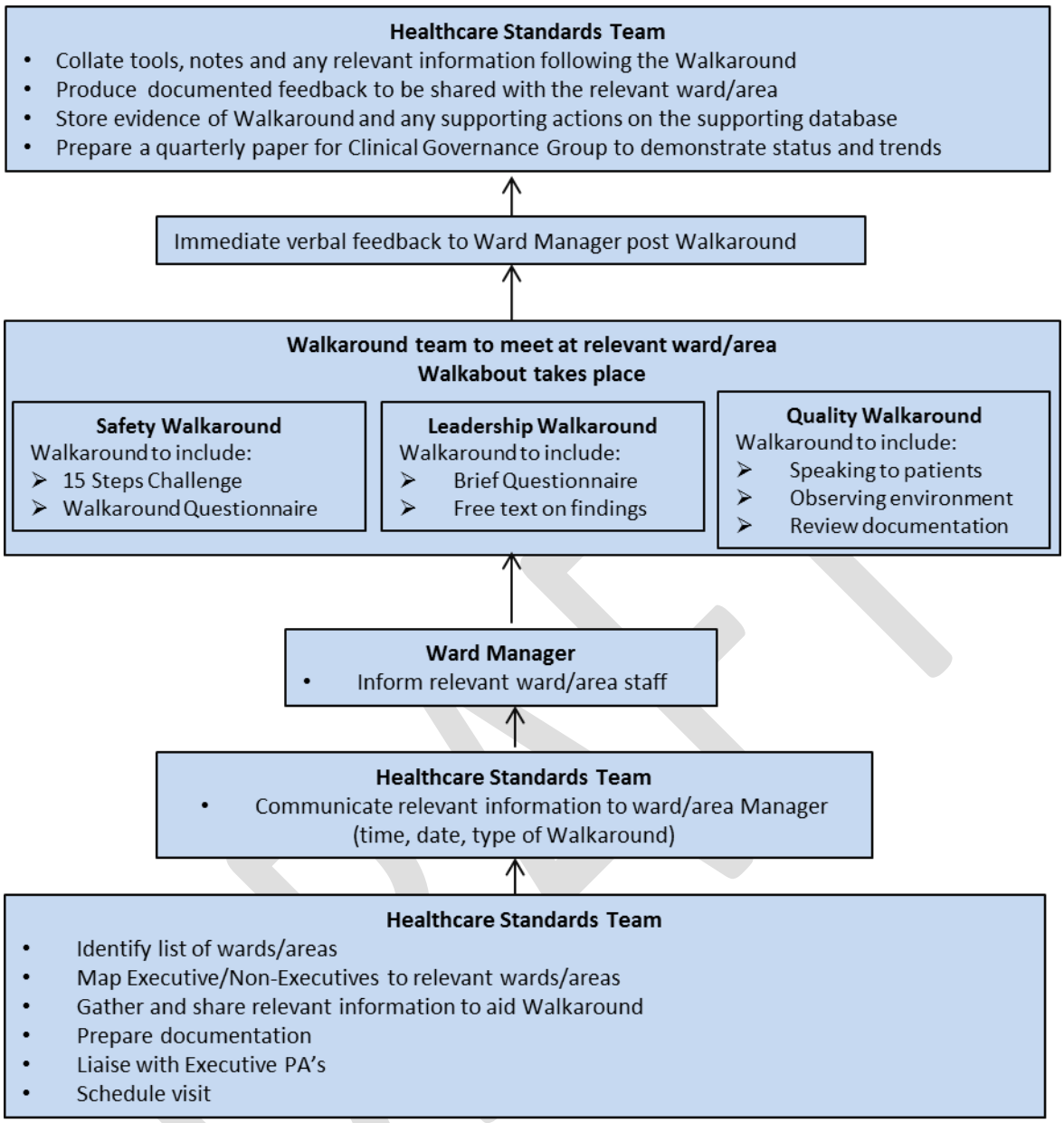
1. Safety Walkaround (Appendix B);
2. Leadership Walkaround (Appendix C);
3. Quality Assurance Walkaround (Appendix D).

Approach

The Safety and Quality Walkarounds must be led by a clinical Executive and/or Non-Executive Director as they refer to clinical practice.

The Leadership Walkarounds can be led by either a clinical or non-clinical Executive and/or Non-Executive.

The above Walkarounds must be pre-planned by the Healthcare Standards Team in conjunction with the relevant Executive and Non-Executive Directors. Prior preparation is essential to the success of the Walkarounds to ensure all involved are aware of the purpose via the following process:



When starting the Walkaround it should be remembered that first impressions count. First impressions give us initial feelings about any situation.

- When first arriving on a ward, does it inspire confidence in the care that we are about to receive?
- What makes us trust a care environment?
- What makes us feel that we will be safe and cared for?
- What are the first clues to high quality care?
- What does 'good' look, feel, sound and smell like?

The Walkarounds are a way for the Executive and Non-Executive Directors to raise awareness of the WAHT priorities, and to gather and share information throughout the Trust.

It must be remembered that the Safety, Leadership and Quality Assurance Walkarounds are not a performance management tool or an inspection.

The Walkarounds provide an opportunity to engage with staff in an informal and non-judgmental way.

They are a way to encourage staff to realise their positive contribution to the Trust.

Top Tips:

- Allow engagement between staff in a safe, informal and non-judgmental way;
- There should be a maximum of 3 people completing the Walkaround to reduce interference to patient care;
- Utilise the visit to identify areas of good practice to be shared across the organisation;
- Be honest, open and fair – listen to staff and use this information to build upon relationships and inspire confidence.

Appendix A

	Safety Walkaround	Leadership Walkaround	Quality Assurance Walkaround
Aim:	Making safety a priority of WAHT.	Aligning the culture of the organisation and priorities of the organisation with frontline staff.	Independent review which can be triangulated against existing data and is a way to help identify inconsistencies of processes and patient experiences across Trust.
Duration:	Approximately 1 hour	Approximately 30 minutes	Approximately 1 hour
Attendees:	Executive and/or Non-Executive Director/Divisional Director of Nursing/Divisional Medical Director, Consultant Leads, scribe & volunteer(s)	Executive and/or Non-Executive Directors & scribe	Executive and/or Non-Executive Directors & scribe
Tool:	There are 3 standard questions at the start of the checklist. The remainder of the checklist focuses on the following: ➢ 15 step approach; ➢ Patient and staff safety; ➢ Concerns raised and feedback received; ➢ Feeling safe.	There are 3 standard questions at the start of the checklist. The remainder of the checklist provides an area to record your findings following your open and honest discussion led by the ward/area staff.	There are standard questions which focusing on: ➢ Speaking to patients; ➢ Observing the clinical environment; ➢ Reviewing the nursing documentation.

Appendix B
Safety Walkaround Plan/Process:

Healthcare Standards Team to:
Confirm date of visit with ward/area manager, send poster to ward/area. to confirm date the send invites to: Executive/Non-Executive Directors, scribe and volunteer member(s).

Members of the Walkaround Team meet outside of the ward/area.

The Walkaround Team enter the ward/area using the First Impressions approach.

After introductions are made and the First Impressions approach completed the team will then separate.

Volunteer member(s):

To stay on the ward and speak to staff, Patients and visitors about their safety concerns/areas of good practice.

Executive and/or Non-Executive & scribe: Discussion with the Ward Manager & Matron about their safety concerns/areas of good practice.

All members of the Walkaround Team to come together to review discussions and agree future actions/timescales:

The Walkaround Team will then feedback the outcome of the visit (including actions and timescales) to the Ward Manager/Area lead/Matron.

Scribe to record all discussions, agreed actions and timescales (on the Safety Walkaround pro forma)

Healthcare Standards Team to use completed pro forma to develop a post walkaround letter confirming all actions and timescales.

Post walkaround letter to be sent to the Ward/Area Manager & Matron within 3 working days of the visit.

Clinical Leadership Team to include: Site/area, Site/Area Medical Director & Consultant Leads.

Safety Walkaround

This document is a tool that will support the individual when completing a scheduled Safety Walkaround to the ward/clinical environment as part of Executive and/or Non-Executive Walkaround programme.

It should be noted that this supports an open and honest culture and should not be seen as an inspection or surveillance tool.[1]

The aim of this visit is to:-

- Engage with staff in a safe, informal and non-judgemental way;
- Listen to staff concerns, ideas and innovations relating to safety in their area;
- Provide the opportunity for raising awareness of the WAHT priorities;
- Provide an opportunity for senior leaders to listen to concerns first hand;
- Provide a connection from ward to board;
- Help staff realise positive contribution to the vision and safety of the Trust.

It will also provide an independent review which can be triangulated against the existing Care Quality Commissions Regulations and Domains as follows:-

Regulations:

Regulation 4: Requirements where the service provider is an individual or partnership	**Regulation 13:** Safeguarding service users from abuse and improper treatment
Regulation 5: Fit and Proper persons: Directors	**Regulation 14:** Meeting nutritional and hydration needs
Regulation 6: Requirement where the service provider is a body other than a partnership	**Regulation 15:** Premises and equipment
Regulation 7: Requirements relating to registered managers	**Regulation 16:** Receiving and acting on complaints
Regulation 8: General	**Regulation 17:** Good governance
Regulation 9: Person centred care	**Regulation 18:** Staffing
Regulation 10: Dignity and respect	**Regulation 19:** Fit and proper persons employed
Regulation 11: Need for consent	**Regulation 20:** Duty of candour
Regulation 12: Safe care and treatment	**Regulation 20A:** Requirement as to display of performance assessments

Domains:

- Safe
- Effective
- Caring
- Responsive
- Well-Led

It is vital that feedback is given on completion of the visit to the Nurse in Charge of the ward. It is recommended that the individuals should be in the ward environment for a minimum of one hour to provide an opportunity for all staff to raise concerns, etc. and also identify areas of good practice.

Process:

To complete this Walkaround, please consider the first impressions in terms of the CareQuality Commissions Domains when entering the area. When undertaking a Walkaround, please sit down with staff (e.g. ward/area manager's office or appropriate alternative location) to discuss the questions detailed[2] below, followed by a walk of the area with the Executive member, Divisional Director and Ward Sister and/or Nurse in Charge (maximum of 3 people to reduce interference to patient care).

Ward/Area:	Sister/Charge Nurse:

Details of person(s) completing the Walkaround:	
Name:	Name:
Job Title:	Job Title:
Signature:	Signature:

[1] Martin et al, 2014, Walkarounds in Practice: Corrupting or Enhancing a Quality Improvement Intervention? A qualitative study. The Joint Commission Journal on Quality and Patient Safety – Vol 40 Number 7, pg 303 to 310.

[2] Cavanagh, P & Hulme, A, Patient Safety First, Leadership for Safety: Supplement 1, Patient Safety Walkarounds.

Ward staff on duty at time of safety walkaround:

Q1) Is the ward meeting planned minimum staffing levels to the number of beds only today? ***Regulation: 18 – Staffing (staffing levels)***	☐ Yes ☐ No ☐ N/A
Q2) Are today's staffing levels displayed to the public? ***Regulation: 17 – Good Governance (information – accurate, robust, appropriate, effectively processed and challenged***	☐ Yes ☐ No ☐ N/A
Q3) Is the ward displaying the previous months' Quality Metrics and Friends and Family data? ***Regulation: 17 – Good Governance (information – accurate, robust, appropriate, effectively processed and challenged***	☐ Yes ☐ No ☐ N/A

Discussion points with staff:

Q4) Have there been any near misses that almost caused harm (e.g. medication)? ***Regulation: 12 – Safe Care & Treatment (medicines handling)***
Notes:
Q5) What do you feel could lead to the next **patient** harm? ***Regulation: 12 – Safe Care & Treatment (learning lessons from incidents)***
Notes:
Q6) What do you feel could lead to the next **staff** harm? ***Regulation: 12 – Safe Care & Treatment (learning lessons from incidents)***
Notes:
Q7) Were you able to care for patients this week as safely as possible? If not, why not? ***Regulation: 9 – Person Centred Care (patient information – clear & accurate)*** ***Regulation: 15 – Premises & Equipment (facilities & premises – appropriate for the needs of the patient)*** ***Regulation 12 – Safe Care & Treatment (accessibility of services – timeliness)***
Notes:

Q8) Are you given the opportunity to raise concerns and how do you receive feedback of incidents/DATIX/concerns raised? ***Regulation: 17 - Good Governance (learning, continuous improvement & innovation – robust processes*** ***Regulation: 12 - Safe Care & Treatment (learning lessons from incidents)***
Notes:
Q9) Do you feel safe in work? ***Regulation: 12 - Safe Care & Treatment (safe systems)***
Notes:
Q10) How do you feel this team could help improve safety on a regular basis for patient and staff safety? ***Regulation: 12 - Safe Care & Treatment (safe systems)***
Notes:

First Impressions:

- **SAFE:**

Positives:

Opportunity for Improvements:

- **EFFECTIVE**:

Positives:

Opportunity for Improvements:

- **CARING**:

Positives:

Opportunity for Improvements:

- **RESPONSIVE**:

Positives:

Opportunity for Improvements:

- **WELL-LED**

Positives:

Opportunity for Improvements:

Summary of discussions with Staff:

This is an opportunity to discuss with staff the Trust priorities (for example: incidents of Hospital Acquired Pressure Ulcers, Falls, C Diff rates and Infection Prevention and Control recommendations, etc.)

Feedback given to Nurse in Charge on completion of the visit:

Appendix C
Leadership Walkaround

This document is a tool that will support the individual(s) when completing a scheduled Executive and/or Non-Executive Directors Walkaround to the ward/clinical environment as part of Executive and None Executive Directors Walkaround programme.

The aim of this visit is to:

- Engage with staff in a safe, informal and non-judgemental way;
- Listen to staff concerns, ideas and innovations relating to their area:
- Provide an opportunity for raising awareness of the Trust priorities;
- Provide an opportunity for senior leaders to listen to concerns first hand;
- Provide a connection from ward to board;
- Help staff realise positive contribution to the vision and safety of the Trust.

Domains:

- Safe
- Effective
- Caring
- Responsive
- Well-Led

It is vital that feedback is given on completion of the visit to the Nurse in Charge/area manager. It is recommended that the individual should be in the ward environment for a minimum of 30 minutes to provide an opportunity for all staff to raise concerns etc. and also identify areas of good practice.

Process:

To complete this Walkaround, please sit down with staff (e.g. ward/area managers office or appropriate alternative location) to allow open discussion with staff followed by a walk of the area with the Trust Board Executive, Non-Executive Director and Ward Sister and/or Nurse in Charge (maximum of 3 people to reduce interference to patient care).

Ward/Area:	Sister/Charge Nurse:

Date of visit:	Time of visit:

Details of person(s)completing the Walkaround: Name: Job Title: Signature:	Name: Job Title: Signature:

Ward staff on duty at time of Leadership walkaround:

Q1) Is the ward meeting planned minimum staffing levels to the number of beds only today? ***Regulation: 18 - Staffing (staffing levels)***	☐ Yes ☐ No ☐ N/A
Q2) Are today's staffing levels displayed to the public ***Regulation: 17 - Good Governance (information – accurate, robust, appropriate, effectively processed and challenged***	☐ Yes ☐ No ☐ N/A
Q3) Is the ward displaying the previous months' Quality Metrics and Friends & Family data? ***Regulation: 17 - Good Governance (information – accurate, robust, appropriate, effectively processed and challenged***	☐ Yes ☐ No ☐ N/A

Headlines pre visit (to be completed by the Healthcare Standards Team)
Notes:

Headlines post visit (to be completed by the scribe)
Including general comments, summary of discussions with staff & feedback given to the Nurse in Charge on completion of the visit – this is an opportunity to discuss the WAHT priorities (for example incidents of Falls, etc.)

Appendix D
Quality Assurance Walkaround

This is a tool that will support the individual when completing an impromptu visit to a ward/clinical environment as part of Exec/Non-Executive Walkaround programme. The tool requires the individual to:

- Observe care being delivered and the environment of care
- Discussion with patients and staff
- Review of key areas within the patients' current care record

The aim of this visit is to increase awareness and visibility of the Executive team and Senior Clinical Leaders with frontline staff, patients, visitors & service users. It will help to identify inconsistencies of processes & patient experiences across the Trust, obtain and act on information, build relationships and enhance staff engagement (Ward to Board).

It will also provide an independent review which can be triangulated against the existing CareQuality Commissions Regulations and Domains as follows:-

Regulations:

Regulation 4: Requirements where the service provider is an individual or partnership	**Regulation 13:** Safeguarding service users from abuse and improper treatment
Regulation 5: Fit and Proper persons: Directors	**Regulation 14:** Meeting nutritional and hydration needs
Regulation 6: Requirement where the service provider is a body other than a partnership	**Regulation 15:** Premises and equipment
Regulation 7: Requirements relating to registered managers	**Regulation 16:** Receiving and acting on complaints
Regulation 8: General	**Regulation 17:** Good governance
Regulation 9: Person centred care	**Regulation 18:** Staffing
Regulation 10: Dignity and respect	**Regulation 19:** Fit and proper persons employed
Regulation 11: Need for consent	**Regulation 20:** Duty of candour
Regulation 12: Safe care and treatment	**Regulation 20A:** Requirement as to display of performance assessments

Domains:

- Safe
- Effective
- Caring
- Responsive
- Well-Led

It is vital that feedback is given on completion of the visit to the Nurse in Charge of the ward. It is recommended that the individual should be in the ward environment for a minimum of 30 minutes to provide an opportunity to observe care delivery, discuss with a patient their current experience of care and to review/discuss one patient care record with a member of the nursing team.

Ward/Area:	Sister/Charge Nurse:

Date of visit:	Time of visit:

Details of person(s)completing the Walkaround: Name: Job Title: Signature:	 Name: Job Title: Signature:

Ward/Area staff on duty at time of Quality Assurance walkaround:

Q1) Is the ward meeting planned minimum staffing levels to the number of beds only today? ***Regulation: 18 - Staffing (staffing levels)***	☐ Yes ☐ No ☐ N/A
Q2) Are today's staffing levels displayed to the public ***Regulation: 17 - Good Governance (information – accurate, robust, appropriate, effectively processed and challenged***	☐ Yes ☐ No ☐ N/A
Q3) Is the ward displaying the months' Quality Matrix and Friends & Family data? ***Regulation: 17 - Good Governance (information – accurate, robust, appropriate, effectively processed and challenged***	☐ Yes ☐ No ☐ N/A

Discussion points with patients:

Q4) Throughout your stay, how often did you feel that you were given help to be as independent as you can and wish to be? ***Regulation: 9 - Person centred care (supporting patients to manage their own health)*** ***Regulation: 10 - Dignity and Respect (dignity & respect)***	
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ N/A	**Comments:**

Q5) Throughout your stay, how often did you feel that the clinical area was kept clean, tidy and not cluttered? ***Regulation: 12 - Safe care and treatment (cleanliness & hygiene and infection control)*** ***Regulation: 15 - Premises and equipment (facilities & premises - design & maintenance is safe)***	
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ N/A	**Comments:**
Q6) Throughout your stay, how often did you feel that you and those that care for you were given full information about your care in a way that you could understand? ***Regulation: 9 - Person centred care (involving patients/families/carers in care and treatment)***	
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ N/A	**Comments:**
Q7) Throughout your stay, do you feel you were treated with dignity and respect? ***Regulation: 10 - Dignity and respect (dignity & respect)***	
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ N/A	**Comments:**

Q8) Did you feel that you were able to get enough rest and sleep? ***Regulation: 9 - Person centred care (patients needed assessed and care & treatment delivered in line with good practice/legislation - including NICE Guidance)*** ***Regulation: 10 - Dignity and respect (dignity & respect)***	
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ N/A	**Comments:**

Q9) Throughout your stay/attendance, how often did you feel you were, as far as possible, kept free from pain? ***Regulation: 12 - Safe Care and Treatment (pain management)***	
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ N/A	**Comments:**

Observations of Care:

Please observe the care delivery in relation to patients encouraged to keep their independence/self-care:

Q10) Are staff polite and respectful when communicating with patients? ***Regulation: 10 - Dignity and respect (kindness, compassion & dignity & respect)*** ***Regulation: 18 - Staff Training (training & development)***	
☐ Yes ☐ No ☐ N/A	**Comments:**
Q11) Are the call bells within reach of patients? ***Regulation: 10 - Dignity and Respect (dignity & respect)*** ***Regulation: 12- Safe Care and Treatment(accessibility of services - timeliness)***	
☐ Yes ☐ No ☐ N/A	**Comments:**

Q12) Are you satisfied that medication is not left outside of a secure environment? ***Regulation: 12 - Safe care and treatment (medicines handling) & (facilities & premises design & maintenance is safe)*** ***NOTE:*** *Observe counter tops in the clean utility, etc. for any medication, in particular TTO medication. Mark NO (where applicable) if the clean utility door is unlocked/open if fluids are accessible.*	
☐ Yes ☐ No ☐ N/A	**Comments:**

Q13) Is there evidence that patients are being taken to the toilet rather than using a commode/bed pan (when appropriate to do so)? ***Regulation: 10 - Dignity and Respect (dignity & respect)***	
☐ Yes ☐ No ☐ N/A	**Comments:**
Q14) Are the call bells answered within a timely manner? ***Regulation: 9 - Person centred care (patients needed assessed and care & treatment delivered in line with good practice/legislation - including NICE Guidance)***	
☐ Yes ☐ No ☐ N/A	**Comments:**

Q15) Are patients prepared appropriately for meal times? ***Regulation: 9 - Person centred care (patients needed assessed and care & treatment delivered in line with good practice/legislation - including NICE Guidance)*** ***Regulation: 14 - Meeting nutritional and hydration needs (nutrition & hydration)*** ***NOTE:*** *for example is hand hygiene offered to patients before their meal? Is the table cleared and repositioned if required?*	
☐ Yes ☐ No ☐ N/A	**Comments:**

Q16) Is the ward clutter free? ***Regulation: 15 - Premises and equipment (facilities & premises – design & maintenance is safe)***	
☐ Yes ☐ No ☐ N/A	**Comments:**

Nursing documentation:

Q17) Is the 'core data set' within new adult nursing assessment documentation completed in all cases? ***Regulation: 9 - Person Centred Care (patient information clear and accurate)*** ***Regulation: 17 - Good governance (health records completeness)***	
☐ Yes ☐ No ☐ N/A	**Comments:**
Q18) Tissue Viability: For patients at medium or high risk: has the patient got an up to date pressure ulcer prevention care plan? ***Regulation: 9 - Person Centred Care (patient information clear and accurate & patients' needs assessed and care and treatment delivered in line with good practice/legislation including NICE guidance)*** ***Regulation: 17 - Good governance (health records completeness)*** ***NOTE:*** *Please review the Waterlow Score document in the risk assessment booklet. Mark NO if the patient is at medium or high risk and there is no pressure ulcer care plan. Mark N/A if the patient is at low risk.* ***Waterlow score = 10 or above (medium to high)***	
☐ Yes ☐ No ☐ N/A	**Comments:**

Q19) Is there a NEWS score for every set of observations?

Regulation: 9 - Person Centred Care (patient information clear and accurate & patients' needs assessed and care and treatment delivered in line with good practice/legislation including NICE guidance)

Regulation: 12 - Safe care and treatment (pain management)

NOTE: *There should always be a NEWS score for every set of observations. Mark NO if the NEWS score had not been calculated for a set of observations.*

☐ Yes ☐ No ☐ N/A	**Comments:**

Q20) For NEWS score above 6 has the appropriate action been documented with escalation to Doctor or Nurse Practioner?

Regulation: 12 - Safe care and treatment(deteriorating patients)

Regulation: 9 - Person Centred Care (patient information clear and accurate & patients' needs assessed and care and treatment delivered in line with good practice/legislation including NICE guidance)

NOTE: *Check the medical and/or nursing notes. Mark NO if the patient had a NEWS score of 6 or greater for more than 1 hour and it was not escalated. Mark N/A if the patient had a NEWS score less than 6 or there is documented evidence in the medical notes that the patient is not for escalation (e.g. palliative care).*

☐ Yes ☐ No ☐ N/A	**Comments:**

Q21) Are patients being repositioned at regular interval, unless patient refused?
Regulation: 12 - Safe care and treatment (deteriorating patient)
Regulation: 9 - Person Centred Care (patient information clear and accurate & patients' needs assessed and care and treatment delivered in line with good practice/legislation including NICE guidance)

NOTE: *Check intentional rounding charts/turning charts. Mark NO if there is no documented evidence that the patient has been repositioned at least once every 4 hours (day and night). Mark N/A if the patient is at low risk or there is documented evidence that the patient has declined to be turned.*

☐ Yes ☐ No ☐ N/A	**Comments:**

Q22) Is the 'About Me' record within new adult nursing assessment documentation completed in all cases?
Regulation: 9 - Person Centred Care (patient information clear & accurate)
Regulation: 17 - Good Governance (health records)

NOTE: *The 'this is what matters to me' record is a record of a meaningful conversation held with patients about what is important to them and is contained within pages 13-14 of the adult nursing assessment document.*

☐ Yes ☐ No ☐ N/A	**Comments:**

General comments:

Summary of discussion with Staff:

This is an opportunity to discuss with staff Trust priorities (for example: incidents of Hospital Acquired Pressure Ulcers, Falls, C Diff rates & Infection Prevention and Control recommendations, etc.)

Feedback given to Nurse in Charge on completion of the visit:

Reviewer's Name…….

Name & Signature of person receiving feedback:

Name……. Signature……

Report to Trust Board 5.7.17

Title	**Leadership and Safety Walk arounds**
Sponsoring Director	**Chief Nursing Officer**
Author	**Vicky Morris**
Action Required	Trust Board are asked to approve the tool and approach.
Previously considered by	Clinical Governance Group

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

Healthcare is a people business. For Worcestershire Acute Hospitals Trust (WAHT) it is now the right time to revise and renew the Executive and Non-Executive Director Walkaround programme. The aim is to promote safety and quality and, most importantly, to engage with our staff and patients/service users.

This information guide will describe the Executive and Non-Executive Directors Walkarounds programme. We anticipate these Walkarounds facilitating the improved accessibility and visibility of our Executive and Non-Executive Directors across the WAHT.

Both the Francis enquiry and the Keogh report make reference of the need for healthcare organisations to foster a culture of improvement, but of equal importance, a listening and transparent culture.

These Walkarounds will support WAHT to enhance the relationship between frontline staff and the Executive and Non-Executive Directors. They will also provide the Executive and Non-Executive Directors with real time feedback and evidence to further focus on safety, leadership, Quality and listening to and valuing staff.

Title of report	Leadership and Safety Walk arounds
Name of director	Vicky Morris Chief Nursing Officer

The future aim of the Walkarounds will include the triangulation of all visit actions and feedback with data supplied by the Healthcare Standards Team. This data will be used to inform future visit discussions and most importantly, to celebrate success on the frontline teams.

Chief Nursing Officer

Worcestershire Acute Hospitals NHS Trust

5 July 2017 **Enclosure E2**

Report to Trust Board (in public)

Title	**Financial Performance – Month 2 2017/18**
Sponsoring Director	**Jill Robinson – Chief Finance Officer**
Author	Jo Kirwan - Assistant Director of Finance Katie Osmond – Assistant Director of Finance Dan Mortiboys – Assistant Director of Finance
Action Required	The Trust Board is asked to: ➢ **note the financial position** ➢ **Consider the following recommendations;** - **Full CIP plans to be developed by the end of July by the divisions supported by the PMO** - **Develop full mitigations to the risks identified in the report with agreed timelines and executive ownership**
Previously considered by	*N/a*

Priorities (√)

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

Related Board Assurance Framework Entries	3290 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service. 3291 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.

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 pre-set price to a defined measure of output of activity, it has been superseded by the national tariff.

1. Executive Summary

1.1 The Trust has a full year financial plan to deliver a £42.7m deficit prior to any Sustainability and Transformational Funding (STF) income and a deficit of £30m including STF in line with its control total target set by NHS Improvement (NHSI). The Trust is held to account by NHSI to deliver this planned deficit.

1.2 In Month 2 the Trust is reporting a pre STF deficit of £4.5m. This is £0.3m adverse to plan, increasing the year to date (YTD) adverse variance to £0.5m. As a result, the Trust would not be eligible to access the month 2 STF allocation assigned to financial performance. In addition, the Trust has not delivered the required operational metrics and consequently would not be eligible for the operational performance element. Including STF increases the adverse variance further, resulting in an overall adverse variance of £0.9m against the Month 2 plan and £1.8m YTD.

1.3 The key issue driving the current position is delivery of the Cost Improvement Programme (CIP). At month 2 the Trust has delivered £1m (53%) of CIP against a plan of £1.9m resulting in an YTD adverse variance to plan of £0.9m. The level of CIP delivery needs to be materially improved. Full plans need to be developed by the end of July and significant effort and focus is required to ensure that agreed targets are met.

1.4 Whilst risk was assessed (and where relevant built in) as part of developing the financial plan, actions identified to address CQC requirements and to recover operational performance faster than first envisaged now need to be considered. This poses a significant risk to the Trust in its ability to deliver the full year pre STF plan of £42.7m which in turn prevents the Trust from accessing STF monies. A detailed financial forecast exercise encompassing these items is underway and will be presented as part of the Q1 financial report.

1.5 The key issues to be considered by the Trust if it is to deliver the agreed control total are summarised below:

- The Trust has a challenging CIP of £20.9m for the year. To date schemes totalling £13.5m have been identified. The Trust has profiled its CIP to achieve 14% in Q1 (£2.9m), 23% in Q2 (£4.8m), 31% in Q3 (£6.4m) and 32% (£6.8m) in Q4. This requires achievement of CIP to be significantly improved from Q2 onwards. It is imperative that delivery is accelerated and supported with robust Quality Impact Assessments (QIA's)
- The cost of delivering improvement in operational performance faster than first envisaged across RTT, diagnostics and emergency access. A number of business cases have been considered by both the Trust Leadership Group (TLG) and the Finance and Performance Committee to address these issues and the financial impact of these will be included.

- These forecasts will include a clear assessment of any operational adverse budget variances with a corresponding corrective action statement – this is likely to include additional investment as a result of quality improvement in response to CQC rectification actions.

It is imperative that the Trust develops robust mitigation action plans to minimise if not eliminate the risk of not delivering its financial control total in this financial year. These are outlined on page 3 of the supporting pack but need to be developed in full with agreed timelines and executive ownership.

2.0 Other Financial Performance

2.1 Cash

The Trust's plan requirement for interim revenue support for 2017/18 is £31.1m, which is reduced by £12.7m from £43.8m, as the Trust is supported with Sustainability and Transformation Funding (STF) if it delivers to its plan. At this stage the Trust does not need to borrow against future STF payments. The level of interim revenue support will increase if the Trust is unable to access the full STF. The additional STF earned in 2016/17 is sufficient to offset the 2017/18 performance element of the STF which will leave the financial element at risk. As the Trust has no borrowing capacity available, it is anticipated that the Department of Health (DH) will continue to issue an uncommitted term loan on a monthly basis based on the Trust's financial performance. The loan draw down requirement of £3.5m for June 2017 has been agreed and transferred by DH.

2.2 Capital

The capital programme remains extremely tight. The capital forecast position for the financial year shows a projected overspend position against the Trust's CRL of £748k. This is prior to any loan applications which are required to mitigate this position. The Trust submitted all loan requests through the STP process by the required deadlines. The Trust is waiting for the final outcome.

3.0 Action Required

3.1 The Trust Board is asked to note the position and the significant risk that the Trust may not deliver to its financial control total as set by NHSI and consider the recommendations set out below:

- Full CIP plans to be developed by the end of July supported by the Project Management Office (PMO)
- Develop full mitigations to the risks identified in the report with agreed timelines and executive ownership.

Report to Trust Board

Worcestershire Acute Hospitals NHS Trust

Finance Report

Jill Robinson

Chief Finance Officer

5th July 2017

May 2017

Month 2

Income & Expenditure Overview

Worcestershire Acute Hospitals NHS Trust

In May the Trust incurred a deficit of £4.5m pre STF. This was £0.3m worse than plan.

Overall, the key driver of the pre STF adverse position in month 2 is the shortfall in CIP delivery.

Including STF the Trust was £0.9m worse than plan as the Trust has not achieved the financial and operational metrics required to access STF funding in May.

The year to date (YTD) deficit now stands at £9.1m pre STF. This is £0.5m worse than plan pre STF and £1.8m worse than plan including STF.

In Month

Income & Expenditure	May-17			Year to Date		
	Plan £000s	Actual £000s	Var £000s	Plan £000s	Actual £000s	Var £000s
Operating Revenue & Income						
Patient Care Revenue (pre STF)	26,760	27,208	448	54,470	54,388	(82)
Other Operating Income	2,260	2,265	5	4,513	4,462	(51)
Non PBR Drugs	2,872	2,872	0	5,776	5,776	0
Non PBR Devices	254	269	15	503	513	10
Total Operating Revenue pre STF	**32,146**	**32,614**	**468**	**65,262**	**65,139**	**(123)**
Operating Expenses						
Pay	(21,653)	(22,204)	(551)	(43,333)	(44,152)	(819)
Non Pay	(9,448)	(9,628)	(180)	(19,851)	(19,338)	513
Non PBR Drugs	(2,868)	(2,873)	(5)	(5,771)	(5,784)	(12)
Non PBR Devices	(254)	(248)	6	(503)	(574)	(71)
Total Operating Expenses	**(34,223)**	**(34,953)**	**(730)**	**(69,459)**	**(69,848)**	**(389)**
EBITDA *	**(2,077)**	**(2,339)**	**(262)**	**(4,197)**	**(4,709)**	**(512)**
EBITDA %	-6.5%	-7.2%		-6.4%	-7.2%	
Depreciation	(960)	(960)	0	(1,919)	(1,919)	0
Net Interest, Dividends & Gain/(Loss) on asset disposal	(1,242)	(1,242)	0	(2,483)	(2,483)	0
Reported Total Surplus / (Deficit)	**(4,279)**	**(4,541)**	**(262)**	**(8,599)**	**(9,111)**	**(512)**
Less Impact of Donated Asset Accounting	4	4	0	7	4	(3)
Surplus / (Deficit) against Control Total pre STF	**(4,275)**	**(4,537)**	**(262)**	**(8,592)**	**(9,107)**	**(515)**
STF	633	0	(633)	1,266	0	(1,266)
Surplus / (Deficit) against Control Total inc STF	**(3,642)**	**(4,537)**	**(895)**	**(7,326)**	**(9,107)**	**(1,781)**

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

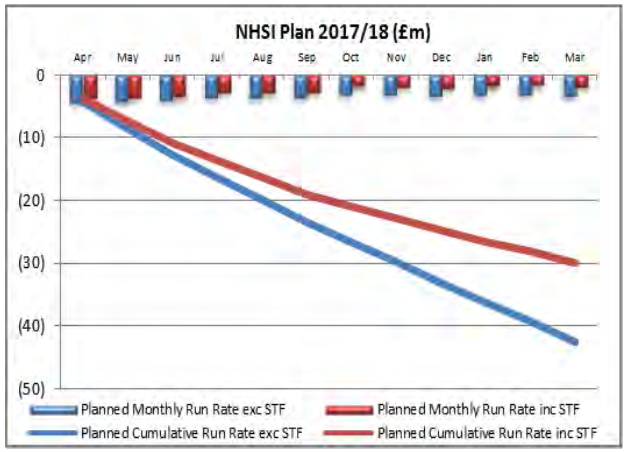
In month 2 the Trust is reporting a pre Sustainability and Transformational Fund (STF) deficit of £4.5m. This is £0.3m adverse to plan and is largely driven by the shortfall in CIP delivery. As a result the Trust has not accessed the month 2 STF allocation assigned to financial performance, nor has it delivered the required operational metrics.

Including STF increases the adverse variance further, resulting in an overall adverse variance of £0.9m against the May plan and £1.8m YTD.

At month 2 the Trust is forecasting to deliver its pre STF control total of £42.7m. A detailed forecast exercise will be undertaken at the end of Q1 and financial recovery plans will be developed where required to ensure the Trust meets its control total.

The underlying May run rate is £4.5m, broadly consistent with April.

2017/18 Full Year Plan



The financial plan has been set in line with the agreed financial control target resulting in a deficit of £42.7m prior to any STF funding and a deficit of £30m including £12.7m STF funding.

Monthly (Deficit) / Surplus Run Rate

Key Risks 2017/18

Worcestershire Acute Hospitals NHS Trust

There are a number of risks which could impact on the financial plan.

A detailed and revised forecast will be undertaken at the end of quarter 1 which will encompass and refresh the risks and opportunities identified to date.

A range of delivery between £54.3m and £61.3m deficits are indicated without actions to mitigate the risks raised to date.

STF funding is reliant on delivering standards to agreed trajectories and achievement of the financial control total. If these targets are not met, the Trust will not be able to access the STF.

The table below shows the financial risks to delivery of the pre STF control total of £42.7m deficit and planned mitigations.

Whilst risk was assessed (and where relevant built in) as part of developing the financial plan, actions identified to address CQC requirements and to recover operational performance faster than first envisaged now need to be considered.

Item	Rationale	Risk This Month (£m)	Planned Mitigation
Forecast Deficit	**As at Month 2**	**(42.7)**	
CIP		(5.0) – (8.0)	Robust Support/ Framework around Model Hospital
Quality Improvement	CQC Rectification Action	*	Limited immediate opportunities
	Organisational Resilience	TBC	Special Measures funding bid for backfill of key posts
	Culture Change Programme	(0.6)	Part funding with Special Measures
Operational Performance Improvement	Elective (RTT / Diagnostics) – Business cases submitted	(4.0) – (6.0)	Assess against cap/collar agreement
	Flow / Non Elective – includes Evergreen	(2.0) – (4.0)	Seek to access Better Care Fund
Planned Deficit adjusted for risk		**(54.3) – (61.3)**	

*The costs associated with CQC rectification actions are being worked through and validated. Experience from other Trusts in special measures would indicate this to be in the region of £5m - £8m for a Trust of our size.

Income - Summary

Worcestershire Acute Hospitals NHS Trust

Income excluding STF was £0.5m above plan in May but driven by the one off £0.4m reversal of previously assumed repatriation which has now been excluded. Including STF - £0.2m below plan.

The Trust's intention is to achieve its financial control target in 2017/18, clawing back the financial control element available within the STF.

The Trust is awaiting final national guidance on the qualification criteria for the 30% performance element of the STF.

The submitted Emergency Access Standard trajectory is compliant with the latest guidance on expected performance.

Income - Patient Care & STF Income combined reported an adverse variance of (£0.2m) in May and (£1.4m) YTD against plan.

Key movements in May:

- Inpatient £0.1m favourable - Electives £0.1m and Emergencies £0.2m favourable with Day cases (£0.2m) adverse.
- Outpatients £68k favourable – Ophthalmology £41k and General Surgery £21k favourable.
- Maternity (£219k) adverse – Deliveries (£108k) and Post & Ante natal visits (£110k) .
- Other Contract Income £0.6m favourable.
- STF Funding (£0.6m) adverse - Trust has not achieved it's financial control total in April. The performance trajectories are waiting to be agreed with NHSI, and we are awaiting final national guidance on the qualification criteria for the 30% performance element.

CQUINs – Total CQUIN is worth £7.5m: Worcestershire CCGs - £6.2m; Associate CCGs - £0.5m; and NHS England - £0.8m
The Transformation team are working with the leads within the Trust to ensure that CQUINs are delivered and tracked. The leads are clear on the targets that have to be delivered each quarter. Q1 CQUIN Programme Board meetings are scheduled June/July.

Sustainability Transformation Fund £12.7m for 2017/18 – Performance trajectories to be agreed with NHSI and final national guidance awaited.

Fines - May's position includes £115k for fines expected from Commissioners relating to 2 week & 31 day cancer waits (outside STF regime)

By Commissioner: Over-performance reported against Worcestershire CCG contract. NHS England (Prescribed services/oral/Screening) contract is slightly below plan YTD. Associate contracts are showing a 1% over performance. Non Contract /Out of Area activity is over performing above planned levels YTD by £136k.

	In Month				YTD				Full Year
	Plan £'000	Actual £'000	Var £'000	% £'000	Plan £'000	Actual £'000	Var £'000	% £'000	Initial Plan £'000
Inpatient	12,769	12,872	104	1%	24,257	25,135	878	4%	148,739
Outpatient	3,789	3,857	68	2%	7,015	6,987	(28)	(%)	43,635
ED/MIU	1,782	1,796	14	1%	3,473	3,521	48	1%	20,861
Maternity	2,218	2,000	(219)	(10%)	4,354	4,024	(330)	(8%)	26,024
Paediatrics	1,250	1,121	(128)	(10%)	2,432	2,288	(144)	(6%)	14,923
Other	8,078	8,703	625	8%	19,216	18,722	(494)	(3%)	112,063
Patient Care Income	**29,885**	**30,349**	**464**	**2%**	**60,748**	**60,677**	**(71)**	**(%)**	**366,246**
Other Operating Income	**2,260**	**2,265**	**5**	**%**	**4,513**	**4,462**	**(51)**	**(1%)**	**27,416**
Patient Care & Other Operating Income	**32,146**	**32,614**	**468**	1%	**65,262**	**65,139**	**(123)**	(%)	**393,662**
STF	**633**	**0**	**(633)**	**(100%)**	**1,266**	**0**	**(1,266)**	**(100%)**	**12,663**
Total Income	**32,779**	**32,614**	**(165)**	**-1%**	**66,528**	**65,139**	**(1,389)**	**-2%**	**406,325**

Note table above is under standard PbR and for Worcestershire CCG's does not reflect cap/collar position.

Pay Expenditure

Worcestershire Acute Hospitals NHS Trust

Pay expenditure in May was £22.2m, an over spend against plan of £0.6m.

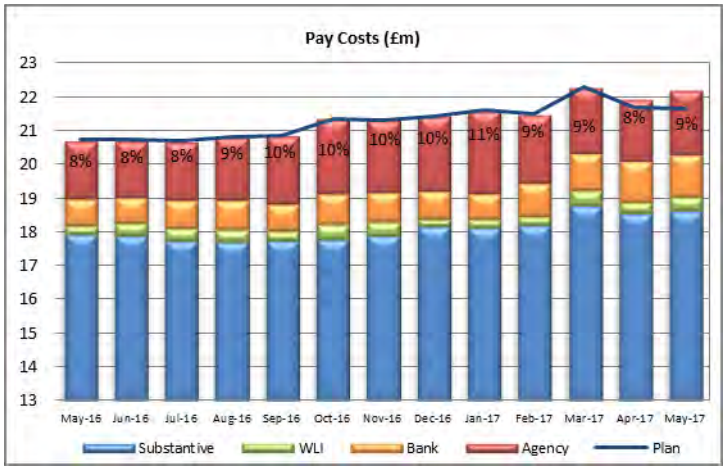
- Substantive pay spend was £19m (inc additional sessions)
- Bank pay spend was £1.3m (see page 6).
- Agency pay spend was £1.9m (see page 6).

The overall pay run rate increased in May compared to April by £0.3m and continues to be in excess of the 2016/17 Q3 average driven by the provision of additional bed capacity.
The in month movement is mainly within medics and relates to an increase in additional sessions predominately within Ophthalmology and Radiology .In Women & Children's division, job planning, acting down and dual cover also contributed to the increase.

In Month

For May total pay expenditure was over plan by £0.6m. Over spends on Temporary Medics and Nursing were partially offset by under spends on substantive lines, mainly due to vacancies.

FT Subjective	May-17			Year to Date		
	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
Medics - Consultants	(3,752)	(3,478)	274	(7,520)	(6,806)	715
Medics - Other	(2,355)	(1,781)	574	(4,636)	(3,501)	1,136
Medics - Agency / Bank	(485)	(1,664)	(1,178)	(973)	(3,330)	(2,357)
Total Medics Pay	**(6,593)**	**(6,923)**	**(330)**	**(13,130)**	**(13,636)**	**(507)**
Non Clinical	(3,460)	(3,149)	311	(6,788)	(6,288)	500
Non Clinical - Agency / Bank	(64)	(147)	(83)	(88)	(305)	(217)
Total Non Clinical Pay	**(3,524)**	**(3,296)**	**228**	**(6,877)**	**(6,594)**	**283**
Nursing & Midwifery	(8,389)	(7,772)	616	(16,707)	(15,655)	1,052
Nursing & Midwifery - Agency / Bank	(178)	(1,201)	(1,022)	(357)	(2,298)	(1,942)
Total Nursing Pay	**(8,567)**	**(8,973)**	**(406)**	**(17,063)**	**(17,953)**	**(890)**
ST&T	(2,912)	(2,790)	121	(5,819)	(5,531)	287
ST&T - Agency / Bank	19	(139)	(158)	38	(275)	(313)
Total ST&T Pay	**(2,893)**	**(2,929)**	**(37)**	**(5,781)**	**(5,806)**	**(26)**
Other	(76)	(82)	(6)	(483)	(162)	320
Total Other Pay	**(76)**	**(82)**	**(6)**	**(483)**	**(162)**	**320**
TOTAL PAY	**(21,653)**	**(22,204)**	**(551)**	**(43,333)**	**(44,152)**	**(819)**



Percentages shows proportion of agency spend against total spend.

Consultants – Substantive
Under spending on substantive Consultants is due to vacant posts. Specialties with more than 4 wte vacant Consultant positions include Acute Medicine, Elderly Care, Respiratory Medicine and Radiology. Favourable variances against substantive posts are offset by the costs incurred by bank and agency staff to cover these vacancies.

Medics Other – Substantive
As with Consultants, under spending on other medical staffing is a result of vacancies, again mainly within Medicine & Surgery. Specialties with more than 6 wte vacancies include A&E, General Surgery, Paediatrics, Gynaecology, T&O and Urology. Temporary staffing budget lines are based on the premium element of covering posts. The overall Medics adverse variance is driven by slippage against CIP.

Nursing
Substantive nursing costs were £7.8m in month, this is an under spend of £0.6m against plan. The cost of covering vacancies and the provision of additional capacity on the agency/bank lines increases total nursing costs to £9m resulting in a £0.4m adverse variance against plan in the month of May.
Bank holiday payments of £0.2m Trust wide were mainly within Nursing and are an increase on the run rate at the end of last year. This will reduce into June.

ST&T – Substantive
May saw an underspend of £121k on ST&T due to vacancies within Pathology, Pharmacy and Radiology. This is offset by the temporary cost of covering positions.

Non Clinical – Substantive
Expenditure on Non Clinical was £3.3m in month, a £0.2m under spend against plan.

Temporary Pay Expenditure

Worcestershire Acute Hospitals NHS Trust

NHSI set the Trust an annual agency expenditure ceiling for 2017/18 of £22.9m.

However, further to the NHSI announcement regarding a year on year reduction in medical agency, the Trust has been set a reduction target of £3.1m against medical agency against 16/17 outturn.

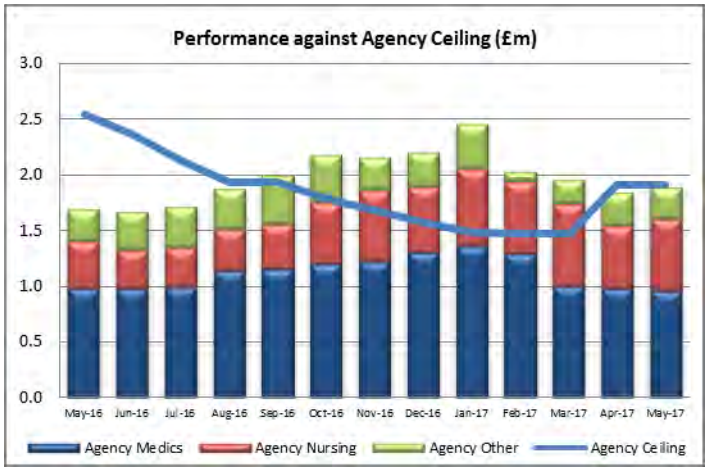
Performance - Agency

The Trusts spend on agency staffing for has increased in month 2 to from £1.8m to £1.9m and is £19k under the monthly agency ceiling. The in month spend continues to be a reduction on the underlying 16/17 run rate for the last two quarters.

The increase in agency spend is within nursing, which increased by £76k from £569k in April to £645k in May, and is across all clinical divisions. Surgery spend increased by £32k in month due to additional capacity and to cover vacant posts. SCSD saw increased activity and additional vacancies in Theatres (£24k) and 1-2-1 care in Haematology (£3k). Medicine had a small increase in nursing agency due to specialing for fall risks (£8k) and W&C had a small increase due to increased vacancies (£6k).

Medical agency reduced in month from £980k to £959k and this is mainly attributable to a 1.00 wte reduction in Radiology agency due to a Trust locum commencing in post.

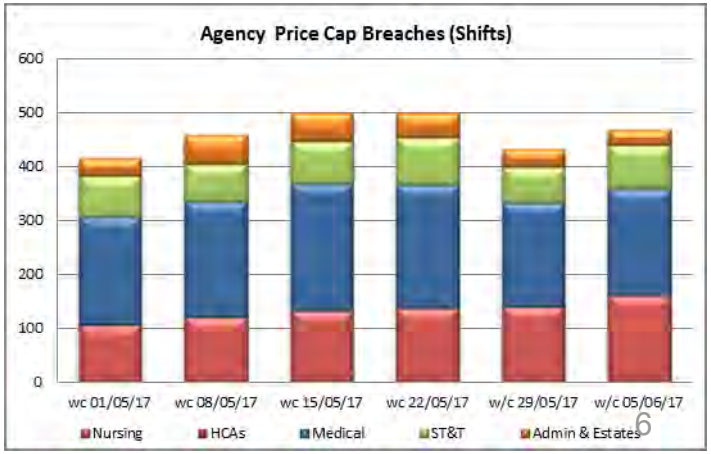
Non clinical and ST&T agency spend remains largely consistent with last month.



Agency Price Cap and Frameworks Compliance

The Trust is obliged to comply with mandatory price caps and approved frameworks for procuring agency staff. In cases where a framework is not used to procure an agency shift these "overrides" are to be reported to NHSI.

The chart below includes price cap performance only.



Non Pay Expenditure

Worcestershire Acute Hospitals NHS Trust

In May non pay expenditure was over spent by £0.2m against plan.

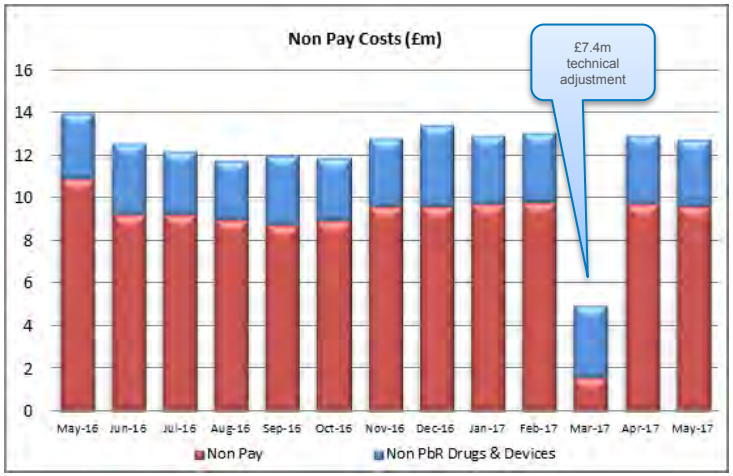
Overall, the key driver of the adverse position in month 2 is the shortfall in CIP delivery.

Year to date (YTD) non pay is under spending against plan by £0.4m.

In Month

For May total non pay expenditure was over plan by £0.2m. Under spends on clinical supplies & services, premises & fixed plant and reserves funding are offset by over spends on tariff drugs, general supplies & services and other.

FT Subjective	May-17			Year to Date		
	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
Clinical Supplies & Services	(3,423)	(3,216)	207	(6,809)	(6,992)	(183)
Drugs	(694)	(741)	(47)	(1,388)	(1,442)	(53)
Non PbR Drugs	(2,868)	(2,873)	(5)	(5,771)	(5,784)	(12)
Non PbR Devices	(254)	(248)	6	(503)	(574)	(71)
Establishment Expenses	(369)	(380)	(12)	(736)	(647)	89
General Supplies & Services	(492)	(546)	(54)	(997)	(1,077)	(80)
Other	(4,471)	(4,745)	(274)	(9,921)	(9,180)	741
TOTAL NON PAY	**(12,570)**	**(12,749)**	**(178)**	**(26,126)**	**(25,696)**	**430**
Depreciation	(960)	(960)	(0)	(1,919)	(1,919)	(0)
PDC - Dividend	(30)	(30)	(0)	(60)	(60)	(0)
Interest Payable	(1,214)	(1,214)	0	(2,428)	(2,428)	0
Impairment Losses	0	0	0	0	0	0
GRAND TOTAL	**(14,775)**	**(14,953)**	**(179)**	**(30,533)**	**(30,103)**	**430**



Clinical Supplies & Services

Expenditure on clinical supplies & services was £3.2m in month. The run rate for clinical supplies is consistent with activity volumes.

Drugs

Over spends of £47k in month are mainly within SCSD and relate to CIP targets.

Premises & Fixed Plant/Other

Key in month variances are due to a coding correction.

Other

Expenditure on Other Non Pay was £4.7m in month and £0.3m over plan predominately due to external consultancy fees & contractors.

Cost Improvement Programme (CIP)

Worcestershire Acute Hospitals NHS Trust

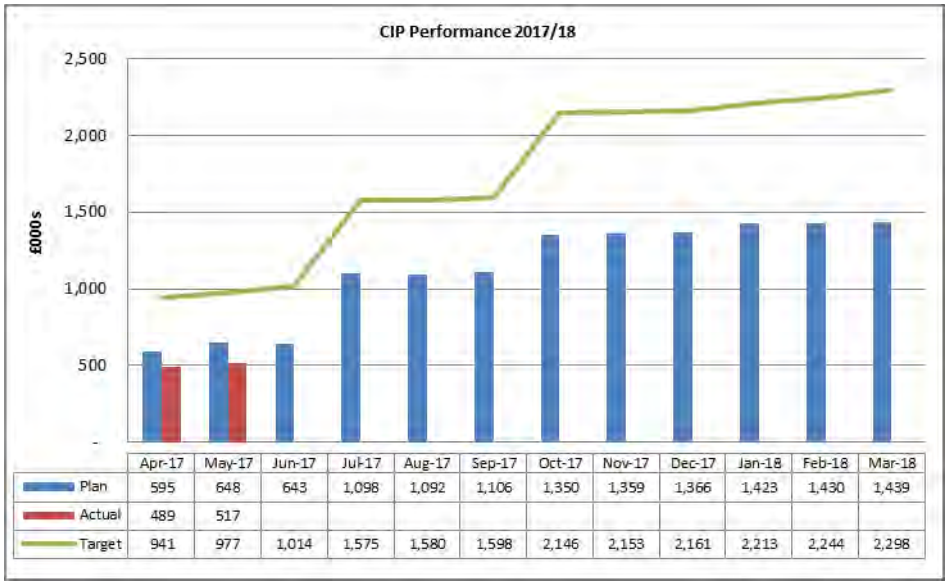
The financial plan assumes efficiency savings of £20.9m (5.3% turnover) are delivered in 2017/18.

In May the Trust had a target to deliver £1.0m of savings and a plan of £0.6m. The Trust has achieved £0.5m of savings resulting in a £0.5m adverse variance to target and £0.1m adverse variance to plan.

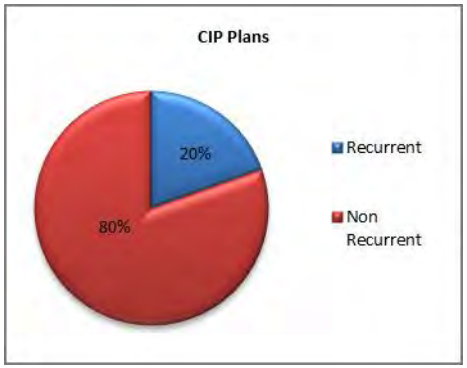
YTD the Trust had a target to deliver £1.9m of savings and a plan of £1.2m. Of this the Trust has achieved savings of £1.0m resulting in a £0.9m adverse variance to target and £0.2m adverse variance to plan.

Plans – Full Year

Division	Income (Other) £000s	Income (Patient) £000s	Non Pay £000s	Pay (Skill mix) £000s	Pay (WTE reduction) £000s	Other £000s	TOTAL £000s	Target £000s	Variance £000s	Variance %
Medicine		262	553	400	2,918		4,133	4,133	0	0%
Surgery	130	125	100	2,007	215		2,577	2,780	(203)	-7%
Women & Children	130	365	128	691	477		1,791	1,781	10	1%
Specialised Clinical Support		263	707	2,004	219		3,193	5,250	(2,057)	-39%
AMIT			928	28			956	2,891	(1,935)	-67%
Corporate	26		19				45	1,565	(1,520)	-97%
Central Trustwide							0	0	0	
Procurement						347	347	2,000	(1,653)	-83%
Drugs						500	500	500	0	0%
TOTAL NON PAY	**286**	**1,015**	**2,435**	**5,130**	**3,829**	**847**	**13,542**	**20,900**	**(7,358)**	**-35%**



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Plan	595	648	643	1,098	1,092	1,106	1,350	1,359	1,366	1,423	1,430	1,439
Actual	489	517										
Target	941	977	1,014	1,575	1,580	1,598	2,146	2,153	2,161	2,213	2,244	2,298



Balance Sheet

Worcestershire Acute Hospitals NHS Trust

The Balance Sheet is variant to plan by £9.8m

The cost of Property, Plant and Equipment (PPE) was re-valued upwards at the end of 2016/17 resulting in the PPE cost being ahead of the plan.

The Trust held cash of £2.8m at the end of month, £0.9m better than plan

May

	Budget £000s	Actual £000s	Fav/(Adv) £000s	Annual £000s	Forecast £000s	Fav/(Adv) £000s
Assets						
Property, Plant and Equipment, non current	167,055	169,733	2,678	177,152	176,609	(543)
PFI Property, plant & equipment, non current	77,661	82,734	5,073	77,316	82,646	5,330
Intangible Assets, non current	3,636	3,665	29	3,768	3,768	0
Trade and Other Receivables, non current	2,194	2,747	553	2,204	2,204	0
Total Non Current Assets	**250,546**	**258,878**	**8,332**	**260,440**	**265,227**	**4,787**
Inventories	5,910	8,813	2,903	5,625	5,625	0
Trade and Other Receivables, current	22,063	32,546	10,483	9,463	12,779	3,316
Other Assets, Current	3,480		(3,480)	3,316	0	(3,316)
Cash and Cash Equivalents	1,900	2,792	892	1,900	1,900	0
Assets Held for Sale	840	570	(270)	0	0	0
Total Current Assets	**34,193**	**44,721**	**10,528**	**20,304**	**20,304**	**0**
Total Assets	**284,739**	**303,600**	**18,861**	**280,744**	**285,531**	**4,787**
Current Liabilities						
Trade and Other Payables	(32,536)	(46,638)	(14,102)	(20,054)	(19,043)	1,011
Borrowings PFI	(1,617)	(1,617)	(0)	(2,106)	(2,106)	0
DH Revenue Support Loan	(1,334)	(1,334)	0	(39,506)	(39,506)	0
DH Capital Loan	(2,436)	(2,693)	(257)	(2,689)	(2,689)	0
Interest payable on DH Loans	0	(745)	(745)	0	0	0
Provisions	(717)	(821)	(104)	(618)	(618)	0
Other Liabilities	(950)	(959)	(9)	(494)	(494)	0
Total Current Liabilities	**(39,590)**	**(54,807)**	**(15,217)**	**(65,467)**	**(64,456)**	**1,011**
Net Current Assets/(Liabilities)	**(5,397)**	**(10,086)**	**(4,689)**	**(45,163)**	**(44,152)**	**1,011**
Non Current Liabilities						
Borrowings PFI	(70,114)	(62,810)	7,304	(68,008)	(60,704)	7,304
DH Revenue Support Loan	(117,856)	(117,711)	145	(102,344)	(102,344)	0
DH Capital Loan	(25,055)	(24,798)	257	(35,532)	(35,532)	0
Provisions	(1,429)	(3,040)	(1,611)	(1,653)	(3,179)	(1,526)
Other Liabilities	(3,306)	(3,252)	54	(3,011)	(3,011)	0
Total Non-Current Liabilities	**(217,760)**	**(211,611)**	**6,149**	**(210,548)**	**(204,770)**	**5,778**
Total Assets Employed	**27,389**	**37,182**	**9,793**	**4,729**	**16,305**	**11,576**
Financed by Taxpayers Equity:						
Public Dividend Capital	185,017	185,017	(0)	185,017	185,017	0
Revaluation reserve	54,320	59,107	4,787	54,320	59,107	4,787
Other reserves	(861)	(861)	0	(861)	(861)	0
I&E Reserve - Breakeven Performance	(173,779)	(168,774)	5,005	(196,439)	(189,650)	6,789
I&E Reserve - IFRS Transition and non breakev	(37,308)	(37,308)	0	(37,308)	(37,308)	0
Total Taxpayers Equity	**27,389**	**37,182**	**9,793**	**4,729**	**16,305**	**11,576**

Cash

At the end of May the cash position is £2.8m, which was over the plan by £0.9m mainly due to payment of debtor invoices.

Interim Support/Borrowings

The Trust's plan requirement for interim revenue support for 2017/18 is £31.1m, which is reduced by £12.7m from £43.8m, as the Trust is supported with Sustainability and Transformation Funding (STF) if it delivers to its plan. However, at this stage the Trust doesn't need to borrow against future STF payments.

Total current and non-current borrowings are summarised in the table below.

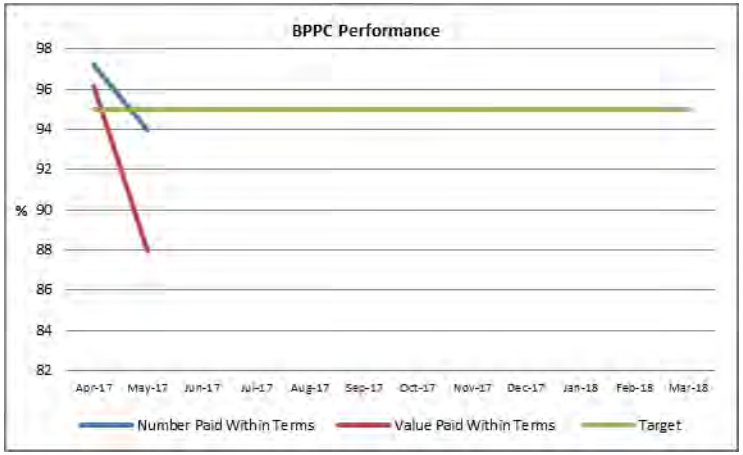
	Borrowing Balances		
	Capital £000s	Revenue £000s	Total £000s
Radiotherapy Loan	18,782		18,782
IT Infrastructure Loan	2,970		2,970
Emergency Department Loan	3,169		3,169
Capital Emergency Loan	2,570		2,570
Interim Revenue Support Loan		119,045	119,045
PFI Borrowings	64,427		64,427
Total borrowing	**91,918**	**119,045**	**210,963**

As the Trust has no borrowing capacity available, it is anticipated that DH will continue to issue an uncommitted term loan on a monthly basis based on the Trust's financial performance. The loan draw down requirement of £3.5m for June 2017 has been agreed and transferred by DH.

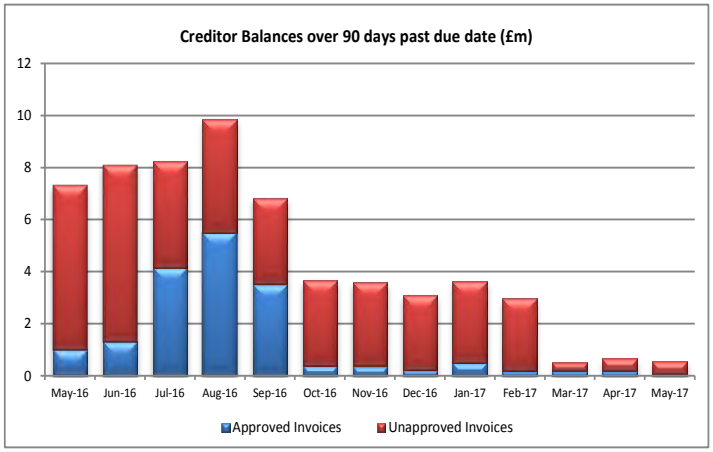
Working Capital

Worcestershire Acute Hospitals NHS Trust

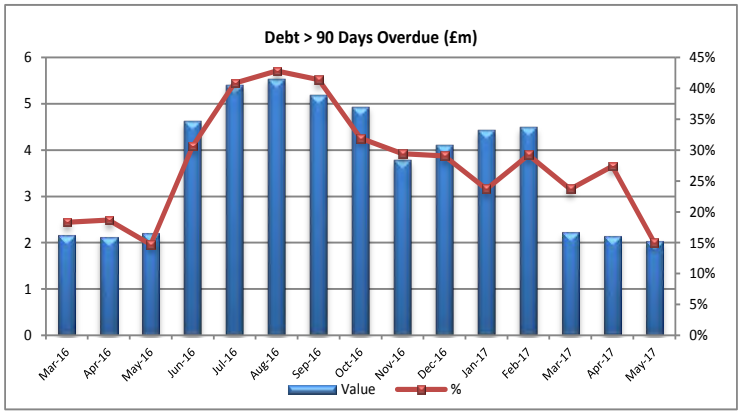
Payments are improving compared to last year and have the capacity to achieve target on volume for the full year.



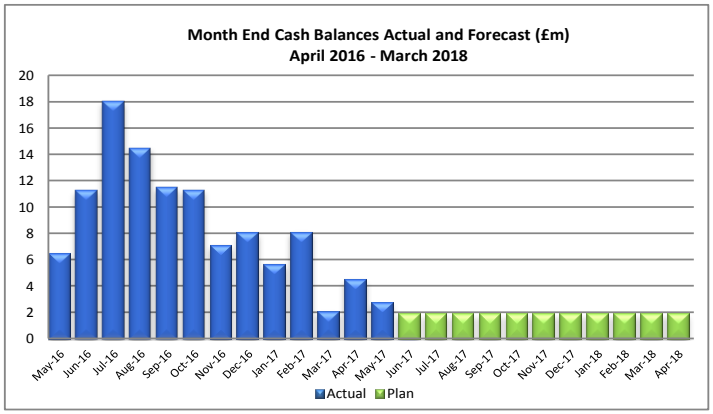
94.4% of creditor invoices have been paid within credit terms this month, which is slightly below the target of 95%. However, only 88% of total invoice value have been paid within the credit terms, which indicates that the lower value invoices have been processed more quickly.



While outstanding creditors have increased this month by £3m, 81% of the creditors are current. The over 90 days value has once again decreased.



The debt over 30 days have decreased this month by £0.5m. The number of days sales outstanding is 13, this tight debtors control allows for prompt payment of creditors.



The Trust held cash of £2.8m at the end of month. The forecast is maintained at the minimum cash level required of £1.9m. It is assumed that the creditor payments will be maintained within credit terms, providing interim revenue support from DH is in place.

Capital Programme

NHS Worcestershire Acute Hospitals NHS Trust

The capital forecast position for the financial year shows a projected overspend position against the Trusts CRL of £748k

An increase in the project costs for ASR has resulted in the FYF movement from £535k at month 1.

This is prior to any loan applications which are required to mitigate this position.

Workstream	Highlevel Summary	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance	
Development	ASR OBC	(42)	(42)	0	(84)	(84)	0	(500)	(1,148)	(648)	
	WRH ED Xray Enabling works	0	0	0	0	0	0	0	(100)	(100)	
	WRH Pathology Workstations	0	0	0	0	0	0	0	(114)	(114)	
	ED Expansion	(19)	(19)	0	(38)	(38)	0	(228)	(228)	0	
Development Total		(61)	(61)	0	(122)	(122)	0	(728)	(1,590)	(862)	
Equipment	Equipment	(1)	(1)	0	(2)	(2)	0	(450)	(450)	0	
Equipment Total		(1)	(1)	0	(2)	(2)	0	(450)	(450)	0	
ICT	Pre-Committed	(48)	(48)	0	(107)	(107)	0	(488)	(473)	15	
	EPR	0	0	0	0	0	0	(38)	(17)	21	
	ESIMP & Infrastructure	(36)	(40)	(4)	(89)	(98)	(9)	(942)	(864)	78	
	Old Year Schemes	0	8	8	0	(13)	(13)	0	0	0	*
ICT Total		(85)	(81)	4	(196)	(218)	(22)	(1,468)	(1,354)	114	
Property and Works	External Regs/ Stds	(13)	(13)	0	(47)	(48)	(1)	(370)	(370)	0	
	Routine works/Backlog Maintenance	(10)	(10)	0	(50)	(51)	(1)	(956)	(956)	0	
	Divisional Development	(1)	0	1	(7)	(5)	2	(146)	(146)	0	
	Old Year Schemes	0	(133)	(133)	0	(136)	(136)	0	0	0	*
	Commitment to manage sche	0	0	0	0	0	0	350	350	0	
Property and Works Total		(24)	(156)	(132)	(104)	(240)	(136)	(1,122)	(1,122)	0	
Total Expenditure		**(171)**	**(298)**	**(127)**	**(424)**	**(582)**	**(158)**	**(3,768)**	**(4,516)**	**(748)**	
Disposals	Sale of Assets - Alex	0	0	0	0	0	0	325	325	0	
Disposals Total		0	0	0	0	0	0	325	325	0	
Grand Total		**(171)**	**(298)**	**(127)**	**(424)**	**(582)**	**(158)**	**(3,443)**	**(4,191)**	**(748)**	

** The old year schemes are not included in the original FYF, the work stream leads will have to manage these costs within the plan.*

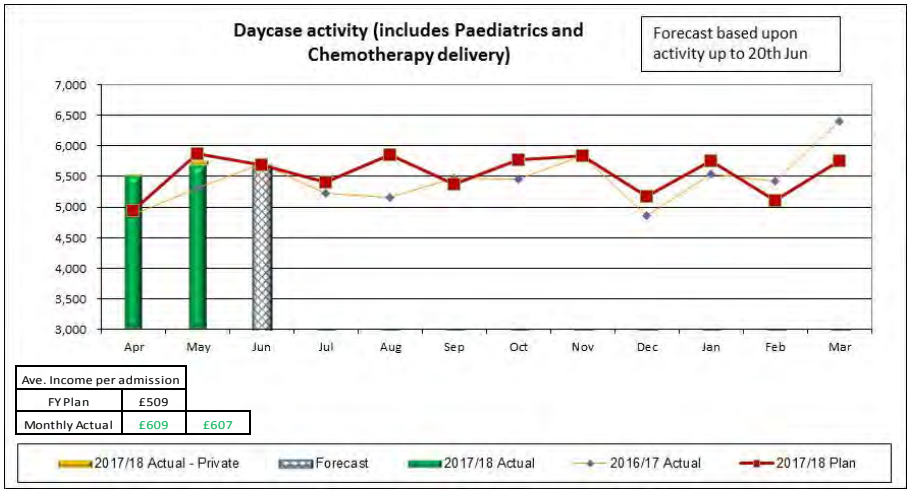
- The capital forecast position for 2017/18 financial year shows an overspend position against the Trusts CRL of £748k compared to £535k as at month 1. This is due to the revised project fees for the ASR capital scheme. This is prior to any loan applications.
- The Trust applied for a £5m loan in May 2017 and was intending on submitting a further loan request in June. Following further advice from NHSI we have been asked to resubmit as a single loan application for 2017/18 totaling c£16m. This will be submitted in late June / early July 2017.
- The position at the end of May 2017 shows an actual expenditure overspend of £158k which is mainly due to a number of schemes from last financial year within Property and Works work stream, including the final invoices for Ward 12 and 14 Alex works, and VAT for the single access card system. A review of the VAT is expected where some VAT may be reclaimable. Within ICT there are 2 invoices which relate to 2016/17 for Mortality review and ICE enhancements £22k.
- Finance are working with the work stream leads with monthly meetings to monitor the capital expenditure to ensure the Trust meets its CRL.
- The Plan excludes the ED Triage project of £920k which is being worked up.

Worcestershire Acute Hospitals NHS Trust

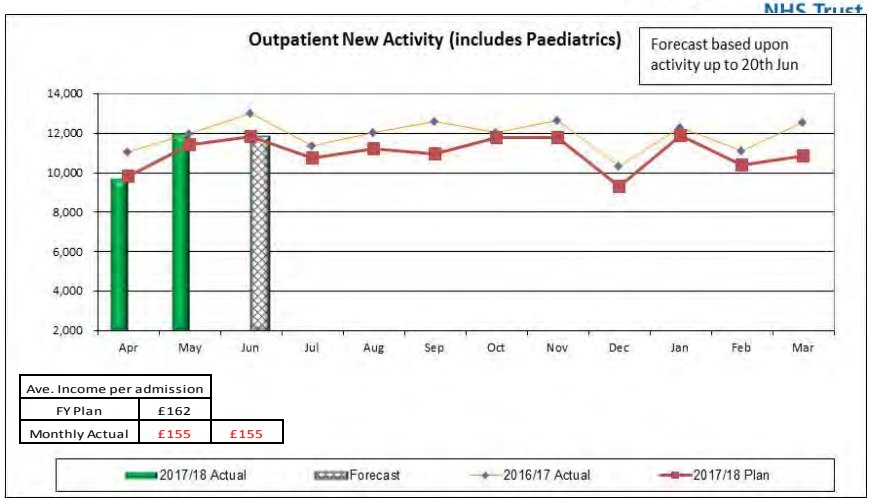
Appendices

Activity - Elective, Day Cases & Outpatients New

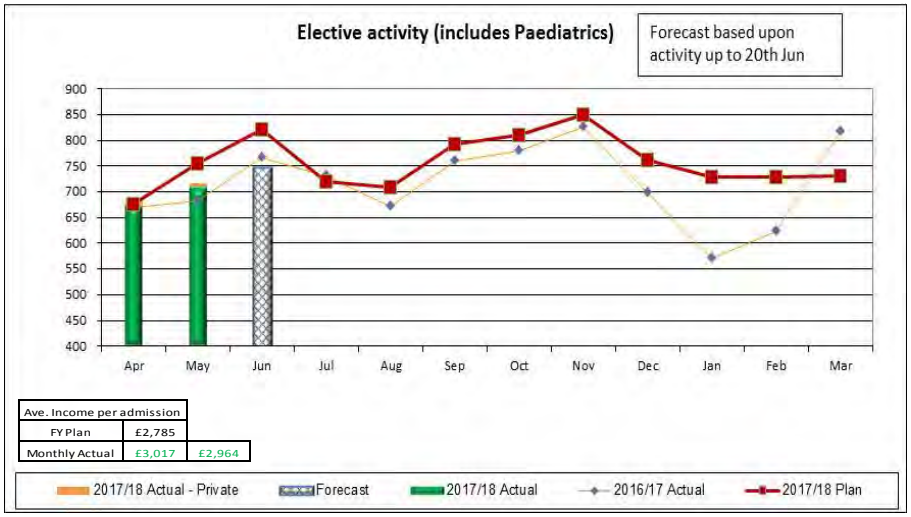
Worcestershire Acute Hospitals NHS Trust



Ave. Income per admission		
FY Plan	£509	
Monthly Actual	£609	£607



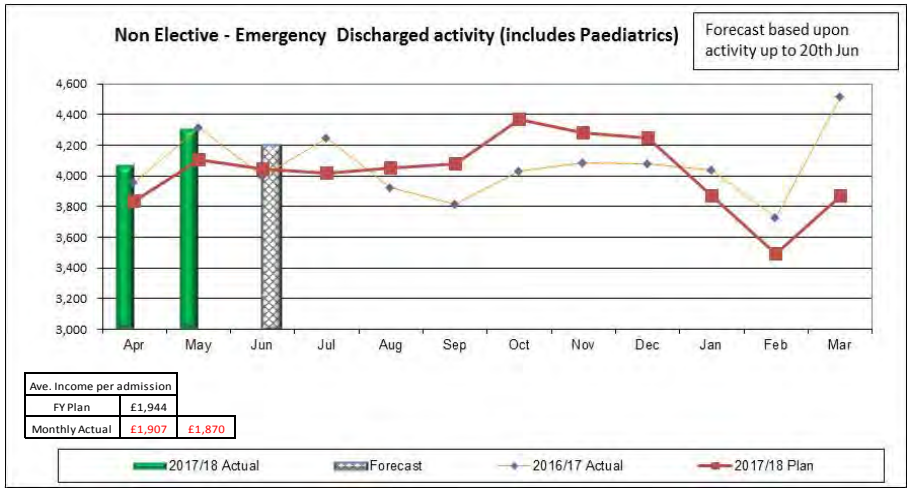
Ave. Income per admission		
FY Plan	£162	
Monthly Actual	£155	£155

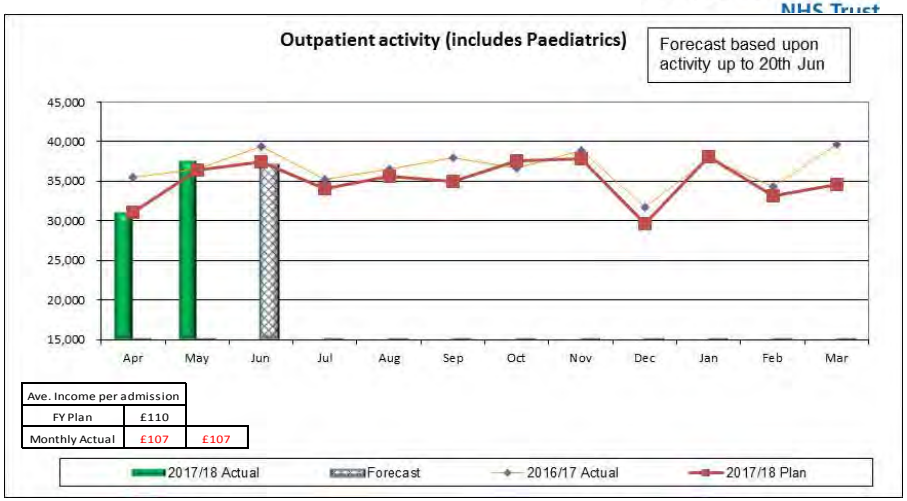


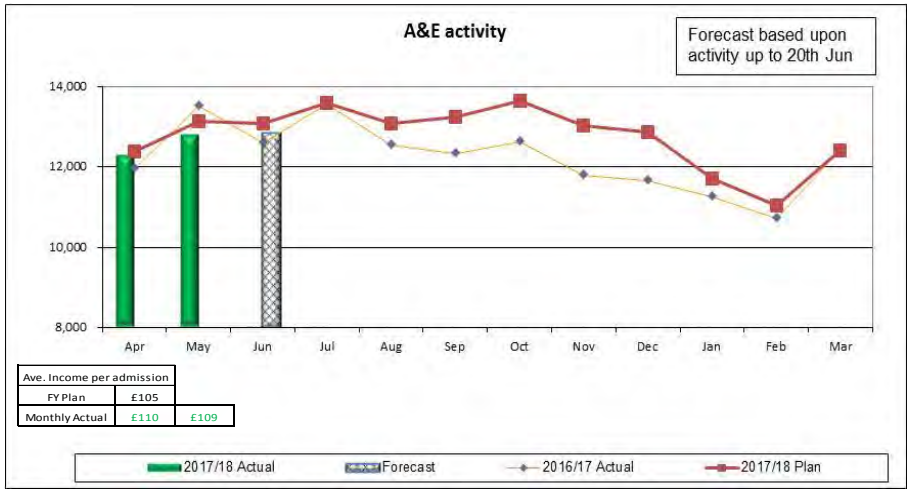
Ave. Income per admission		
FY Plan	£2,785	
Monthly Actual	£3,017	£2,964

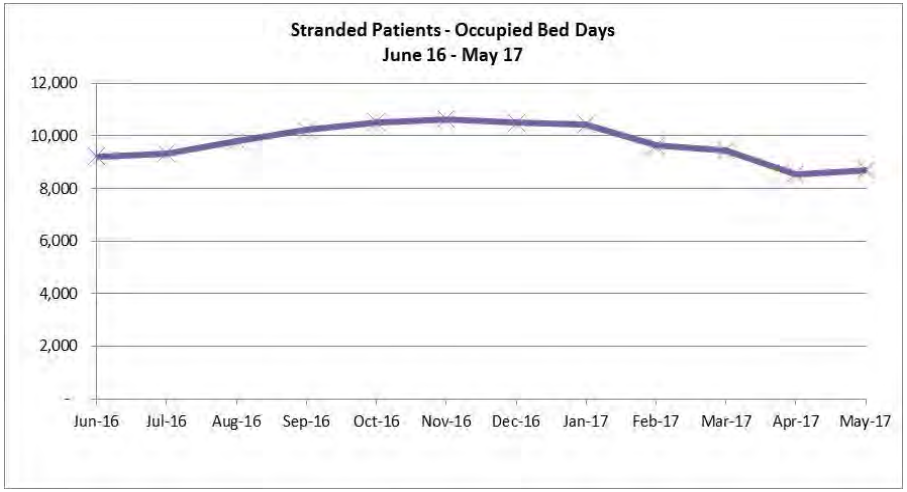
Activity - Outpatients, Non Elective and A&E

Worcestershire Acute Hospitals NHS Trust









5 July 2017 **Enclosure F1**

Report to Trust Board

Title	Integrated Performance Report (Month 2)
Sponsoring Director	Haq Khan, Acting Director of Performance
Author	Rebecca Brown, Assistant Dir. of Information and Performance Hannah Baars, Performance Support Officer
Action Required	The Board is asked to: 1. Review the Integrated Performance Report for Month 2. 2. Seek assurance from the relevant Executive Directors as to whether: a. the risks of under-performance in each area have been suitably mitigated, and; b. robust plans are in place to improve performance. 3. Consider the level of detail to be presented to future meetings.
Previously considered by	Finance and Performance Committee [28/06/17]

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 3291 Deficit is worse than planned and threatens the Trust's long term financial sustainability 3038 If the Trust fails to improve performance, strengthen governance and patient safety it will not address CQC inspection concerns. 3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected.
Legal Implications or Regulatory requirements	Section 92 of the Care Act 2014 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	EAS – Emergency Access Standard STF – Sustainability Transformation Fund YTD – Year to Date NHSi – National Health Service Improvement CQC – Care Quality Commission TTIA – Time to Initial Assessment

REPORT TO TRUST BOARD

1. Situation and background

1.1 This paper presents an overview of performance for May 2017 (Month 2). The report summarises issues with current performance, and areas of risk for the Trust. An exception based approach is taken, escalating areas of particular risk in performance against national and local targets and standards.

1.2 The new, high level, Performance Management and Accountability Framework was formally adopted by the Trust in the April Finance and Performance Committee. Work continues to embed this strategy and to work on the 3 areas of focus:

1. Create a clear structure to ensure the components of successful performance management are effective.

2. Support cultural change to embed enhanced accountability and a performance improvement culture through the whole organisation.

3. Ensure our workforce has the right tools to manage performance well.

2. Assessment

2.1 The format of the **Integrated Performance Report** has been reviewed and enhanced to take into account Non-Executive and Executive direction, and best practice.

2.2 The **Key Performance Indicators** (**KPI) Highlight Quadrant** outlines trends between month 1 and 2 for KPIs in operational performance, quality and safety and workforce (see page 4). Financial Performance metrics are covered in the Finance report. The full dashboard covering the 4 sectors of Integrated Performance is available as Appendix 1. The KPI Highlight Quadrant aims to draw out and signpost key indicators from the detailed dashboards.

2.3 In future months, four **Summary Reports** will be presented to the Board for Operational Performance, Quality and Safety, Finance and Workforce. The summary will include performance issues which require escalation to Committee level. This will be in an easily accessible overview format, and written in 'plain English'. For Month 2, an example Operational Performance Summary has been produced and is available on page 5 of the report.

2.4 **Corrective Action Statements** are provided this month for areas within Operational Performance and Workforce which are off track. Quality and Safety issues are considered separately within the Quality Governance Committee. Finance issues are covered within the Finance Report. The Corrective Action Statements are available from page 6 onwards.

2.5 Performance Review meetings continue to take place on a monthly basis, with the most recent being for the Medicine and Surgery Divisions, week beginning 19th June.

2.6 Discussions with the Chief Operating Officer have taken place to discuss the performance timeline, and a review of meeting timings will take place to ensure that Divisional Reviews occur at an appropriate time to feed the NHSi Progress Review Meetings (PRM).

Title of report	Integrated Performance Report – Month 2 2017/18
Name of Director	Haq Khan, Acting Director of Performance

3. Recommendations

The Board is asked to:

1. Review the Integrated Performance Report for Month 2.
2. Seek assurance from the relevant Executive Directors as to whether:
    a. the risks of under-performance in each area have been suitably mitigated, and;
    b. robust plans are in place to improve performance.
3. Consider the level of detail to be presented to future meetings.

Title of report	Integrated Performance Report – Month 2 2017/18
Name of Director	Haq Khan, Acting Director of Performance

KPI Highlight Quadrant - Operational Performance, Quality and Safety, and Workforce

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 Finance report.

Metrics in italics are managed through the Quality Governance Committee (QGC)

Page	Performance on /above target with positive trend
	• Bed occupancy – ALX
	• Beds occupied by NEL stranded patients (snapshot)
	• *Hip fracture time to theatre (all)*
	• *Hip fracture time to theatre (excluding unfit pts)*
	• *Never event occurrence*
	• *Grade 3 and 4 pressure ulcer occurrence*
	• *CDiff*
	• *FFT acute inpatients score*
	• *FFT maternity score*
	• *Falls resulting in serious harm*

Page	Performance on /above target with negative trend
	• Time to Initial Assessment median

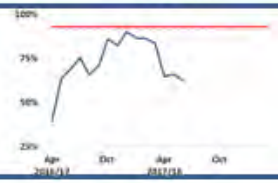
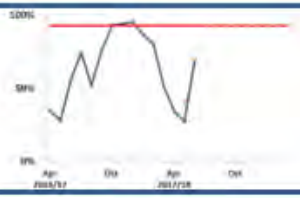
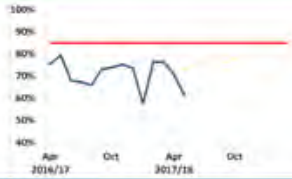
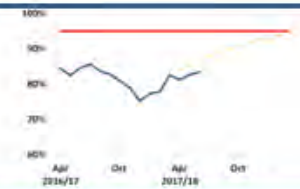
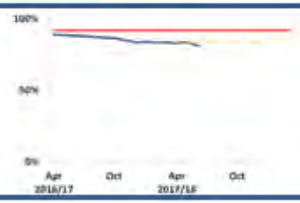
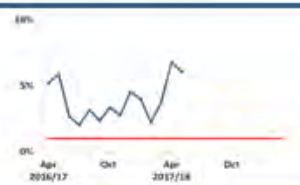
Page	Performance under target with positive trend
5	• Cancer 2 week wait (All)
11	• 104+ day waits
13	• Emergency Access Standard – Trust and MIU
13	• Emergency Access Standard - ALX
	• Ambulance handover within 15 minutes
	• Ambulance handover within 30 minutes
16	• RTT – Incomplete
19	• 6 week diagnostics
23	• 80% of Patients spend 90% of time on a Stroke Ward
	• Delayed Transfers of Care
	• % of discharged FCEs not coded by SUS submission
	• Staff turnover
25	• Sickness absence
	• *Mixed sex accommodation breaches*
	• *VTE risk assessment*
	• *Primary and Secondary mortality review completion*
	• *FFT A&E score*
	• *Safety Thermometer harm free care score*
	• *SHMI rolling 12 months*
	• *HSMR rolling 12 months*

Page	Performance under target with negative trend
8	• Cancer 2 week wait (Breast)
10	• Cancer 62 day wait (All)
	• Cancer 31 day for 2nd / subs treatment (Surgery)
13	• 12 hour trolley breaches
13	• Emergency Access Standard – WRH
	• Time to Initial Assessment (All) 95th percentile
	• Ambulance handover over 60 minutes
	• Unplanned re-attendance
17	• 52 week waits
23	• Direct Admission (via A&E) to a Stroke Ward
	• Bed occupancy – WRH
	• 28 day breaches as % of cancellations
	• Urgent operations cancelled for a second time
27	• Total staff vacancies
	• *Serious Incidents open over 60 days*
	• *Complaints response*

Title of report	Integrated Performance Report – Month 2 2017/18
Name of Director	Haq Khan, Acting Director of Performance

Month 2 2017 Operational Performance Summary

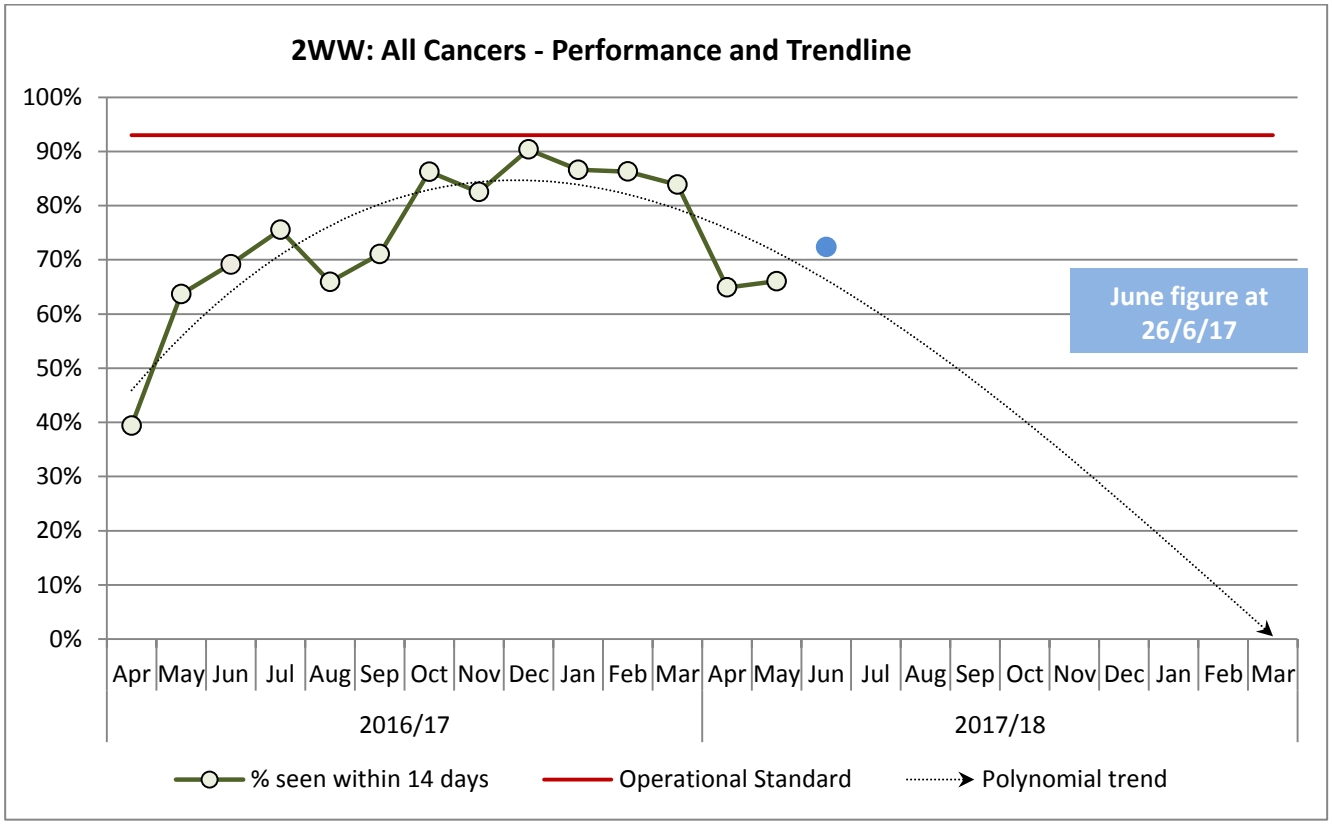
Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	What are we aiming for in June?
Did we see urgent cancer patients quickly?	**93%** of potential cancer patients seen by a specialist within 2 weeks.	66% — We saw 66% of our cancer patients within 2 weeks. Particular issues in skin, urology, lower and upper GI, thoracic.		Recruitment in key specialties, use of nurse practitioners, work with CCGs re urgency of 2ww referrals, triaging lists, daily monitoring, introduction of multi-disciplinary approach.	See more on pg 6
Did we see patients with potential breast cancer quickly?	**93%** of patients with potential breast cancer seen by a specialist within 2 weeks	27.37% — 27.37% of patients were seen within 2 weeks. This means that 138 patients were seen outside of the NHS constitutional standard in May.		Increased in week and weekend slots, enhanced consultant radiology cover, proactive cover for breast consultants over summer period.	**70%** See more on pg 9
How quickly did we start treating cancer patients?	**85%** of cancer patients to start treatment within 62 days.	61.4% — 61.4% of patients started treatment within 62 days. Specialties requiring access to endoscopy are a particular focus.		Recruitment in key specialties, additional sessions, business case around insourcing and outsourcing endoscopy, new method of triage, suitable use of Laurel 2 triage room	**75.3%** See more on pg 11
Are we seeing patients with an emergency within 4 hours??	The Trust should see **95%** of patients within 4 hours from arrival to admission, transfer or discharge	82.7% — Trust performance was 82.7%. At Worcestershire Royal, performance was 66.29% and at the Alexandra performance was 85.41%.		Increase consultant establishment, overseas recruitment, capital funding to enable streaming, reduce 'stranded' patient numbers.	**86.5%** See more on pg 14
Did we start treatment within18 weeks?	**92%** of patients on a 'referral to treatment' (RTT) pathway should be seen within 18 weeks.	84.07% — We treated 84.07% of patients within 18 weeks in May. Key areas of concern are thoracic, neurology, ophthalmology, T&O, Gen Surg and oral surgery.		Actions around recruitment and staff capacity are the most critical factor for RTT. Enhanced nursing roles and additional sessions.	**84.7%** See more on pg 17
When a patient needs a diagnostic test, do we do this within 6 weeks?	A maximum of **1%** of patients who need a diagnostic test can be seen outside of 6 weeks	6.07% — We saw 93.97% of patients requiring a diagnostic test within 6 weeks, so 6.07% were seen outside of the timescale. Key areas for improvement are endoscopy and radiology. 622 patients were not seen in time in May.		New insourcing and outsourcing initiatives, waiting list initiatives, ensuring best use of equipment availability, staff vacant sessions.	**5.79%** See more on pg 20

Note: RAG ratings are against M2 internal trajectories

Consolidated Cancer 2WW (inc. Breast Suspected) Corrective Action Statement | May 2017 Reporting

Reporting Month	May 2017
Operational standard	93.0%
In Month Performance	**66.0%**



Trust	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	64.9%	66.0%	72.4%									
Trajectory	Not available. Due for completion in July											

Operational Standard: 93% of patients are seen by a specialist within 14 days

Performance Overview

Overall Trust performance against this standard continues to decline. SCSD and W&C divisions buck the trend; both consistently performing over 92%. The majority of W&C breaches are due to patient choice. Surgery and Medicine show a more variable performance with Surgery's performance against Skin, Urology, and Breast continuing to deteriorate and Medicine's Thoracic trajectory proving problematic (please note Breast 2WW symptomatic covered in separate CAS.)

Service Commentary

The 5 specialties with significant risks to 2WW delivery are **Skin** (demand outstrips capacity, recruitment), **Urology** (capacity just meeting demand, no lee-way if staffing issues), **Lower GI** (demand outstrips capacity), **Thoracic** (inability to recruit), **Upper GI** (inability to recruit and increased referrals).

MEDICINE Specialty	April	May		
	2WW (%)	2WW (%)	Not seen within 14 days	Total Seen
Lung	67.7%	78.3%	5	23
Upper Gastrointestinal	82.3%	87.0%	25	192
Medicine Total	80.3%	86.0%	30	215

SURGERY Specialty	April	May		
	2WW (%)	2WW (%)	Not seen within 14 days	Total Seen
Lower Gastrointestinal	59.4%	71.7%	105	371
Skin	67.9%	50.5%	146	295
Urological	59.5%	58.3%	80	192
Surgery Total	58.3%	60.3%	518	1304

W&C Specialty	April	May		
	2WW (%)	2WW (%)	Not seen within 14 days	Total Seen
Gynaecological	93.0%	93.2%	6	88

Corrective Actions Log

	Specialty	Actions	Progress	Lead	Deadline
1.	Urology Skin	Increase clinical haematuria capacity. Explore consultant staffing model alternatives	Recruitment underway. Business case required. Scope case for Nurse consultant & nurse practitioners.	CLS, DM AMD, DM, DDN	Complete, In action In action, Jun 17
2.	Skin	Introduce multi-disciplinary approach to include Head & Neck, Dermatology and Oncology	Job plan changes will be required		In action. Summer 17
3.	Lower GI	Mainstream nurse triage service. Source additional consultant colorectal surgeon	Business case completed. Business case not yet approved.		On going
1.	Thoracic/ Upper GI	Daily monitoring of 2ww escalation lists and identification of sufficient capacity	On-going	DDOPs/Directorate Managers	On-going
2	Thoracic/ Upper GI	Recruitment of substantive consultants to vacant posts	On-going	Divisional Medical Director	Jan 18
3.	Thoracic	Triage of thoracic 2WW referrals which will downgrade some 2WW referrals.	June 2017	Thoracic Consultant Body	July 2017
4..	Thoracic	Recruitment of 6 month Locum for Thoracic Cancer Services for cross county cover	on-going	DDOP's/Directorate Managers	On going
5.	Thoracic/ Upper GI	Work with commissioners to ensure GPs increase patient awareness of the reason and urgency of their referral	On-going	Deputy COO/CCG Deputy Director of Commissioning	May 2017 onwards
6.	Upper GI	Trialling of 2 additional patients on endoscopy list for SpR	On-going	Directorate Manager	May 2017

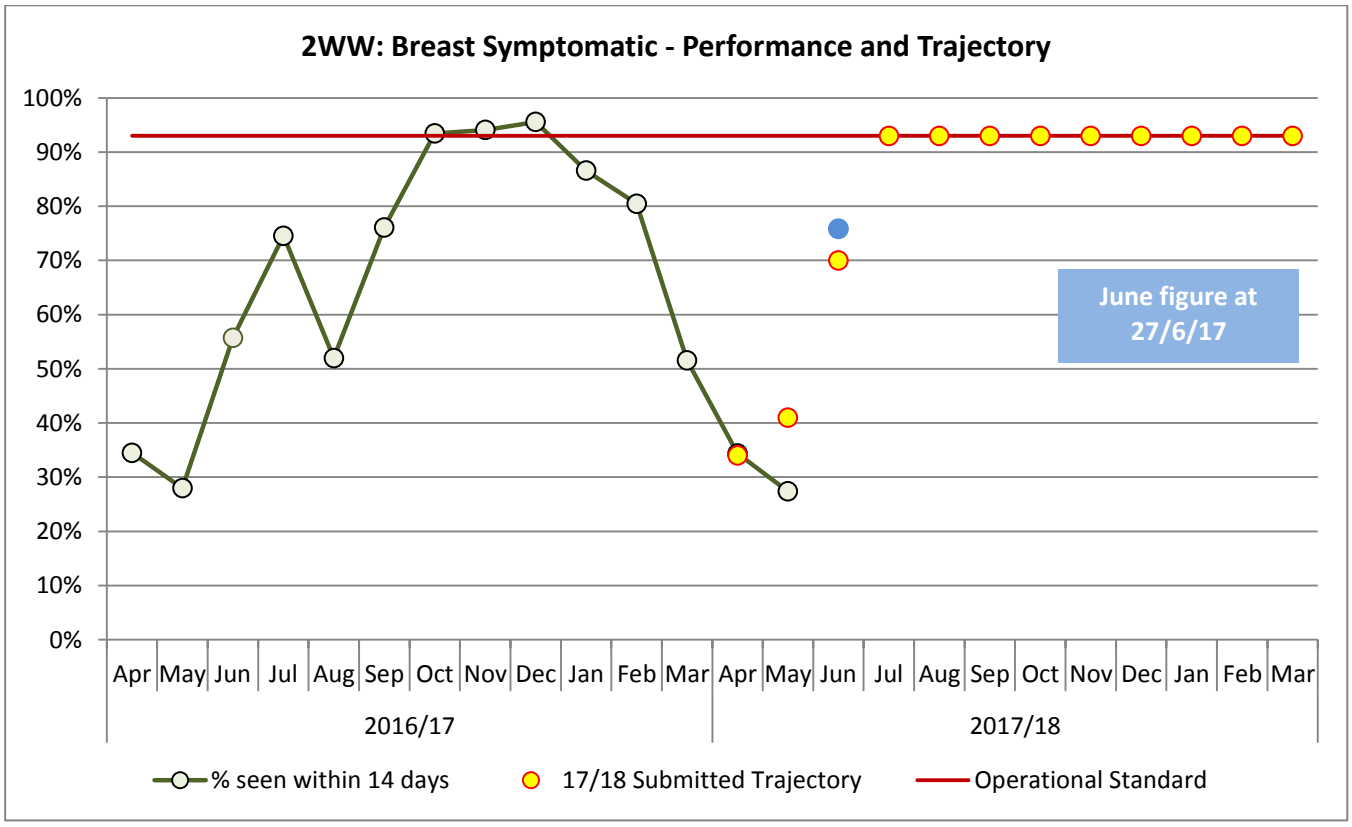
Risk Summary

	Specialty	Risks	Risk Score	Mitigations
1	Gynae.	Further deterioration of O&G staffing rotas may negatively impact on the 2WW compliance	12	Request made for 4 resident on call locums consultants. Additional clinics.
2	Skin, urology, colorectal	Additional sessions to job plan are voluntary	16	
3	Urology/colorectal	Increased endoscopy capacity required	16	
4	Colorectal	Business case for nurse not approved	9	
5	Thoracic	Triage of thoracic 2WW referrals does not work.	TBC	Review of pathway and the impact it is having on the service after 3 months. Changes to be made as necessary
6	Thoracic	Inability to recruit to vacant consultant posts across county	TBC	If recruitment is unsuccessful on the Alex site we will look at creating countywide posts with a rotation between sites
7	Thoracic	Increase in referrals due to TV campaign – lack of capacity	TBC	Close monitoring of referrals and the impact of the triage service
8	Upper GI	Inability to recruit to vacant consultant post	TBC	Review of JD and further attempt at recruitment/out to agency
9	Upper GI	Unable to cope with increased demand following TV/Radio campaign	TBC	Additional WLI clinics to help clear backlog

Consolidated Cancer 2WW Breast (symptomatic) Corrective Action Statement | May 2017 Reporting

[CAS received from Surgery]

Reporting Month	May 2017
In Month Trajectory	41.0%
In Month Performance	**27.7%**



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	34.4%	27.7%	75.8%									
Trajectory	34.0%	41.0%	70.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

Operational Standard: 93% of patients are seen by a specialist within 14 days

Service Commentary

Overall Trust performance against this standard has been in decline since January 2017 following a period of 3 months where the standard was achieved. The main reason behind the fall in performance is that demand has outstripped capacity with the Surgery division struggling to manage the increase in referrals with annual leave and the spring Bank Holidays resulting in a loss of clinic slots. The Radiology Consultant capacity is also fragile, which is an on-going issue.

Corrective Actions Log

	Specialty	Actions	Progress	Lead	Deadline
1	Breast	Increased Breast Consultant sessions planned on weekends. Increase Consultant Radiology commissioned via locum agency secured	100 slots created during June	Surgery and SCSD	Completed

2	Breast	Additional consultant & Nurse Practitioner clinics scheduled during the week	40 slots created during June	Surgery/SCSD	Completed
3	Breast	Increase in Breast Consultant Capacity – July – August to mitigate loss of activity over summer period.	Consultant identified , agreeing terms and conditions	Surgery	In progress

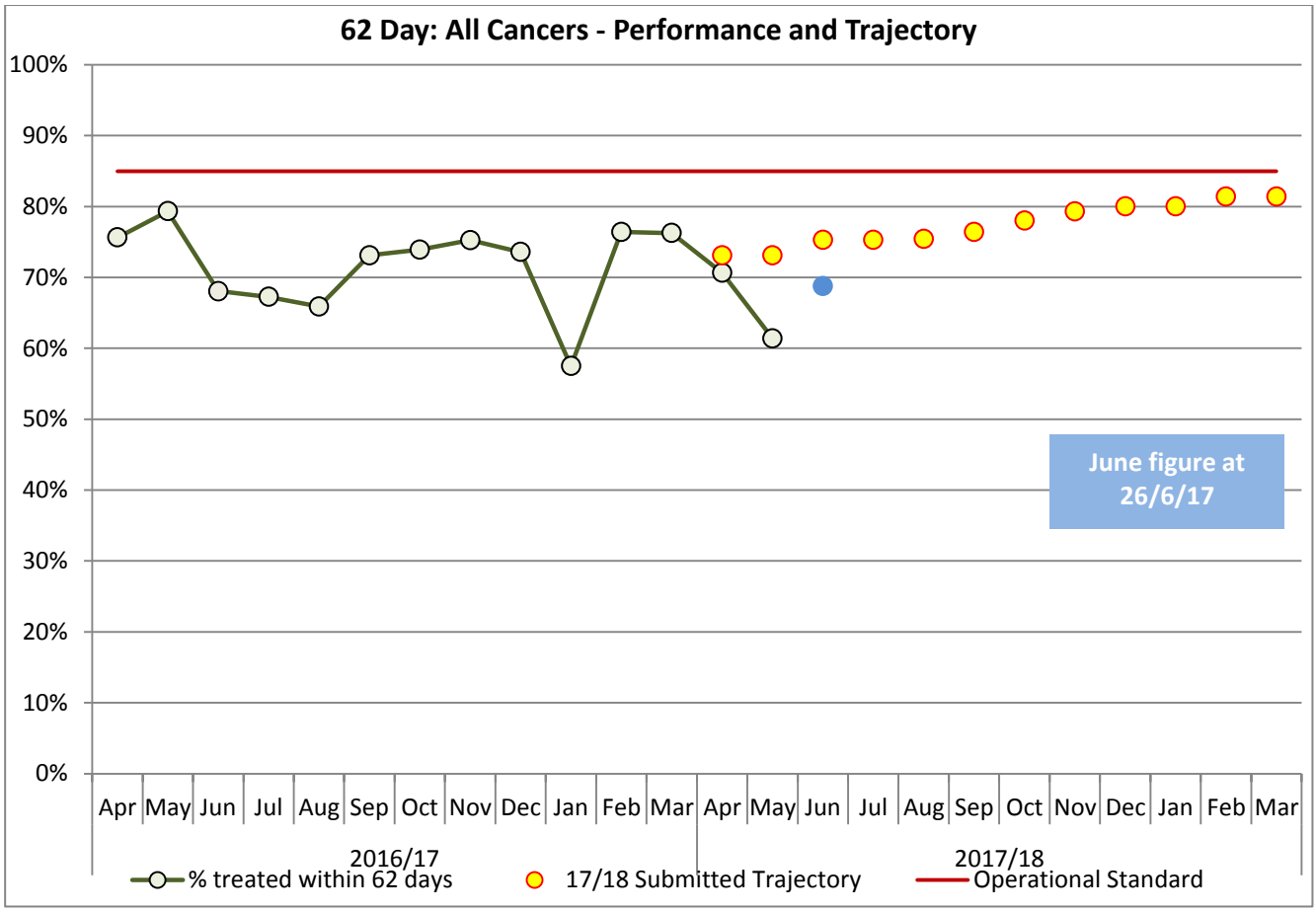
Risk Summary

	Specialty	**Risks**	**Risk Score**	**Mitigations**
1	Breast	Consultant, radiologist, radiography and nurse practitioner - additional sessions to job plan are voluntary	16	An additional consultant has been secured for July & August
2	Breast	Additional Radiologist are commissioned via agency and are current commission over cap rates	16	Advertise a substantive joint WAHT / WVT consultant breast radiologist post
3	Breast	The % of patients breaches is considerable higher within Breast, in particular Breast Symptomatic	9	Implementation of E referral.
4	Breast	Resignation of operational manager with SDSC	6	Weekly meeting to continue. Review of roles and responsibilities with breast imaging team

Consolidated Cancer 62 Days Corrective Action Statement | May 2017 Reporting

[CAS received from Medicine, Surgery, W&C. SCSD have only small numbers on pathway]

Reporting Month	May 2017
In Month Trajectory	73.1%
In Month Performance	**61.4%**



Trust	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	70.7%	61.4%	68.8%									
Trajectory	73.1%	73.1%	75.3%	75.3%	75.4%	76.4%	78.0%	79.3%	80.0%	80.0%	81.4%	81.4%

Operational Standard: 85% of patients to be treated within 62 days

Performance Overview

The May performance shows deterioration compared to April (61.4% versus 70.7%) and is below the Trust's trajectory of 73.1% for May. Urology and Lower GI account for 62% of the breaches in May. The underperformance in these specialties continues to be driven by diagnostic delays for endoscopic and transrectal ultrasound (TRUS) biopsies.

Service Commentary

Surgery Divisions performance is significantly impacted by transrectal ultrasound (TRUS) biopsies and access to diagnostics, in particular endoscopy including colonoscopy and cystoscopy which impact upon performance in Urology and Lower GI cancer site performance. The division is working closely with the SCS Division to increase productivity and sessions available to be undertaken. Endoscopy outsourcing is imminent with insourcing progressing through the tendering process. Until access to endoscopy is resolved, achievement of 62 days will continue to be at high risk.

The Medicine division expects Upper GI performance to pick up now the upper GI awareness campaign has finished and work can be done to clear the backlog over the coming months. The increased referrals due to the lung campaign are expected to adversely impact performance over the next 2 months as consultant recruitment in Respiratory continues to be a challenge.

The majority of W&C patients in this group are operated on/receive treatment outside the Trust. W&C division is working towards achievement of the referral to tertiary centre by day 38 standard.

SURGERY Specialty	April	May		
	62 Day (%)	62 Day (%)	Treated over 62 days	Total Treated
Urology	59.3%	38.9%	11	18
Lower Gastrointestinal	38.5%	33.3%	12	18
Surgery Total	**71.3%**	**55.1%**	**28.5**	**63.5**

W&C Specialty	April	May		
	62 Day (%)	62 Day (%)	Treated over 62 days	Total Treated
Gynaecological	33.3%	100.0%	0	3

MEDICINE Specialty	April	May		
	62 Day (%)	62 Day (%)	Treated over 62 days	Total Treated
Lung	79.3%	40.0%	4.5	7.5
Upper GI	68.8%	62.5%	3	8
Medicine Total	**73.8%**	**51.6%**	**7.5**	**15.5**

104+ day waits

2017/18	May-17
Breast	1
Colorectal	5
Gynaecology	3
Haematology	
Head & Neck	1
Lung	2
Skin	2
Upper GI	2
Urology	5
Total	**21**

Service Commentary 104+ day waits

It is noteworthy that the backlog of 104+ day waiters at the end of May 2017 is 21 which is the lowest it has been since March 2016.

Colorectal and Urology are significantly impacted by diagnostic delays (actions as per diagnostic CAS). Gynae performance is impacted by workforce issues, and a business case has been submitted for an additional four locums. In addition the directorate is reviewing the Urology pathway in its entirety with support from NHSi.

Corrective Actions Log

	Specialty	Actions	Progress	Lead	Deadline
1	Thoracic	Advertise for 2 WTE consultants	JD is currently being written	Dr Lal	Dec
2	Thoracic	New triage service of 2ww referrals- this is anticipated to reduce 2ww referrals by up to 40%	Planned to commence end of June 17	Dr Hooper/Dr Cusworth	Jen 17
3	Upper GI	Continue to do extra sessions to meet current demand	On-going until back log is cleared	Upper GI Consultants	On-going
4	Thoracic	Prevent Laurel 2 procedure room being used for inpatients	This room can now only be used at exec approval and is used less	Jo Kenyon	On going
5	Colorectal and Urology	Inadequate endoscopy capacity to enable colonoscopy and cystoscopy within 2 weeks or less of request.	Clinical Support have submitted a tender which closes in June to in-source and out-source endoscopy capacity.	Julian Berlet	30 June 2017
6	Urology	Singular Radical Prostate pathway required	Commence pathway mapping in July with agreed timescales at each milestone	CSL and DM	31 August 2017
7	Skin	Lack of consultant capacity	Exploration of Consultant Nurse role Negotiation with current locum on rate of pay (over cap) On-going search for further locums Use of IS providers	CSL and DM	

Key risks to delivery of the Trajectory/Target

	Specialty	Risks	Risk Score	Mitigations
1	Thoracic	Failure to recruit		If recruitment is not successful on the Alex site then we will be advertising countywide posts
2	Thoracic	Large increase in referrals due to current lung cancer campaign		The new triage service will hopefully take some of this pressure and reduce the 2ww patients
3	Thoracic/Upper GI	Patient with complex pathways and requiring treatment of patients at tertiary centres		Weekly review of all patients and necessary escalations put in place

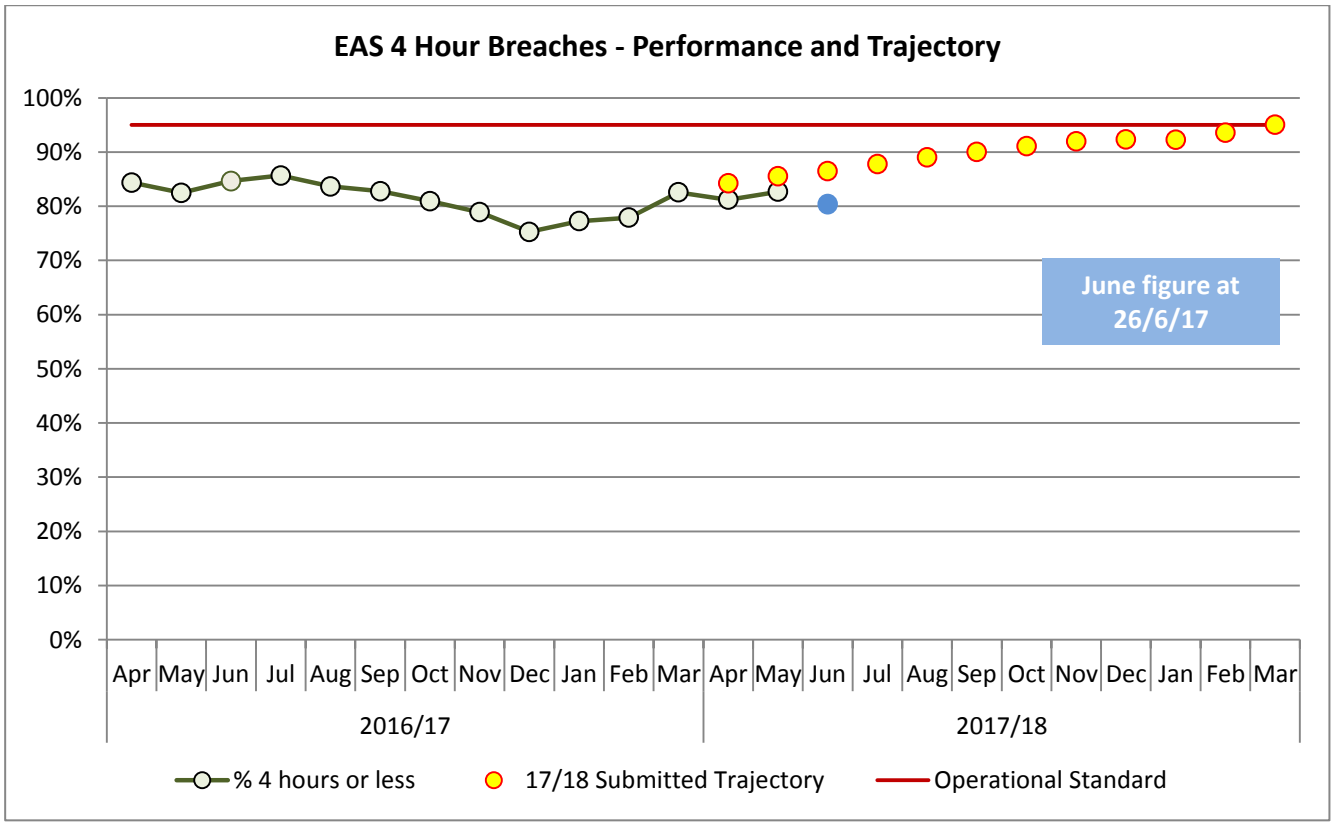
Consolidated EAS Corrective Action Statement | May 2017 Reporting

[Medicine only]

Reporting Month	May 2017
In Month Trajectory	85.5%
In Month Performance	**82.7%**

Performance Overview

The Trust's performance against this target improved between December and March but has plateaued in April and May. There is a marked difference in performance between the 2 main acute sites (WRH 66.29% and Alex 85.41%) Attendances between March and May have increased by 7.5% (WRH 10.3% and Alex 5.3%) and high numbers of stranded and delayed transfers of care have contributed to discharge performance which has had a knock-on effect on the ability to admit patients from ED in a timely way. This has particularly affected WRH.



Medicine	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	81.2%	82.7%	80.4%									
Trajectory	84.2%	85.5%	86.5%	87.8%	89.0%	90.0%	91.1%	92.0%	92.3%	92.3%	93.6%	95.0%

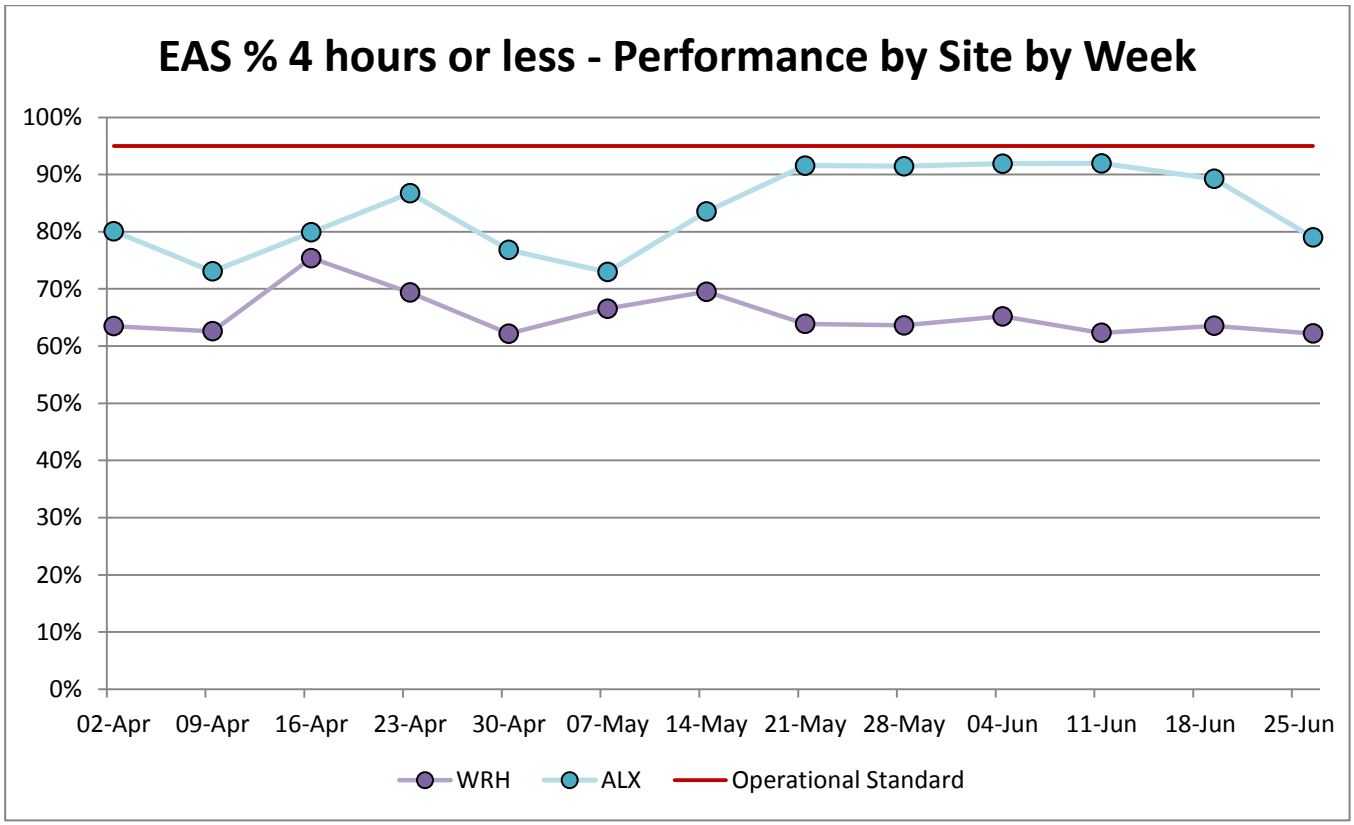
Operational Standard: 95% of patients < 4 hours from arrival to admission, transfer or discharge

12 hour breaches

Medicine	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	4	6										
Trajectory	-	-										

Service Commentary

Performance against this standard has been significantly impacted by increased workload (particularly at WRH), medical staffing gaps linked to inability to recruit, IR35, adhering to capped rates and problems securing locum cover and inability to move patients out of WRH ED into a hospital bed.



Corrective Actions Log

	Specialty	Actions	Progress	Lead	Deadline
1.	Emergency medicine	Ambulance handover plan developed following ECIP observational audit and subsequent report.	Draft plan completed to be agreed with WMAS. Elements of plan require costing and case being prepared to request funding for equipment & reception estates work.	Chris Yarnold	August 2017
2.	Emergency Medicine	Successful round of overseas middle grade doctor recruitment complete and 7 middle grade doctors offered substantive posts.	Doctors take up their posts starting in July.	Jules Walton	September 2017
3.	Emergency Medicine	Agreement reached to increase consultant establishment at both WRH and Alex to ensure extended senior cover in the department	WRH posts advertised in June and Alex posts to be advertised in July.	Jules Walton / Abdul Jalil	November 2017
4.	Emergency Medicine	Successful bid for capital funds to facilitate primary care streaming, facilitated by re-providing ambulatory care unit at WRH.	Funds received and plans being finalised identifying preferred option identified.	Sarah Smith	December 2017
5.	Trust - wide	Focused work on reducing the number of stranded patients in order to release inpatient beds.	Daily review regimen established and reporting process established which already shows reducing numbers of stranded patients.	Trevor Hubbard	On-going
6.	Division of Medicine	Reducing length of stay through ensuring every day of a patient's stay adds value to their treatment and reduces the time waiting for diagnostics / treatment / discharge planning.	Preparations currently underway to facilitate an intensive R2G week at the end of June to launch an on-going process to embed best practice.	Steve Jezard	July 2017 and on-going

7.	Emergency Medicine	Focus on turnover in MAU and MSSU to ensure units work as intended. Both Units currently reverting to base ward operation due to bed pressures in the hospital.	Dependent on outcome of R2G week and on-going embedding of process.	Steve Jezard	August 2017

Risk Summary

	Specialty	Risks	Risk Score	Mitigations
1	Emergency Medicine	Inability to influence WMAS behaviour in terms of handover processes.	6	Ensuring acute staff take control of process
2	Emergency Medicine	Middle grade doctors withdrawing from recruitment process	9	Attractive packages offered.
3	Emergency Medicine	Inability to recruit to Consultant vacancies.	12	Early advertisement to take advantage of several known potential candidates available for recruitment.
4	Acute and Emergency Medicine	Unable to agree plans to expand AEC in order to facilitate primary care streaming bid.	12	Plans being developed on the basis of temporary short term solution with long term solution being worked in a defined period.
5	Trust wide	Limited ability to reduce the number of stranded patients and ensuring sustained impetus	12	Daily review regimen established
6	Division of Medicine	Maintaining impetus to implement R2G.	12	Post-intensive R2G week arrangements for maintaining impetus.

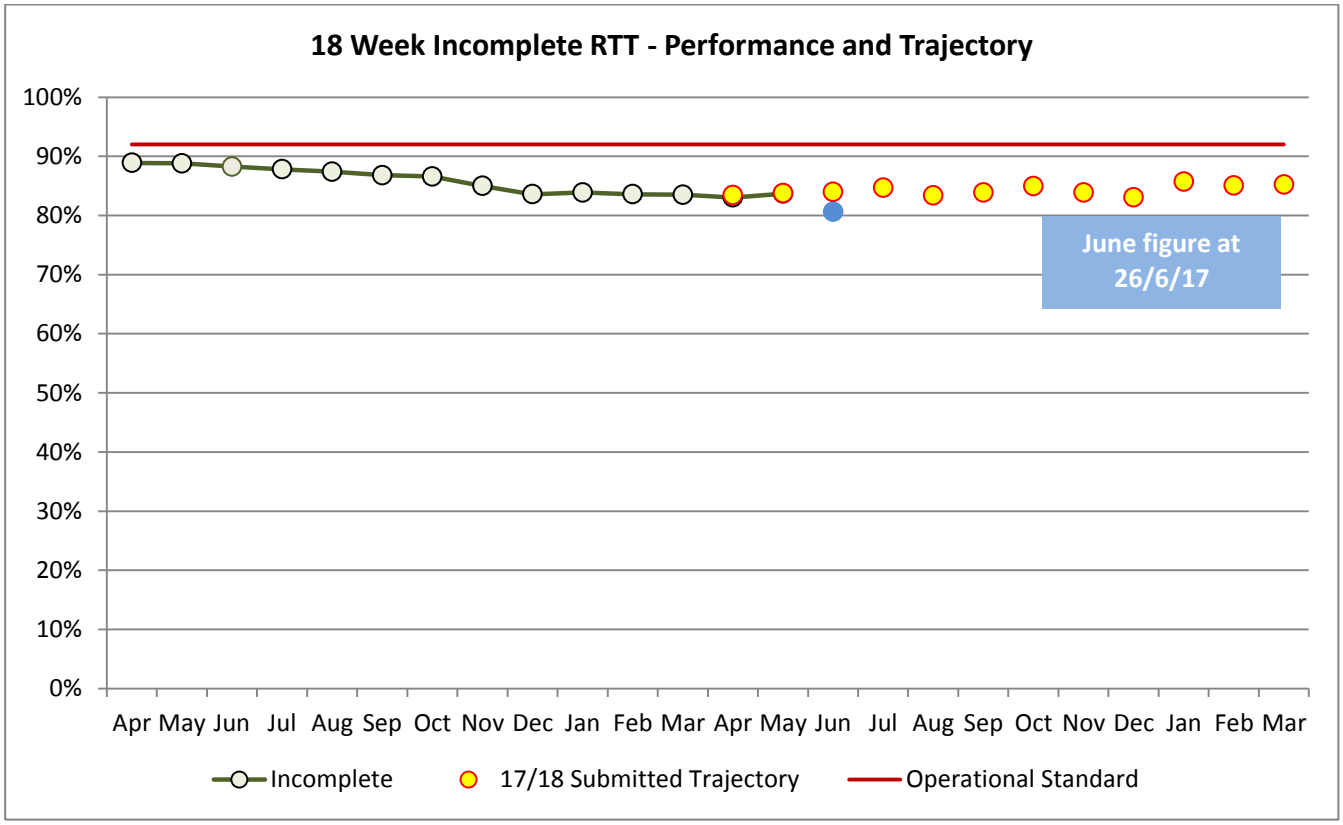
Consolidated RTT Corrective Action Statement | May 2017 Reporting

[CAS received from Medicine, Surgery, SCSD, W&C]

Reporting Month	May 2017
In Month Trajectory	83.8%
In Month Performance	**84.07%**

Performance Overview

Trust performance against this standard has consistently deteriorated across all divisions, due to workforce issues, access to inpatient beds, reduced elective operating and increase in referrals. The position will continue to decline unless the medical staffing gaps are successfully recruited to and the backlog of long-waiter cases addressed through the actions detailed in the corrective action log.



Trust	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	83.0%	84.07%	80.6%									
Trajectory	83.5%	83.8%	84.0%	84.7%	83.4%	83.9%	84.9%	83.9%	83.0%	85.7%	85.1%	85.2%

Operational Standard: 92% of patients are treated within 18 weeks

Service Commentary

The 6 specialties with the highest risks to delivery are **thoracic** (capacity and recruitment), **neurology** (recruitment), **ophthalmology** (increasing high risk referrals), **trauma and orthopaedics** (capacity following cessation of elective operation at WRH and recruitment), **general surgery** (recruitment), **oral surgery** (recruitment) and **gynaecology** (recruitment).

Medicine Specialty	April	May			June Forecast
	RTT (%)	RTT (%)	Breaches	Waiting List	RTT (%)
Thoracic	63.13%	60.65%	617	1568	63.26%
Neurology	75.36%	73.23%	231	863	82.12%
Total	**86.15%**	**80.35%**	**1,819**	**9,256**	**85.19%**

SCSD Specialty	April	May			June Forecast
	RTT (%)	RTT (%)	Breaches	Waiting List	RTT (%)
Ophthalmology	91.66%	88.61%	694	6,094	
Total	**92.49%**	**90.25%**	**800**	**8,203**	

Surgery Specialty	April	May (at 16/6)			June Forecast
	RTT (%)	RTT (%)	Breaches	Waiting List	RTT (%)
General	76.87%	77.56%	767	3,418	
Oral	75.62%	75.23%	574	2,317	
T&O	66.99%	69.23%	1,143	3,715	
Total	**78.69%**	**80.17%**	**3,512**	**17,770**	

W&C Specialty	April	May			June Forecast
	RTT (%)	RTT (%)	Breaches	Waiting List	RTT (%)
Gynaecology	70.52%	69.15%	912	2,956	
Total	**77.21%**	**75.13%**	**993**	**3,993**	

It is anticipated that there will be further negative impact on this standard following the validation of non-RTT pathways, Based on simple validation the anticipated conversion of non-RTT pathways to RTT pathways is circa 2,500 with associated decrease in performance of circa 2%.

Service Commentary 52+ week waits

T&O, Gynaecology and Thoracic Medicine are particularly challenged in terms of 52+ week waiters. Whilst all three specialties have plans for additional investment to address the long waiters, Thoracic Medicine has the greatest risk to implementation due to on-going recruitment issues.

52+ week waits

Specialty	April	May*	June Forecast
Medicine (Thoracic)	5	5	8
W&C (Gynaecology)	0	4	TBC
Surgery	16	34	TBC

*not finalised at time of writing | Note: SCSD - Nil

Actions to address 52+ waiters

- Gynaecology - Business case for 4 locum consultants to cover gaps in middle grade rota.
- T&O - agreement with ROH to outsource 60 long waiters
- Thoracic - directorate out for additional locum, business case for additional physiologist and clinical nurse specialist.

Corrective Actions Log

	Specialty	Actions	Progress	Lead	Deadline
1	Gynae, thoracic, neurology	Recruitment for 8 substantive consultants across 3 specialties	JDs being prepared/business case accepted in principle	DDops, clinical leads	July and Dec 2017

2	Gynae, geriatric	Middle grade and consultant locum recruitment	Gynae recruitment progressing, geriatric posts with agencies.	DMs	On going
3	Gynae	Develop enhanced nurse roles	In progress	Matron	On going
4	Ophthalmology	Outsourcing / insourcing service specification to be agreed and short term spot contract to be awarded	Service spec in progress and contract tender closed in May	Emma Streete	16 June 2017
5	Ophthalmology	Review of internal efficiencies and capacity and demand levels to be undertaken	Both in progress,	Emma Streete, DMT	31 Aug 2017
6	Urology	Recruit consultant	Consultant recruited. Start date 5 June 2017.		13/2/17 Complete
7	Dermatology	Recruit locum consultant	Locum recruited and started on 21 May 2017.		21/5/17 Complete
8	Dermatology	Explore alternatives to consultant staffing model	Recent resignation of CNS. Directorate is reviewing nursing structure and considering Nurse Consultant roles.		21/5/17
9	ENT	Recruit consultant	Successful appointment on 13/6/17.		13/6/17
10	Oral Surgery	Recruit SpR	Advert closes on 10 June 2017.		Jul 17
11	Oral Surgery	Additional activity sessions to manage any potential increase in referrals due to cessation of services at Dudley	3 additional activity sessions in April treated 20 patients. 5 additional activity sessions in May treated 45 patients.		On-going

Risk Summary

	Specialty	**Risks**	**Risk Score**	**Mitigations**
1	Gynae	Failure to recruit	16	Attempt recruitment to different posts
2	Gynae	Poor fill rate for August middle grate rotation	Not scored	Continued recruitment
3	Thoracic, Neurology, Geriatrics	Failure to recruit.	Not scored	Consideration will be given to countywide positions, collaborative approach with UHB.
4	Thoracic	Complex pathways requiring multiple investigations and therefore delays in clock stops	Not scored	Weekly review of the PTL and escalation where appropriate
5	Thoracic	As only one consultant covering allergy patients, patients on allergy pathway will continue to be long waiters (up to 52 weeks)	Not scored	Weekly monitoring and additional WLI clinics taking place to help reduce the long waiting patients
6	Dermatology	High levels of consultant and Clinical Nurse Specialty vacancy	16	Exploration of Consultant Nurse role Negotiation with current locum on rate of pay (over cap) On-going search for further locums Use of IS providers

Consolidated Diagnostics Corrective Action Statement | May 2017 Reporting

[SCSD only]

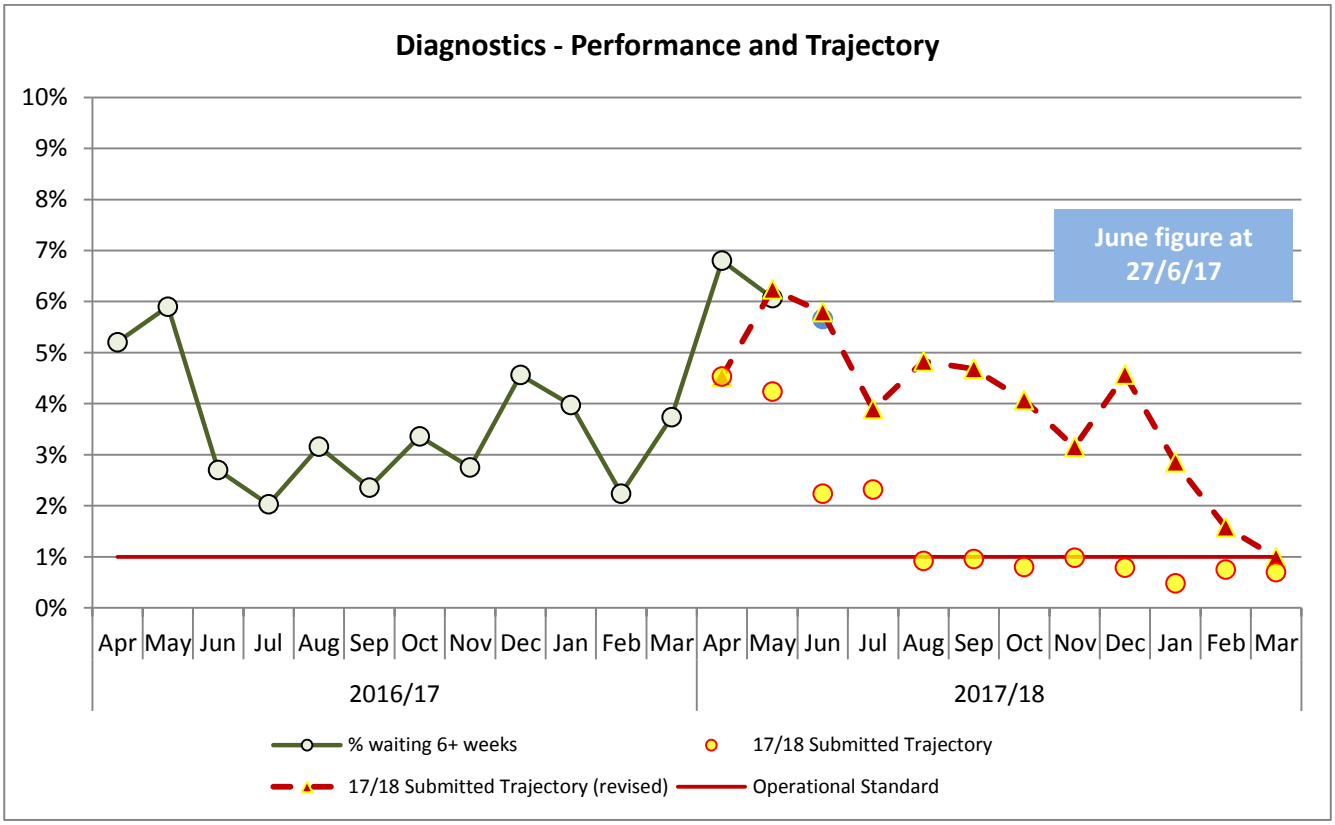
Reporting Month	May 2017
In Month Trajectory	4.20%
In Month Performance	6.07%

Performance Overview

Diagnostics performance started to deteriorate at the start of 2016. The main deviation has been seen in Endoscopy who until January 2016 consistently delivered the target. There is not enough core capacity within endoscopy to meet demand. Monthly referrals on average run at 1,400, there is only core capacity for 900 appointments; the remainder historically has being met through additional out of hours sessions and outsourcing. In January 2016 outsourcing was switched off for a period of 3 months due to the declining financial position then in March changes were made to the additional session payment and this activity ceased for a 3 month period before recommencing in June 16. Additional sessions activity has halved and there is currently a capacity gap of c.200 patients per month.

Since January 2017 Radiology has also started to see a decline in performance after plateauing around 0.6% the previous 6 months. The decrease in Radiology performance is as a result of increased emergency capacity requirements with the need to switch outpatient CT slots to inpatient slots and un-foreseen reduced equipment capacity within ultrasound.

The May breaches currently stand at 321 scans for radiology, of which 286 are within Ultrasound, 29 in CT and 6 in MRI 6.53% compared to the trajectory of 1.29%. For endoscopy the breaches are 281 (17.05%) which is slightly better than the trajectory of 309 (18.03%).



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	6.80%	6.07%	5.66%									
Trajectory (initial)	4.5%	4.2%	2.2%	2.3%	0.9%	1.0%	0.8%	1.0%	0.8%	0.5%	0.8%	0.7%
Draft Trajectory (revised)	-	-	5.79%	3.89%	4.83%	4.68%	4.07%	3.15%	4.57%	2.85%	1.58%	0.99%

Operational Standard: no more than 1% of patients are waiting for 6 or more weeks for a diagnostic test

	April	May		
Specialty	**6+ weeks (%)**	**6+ weeks (%)**	**Breaches**	**Waiting List**
MRI	0.10%	0.30%	6	1,747
Computed Tomography	9.40%	2.00%	29	1,489
Non-obstetric ultrasound	7.50%	8.30%	286	3,429
Barium Enema	-	-	-	-
DEXA Scan	0.00%	0.00%	0	288
Audiology	0.50%	0.40%	3	681
Echocardiography	0.00%	0.30%	2	778
Electrophysiology	-	-	-	-
Neurophysiology	0.00%	0.00%	0	96
Sleep studies	0.00%	3.60%	1	28
Urodynamics	17.90%	22.70%	15	66
Colonoscopy	28.20%	22.20%	159	715
Flexi sigmoidoscopy	14.60%	8.70%	19	219
Cystoscopy	22.30%	22.70%	69	304
Gastroscopy	2.00%	8.30%	34	410
Total	6.80%	6.07%	622	10,250

Service Commentary

Endoscopy

Performance in May was negatively impacted as a result of the following contributing factors, despite this however performance was still in line with the trajectory submitted.

- 2 Bank Holiday days in May:- lost 7 sessions = 42 patients.
- 15 vacant sessions in May for GI endoscopy = 90 patients.
- 1 clinician withdrew services from Trust as a result of IR35 – lost 6-8 WLI sessions per month = 36-48 patients
- Locum Gastroenterologist left end of April – still no replacement – 2 sessions per week uncovered = 12 patients.

Radiology

Performance against the diagnostic standard has been significantly impacted due to several factors. Due to poor image quality and the associated clinical risks, two ultrasound machines were removed from service in March, this significantly impacted on the provision of services with remaining capacity being dedicated to A&E, In-patient and clinically urgent requests. Replacement equipment was delayed, impacting further on service provision during April. 23 additional sessions were undertaken in May generating an additional 207 scans however all this did was negate the impact of lost capacity due to bank holidays and made no dent into the backlog which actually grew in May due to increased demand. It is anticipated that with the equipment now replaced and the provision of additional clinical sessions in June the backlog will be reduced significantly in line with target.

In support of increased emergency pressures and patient flow, in particular at WRH site, the CT scanners at WRH were dedicated to A&E, Ambulatory care, In-patients and 2ww. This reduced the ability to support all out-patient requests. Additional capacity was provided at KTC and AH sites in support but was insufficient to support the radiology trajectory. With weekly review of demand it is anticipated that one of the WRH scanners will improve capacity to scan

outpatients. It is not anticipated that this will be to previous levels due to continued requirement to support emergency and patient flow. Additional sessions have been utilised to reduce the breaches from 138 in April to 29 in May and will continue to be utilised to manage waits.

Corrective Actions Log

	Specialty	Actions	Progress	Lead	Deadline
1	Radiology	Identify un-resourced equipment capacity	Combined with business case	Deena Smith	30/06/17
2	Radiology	Recruit locum CT Radiographer	Locum recruited and started May 2017.	Tracy Robson	21/5/17 Complete
3	Radiology	Identify available capacity in private sector		Deena Smith	30/06/17
4	Radiology	Additional activity sessions planned in anticipation of increased referrals as a result of cancer Lung campaign May-August		Deena Smith	30/06/17
5	Radiology	Arrange WLI sessions in ultrasound	56 additional sessions arranged for June, this equates to 393 (20 min) slots	Deena Smith	12/06/17
6	Endoscopy Surgery Medicine	Continue to attend weekly endoscopy capacity meeting, circulate vacant endoscopy sessions and seek backfill to increase capacity.	First meeting held 22nd May 2017.	Kate Winwood	
7	Endoscopy	Circulate vacant sessions to all Clinicians and Nurse Endoscopists.	On-going month on month. Utilisation reports demonstrate approx. 90% utilisation for GI Endoscopy per month.	Kirsty Hinton	
8	Endoscopy	Continue to outsource:- 60 patients per month to SPIRE 45 patients per month to BMI	Outsourcing continuing. SPIRE seems to be returning more patients to the Trust prior to endoscopy due to suitability. SPIRE has also declared that they are unable to take surveillance patients that do not have a recent EGFR result.	Kirsty Hinton	
9	Endoscopy	Agree contract for further SPOT provider to undertake outsourcing work for the Trust.	Contract awarded to St Joseph's, Newport.	Lynne Mazzocchi	
10	Endoscopy	Commence outsourcing week commencing 19th June, following visit to St Joseph's.	Outsource 200 patients per month.	Lynne Mazzocchi / Kirsty Hinton	
11	Endoscopy	Proceed to insourcing tendering process.	Insource 250 patients per month.	Darren Henderson / Kate Winwood	

Key risks to delivery of the Trajectory/Target

	Specialty	Risks	Risk Score	Mitigations
1	Radiology	Significant increase in CT referrals as a direct result of lung campaign, for which additional capacity cannot be identified		Identify internal and external capacity in advance
2	Radiology	Equipment failure		
3	Radiology	Unavailability of internal staff to provide additional sessions		
4	Radiology	Unavailability of external capacity		
5	Endoscopy	The Trust is currently undertaking a review of any patient currently on the NON-RTT PTL this is a Programme of work being delivered with support from the Intensive Support Group. The impact of this is currently being investigated and this trajectory does not include adjustments for the outcome of this	20	No mitigating actions continue to outsource / progress insourcing.

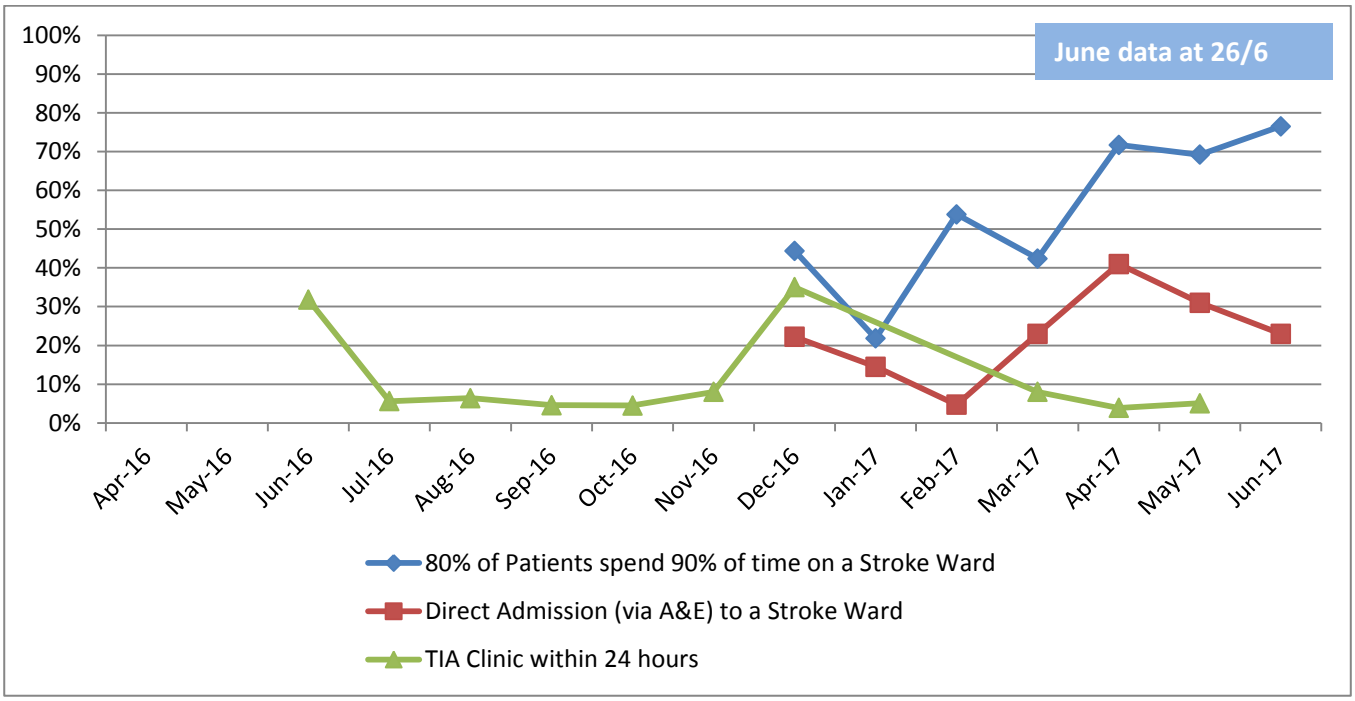
		Programme.		
6	Endoscopy	Patient's reluctance/refusal not to go to outsourcing provider.	12	50% uptake factored into trajectory.
7	Endoscopy	Delay to insourcing tender process, impacting start date of insourcing process (October 2017).	12	
8	Endoscopy	Equipment failure due to age of key equipment.	16	Hire in equipment if required.

Consolidated Stroke Corrective Action Statement | May 2017 Reporting

[Medicine only]

Performance Overview

The Trust's performance against the 3 metrics below has been consistently below target over the last 18 months. April 17 is the latest fully validated position and does show an improvement in both the amount of time patients spend on the Acute Stroke Unit and Direct Admission to a Stroke Ward. A further deterioration has been seen for patients being seen within 24 hours of referral to TIA service and is due in the main to significant staffing issues.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
90% of time spent on Stroke Ward	71.7%	69.2%	76.5%									
Direct admission to Stroke Ward	41.0%	31.0%	23.0%									
TIA Clinic within 24 hours	3.88%	5.08%	**n/a**									
Trajectory	-	-	-	-	-	-	-	-	-	-	-	-

Operational Standards: 80% of Patients spend 90% of time on a Stroke Ward,
Direct Admission (via A&E) to a Stroke Ward = 90%,
TIA clinic in 24 hours = 60%

Service Commentary

Performance against these standards has been significantly impacted by the capacity and flow issues faced across the organisation along with an inability to recruit to substantive consultant vacancies.

Direct access to a Stroke Bed and patients spending time on a stroke ward, whilst improved during April, are still fragile due to the on-going capacity issues.

Attendance at TIA clinic within 24 hours of referral is currently not achievable due to the service only being available Monday to Friday and limited clinic slots due to the medical workforce constraints.

Corrective Actions Log

	Specialty	Actions	Progress	Lead	Deadline
1	Stroke	Employment of 4 Clinical Nurse Specialists to support TIA clinics and Straight to scanner target	4 nurses offered posts – start date as yet unconfirmed	Matron – Stroke	31/07/17
2	Stroke	Introduce protected trolley assessment area for stroke and TIA patients for early specialist assessment. Agreement required at Executive Level to remove this 2-bedded area from options for surge capacity.	Space available but continues to be used as surge inpatient capacity. Discussion required with COO	Deputy Divisional Director of Operations	30/06/17
3	Stroke	Ensure adequate HASU capacity to provide treatment and care for all stroke patients in accordance with National Stroke Guidance – 1 space within HASU to be protected at all times.	As above	Deputy Divisional Director of Operations	30/06/17
4	Stroke	HASU and Assessment Trolley SOP to be completed	HASU SOP approved, Assessment trolley SOP to be approved at June Divisional Management Board	Matron – Stroke	30/06/17
5	Stroke	Devise recruitment plan to recruit into substantive consultant vacancies and advertise	New clinical lead for service commenced early June. Divisional Medical Director to discuss with lead and action	Divisional Medical Director – Specialty Medicine	31/07/17
6.	Stroke	Finalise workforce strategy plan with health economy partners across the stroke pathway – new models of working to be explored	1st draft of strategy discussed at Stroke Strategy Forum 6/6/17 – further work to be completed in time for next meeting 12/07/17	Clinical Lead	12/07/17

Key Risks to Delivery

	Specialty	Risks	Risk Score	Mitigations
1	Stroke	Failure to release 4 staff nurses from their current posts due to high vacancy factor on ward (all 4 successful candidates currently working on stroke ward)	9	Rotas currently being explored to understand options. Dedicated stroke service recruitment campaign to be actioned In the short term, use additional agency staff to fill vacant shifts
2	Stroke	Inability to protect 1 HASU bed and assessment trolley area due to on-going capacity issues	12	Agreement with Executive team required to support the protection of these areas. Stroke to regularly feature within the 3 daily bed meetings to highlight demand vs capacity and options explored at each meeting to support correct placement of patients.
3	Stroke	Inability to recruit to substantive consultant vacancies (currently 2.4 WTE)	9	Continued use of agency staff. Identify alternative models of delivery service via Health economy wide workforce group.

Consolidated Sickness absence Corrective Action Statement | May 2017 Reporting

Area of Concern	Sickness Absence	**Reporting Month**	May 2017
Division	Trust wide	**In Month Trajectory**	
Author	Deborah Drew	**In Month Performance**	**3.83%**

Performance Overview

The Trust sickness absence rate for May 2017 is 3.83% which shows a 0.15% improvement on the previous month which was retrospectively adjusted to 3.98%. Long term sickness remained at 2.77% continuing consistently around 2.7% over the last 12 months. The Divisions have engaged with HR to ensure active and supportive management plans are in place in line with Trust Policy. Short term sickness has reduced by 0.03% to 1.49% this month. When compared to other Trusts on the NHSI Model Hospital portal our sickness absence rates in November 2016 (which are the latest benchmarked figures), are slightly above median of our peers in the region and average for the STP. Our Trust at that time was 4.79% with our peers within our Region being 4.53%, and our STP footprint being 4.79%.

Service Commentary

There has been an improvement in the sickness rates in all Divisions except Asset Management and IT this month compared to April 2017:

Monthly Sickness Absence by Division	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017
Asset Management and IT	5.79%	4.99%	4.52%	4.86%	5.05%
Corporate	3.75%	3.15%	2.70%	2.13%	3.00%
Medicine	5.02%	4.50%	4.23%	4.22%	3.85%
Specialised Clinical Services Division	4.87%	4.06%	3.81%	3.84%	3.79%
Surgery	5.90%	4.31%	4.65%	4.25%	4.07%
Women & Children	5.40%	4.13%	4.35%	4.32%	3.65%
Grand Total	5.08%	4.19%	4.05%	3.96%	3.83%

Note: green indicates improvement on last month, not position against target.

4 out of 6 divisions are under 4% with corporate sickness remaining below Trust target of 3.5% for the fourth month in a row. Asset Management and IT have increased again this month. Our top reasons for sickness are:

Absence Reason	Sum of FTE Days Lost	Sum of No Of Episodes
S98 Other known causes - not elsewhere classified	168.06	12
S10 Anxiety/stress/depression/other psychiatric illnesses	165.43	14
S26 Genitourinary & gynaecological disorders	80.48	8
S25 Gastrointestinal problems	61.21	10
S99 Unknown causes / Not specified	38.53	7
S30 Pregnancy related disorders	32.69	3
S21 Ear, nose, throat (ENT)	32.27	7
S14 Asthma	24.80	1
S11 Back Problems	18.36	4
S24 Endocrine / glandular problems	12.40	1
S13 Cold, Cough, Flu - Influenza	8.60	5
S15 Chest & respiratory problems	8.00	3
S16 Headache / migraine	5.84	5

S27 Infectious diseases	4.80	1
S12 Other musculoskeletal problems	3.68	2
S22 Dental and oral problems	1.92	1
S28 Injury, fracture	0.50	1
Grand Total	667.57	85

Musculo-skeletal problems have reduced and back problems have reduced this month. We have completed a review of the Physiotherapy pilot for staff which indicates that there has been an improvement in number of staff who are reporting absence due to musculoskeletal injuries. The majority of staff who access the physiotherapy are not absent, therefore there will be additional benefits to this scheme in terms of staff health and wellbeing and preventing further absence.

The introduction of the pilot physiotherapy service was successful in contributing to the success of meeting the CQUIN Health and Wellbeing standards 2016 -2017 releasing £1.2m into the Trust. It would appear that the pilot has also had a positive impact on the sickness absence rates due to musculo-skeletal problems.

For the first four months of 2017, compared with first four months of 2016 there has been a reduction of 13.8% of episodes of MSK and a reduction of 16.8% of WTE days (950) lost due to MSK, despite overall sickness absence in that period increasing by 0.7%.

This indicates that the physiotherapy service for staff is having a dramatic positive effect on keeping staff at work if they have had MSK problems, and this is confirmed in some of the very appreciative and heartfelt feedback and testimonials that we have received from staff.
As anticipated we experienced an increase in sickness in November, December 2016 and January 2017, due to seasonal illnesses. These are historically higher months for sickness absence for the Trust. However, there has been a month on month reduction since January 2017.

Corrective Actions Log

	Staff Group	Actions	Progress	Lead	Deadline
1	Corporate staff/Administrative	Physiotherapy pilot has impacted on a number of staff who work in sedentary jobs	Staff are reporting significant improvements to musculoskeletal conditions which has kept them at work	Di Pugh Sandra Berry	
2	Nursing and Healthcare Support Workers	Physiotherapy pilot has impacted on a number of Nursing staff.	Staff are reporting significant improvements to musculoskeletal conditions which has kept them at work	Di Pugh Sandra Berry	
3	All staff	Sick pay should not be payable to staff who do not give a reason for absence	HR Business Partners reminding divisions of importance of accurately recording absence reasons.	Di Pugh Sandra Berry	

Impact on Specialty Trajectories

TARGET	December	January	February	March	April	May
3.5%	4.97%	5.06%	4.16%	4.00%	3.96%	3.83%

Consolidated Vacancies Corrective Action Statement | May 2017 Reporting

Area of Concern	Vacancies	**Reporting Month**	May 2017
Division	Trust wide	**In Month Trajectory**	
Author	Deborah Drew	**In Month Performance**	**513.40 (9%)***

*total vacancies

Performance Overview

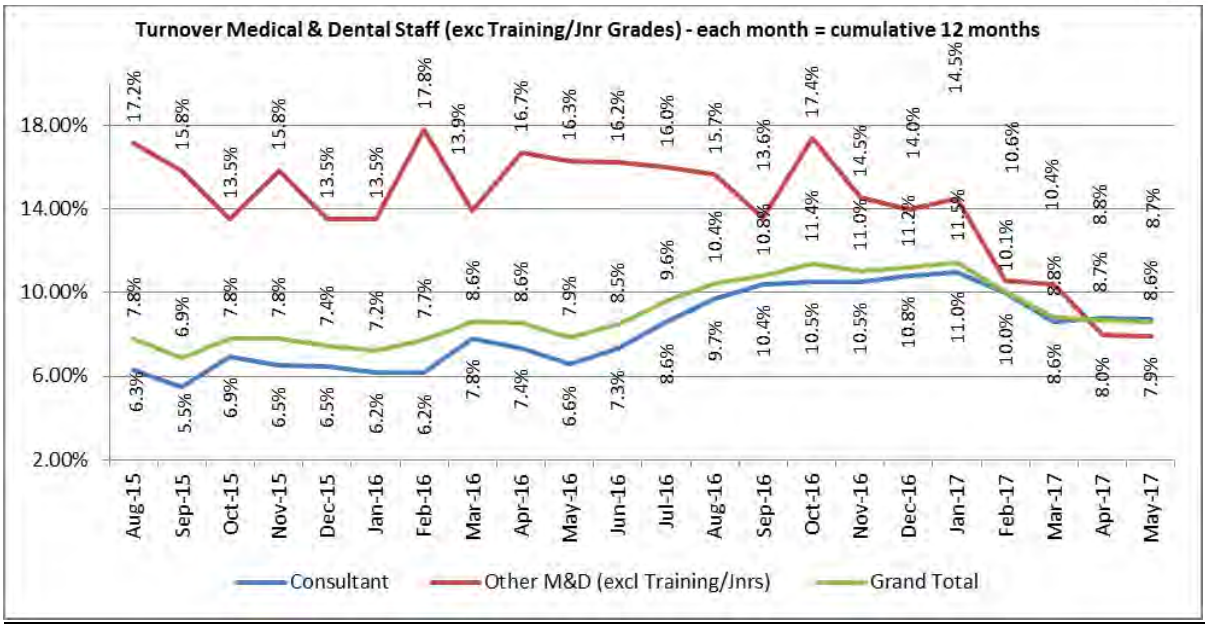
We have been closely monitoring "all staff" turnover since it started steadily increasing in July 2015 peaking at 13.03% in November 2016. There has been a month on month improvement since then to April 2017 rate of 12.47%. However in May 2017 there has been a slight increase in turnover to 12.54%. Both Medical and Nursing Vacancies remain a high risk for the Trust with some 513.40 wte reported in May (9% vacancy rate). This compares to 476.83 vacancies in April 2017 (8.5% vacancy rate). However, budgeted establishment increased in month by 45.23 wte, so in real terms our vacancies have reduced by 8.66 wte since last month.

Service Commentary

Medical Vacancies

A project plan has been developed within the Trust with a primary focus on Medical Recruitment to fill the current gaps efficiently in support of service provision, patient care and cost reductions. As at the end of May 2017 we had 160.01 wte medical vacancies at all grades with 69.60 wte appointed but not yet started. A targeted recruitment drive is taking place to fill the remaining vacancies via national advertisement, Open events, Social Media campaign, Careers Fairs, and Overseas Recruitment planned to India in July. Finance and HR have completed a project plan to map budget against vacancies and recruitment activity for every medical post. From the current rate of applications, and shortlisting we would anticipate appointing 26 of our current candidates by August which will reduce vacancies to 84.41 wte (less any further attrition).

VACANCY POSTION AS AT 12/06/2017								RECRUITMENT ACTIVITY						PROJECTED VACANCY POSITION					
Grade	1. Budgetary Establishment (WTE)	2. Substantive in post (WTE)	3. Budgeted Vacancies (WTE)	4. Over Recruitment (WTE)	5. Appointed not started (WTE)	6. Pending Vacancies (WTE)	7. Recruitment Requirement (WTE)	8. In Progress (No. of posts)	9. Applications Received	10. Shortlisted	11. Interviews Planned (No of posts)			12. Projected Appointments (WTE)			13. Projected Vacancies (WTE)		
											Jun	Jul	Aug	Jun	Jul	Aug	Jun	Jul	Aug
Consultant	311.56	258.56	53.00	3.20	18.30	5.00	39.70	37	15	7	1	14	4	1.00	10.00	4.00	38.70	28.70	24.70
Trust Posts (Speciality Doctor/ Clinical Fellow)	122.34	67.37	54.96	7.00	22.30	3.00	35.66	28	56	20	3	6	0	3.00	5.00	0.00	32.66	27.66	27.66
Training Grade (FY1/FY2/ CT1/CT2/ ST1-8)	280.31	228.26	52.05	0.00	29.00	12.00	35.05	4	14	7	3	0	0	3.00	0.00	0.00	32.05	32.05	32.05
Total	714.20	554.20	160.01	10.20	69.60	20.00	110.41	69	85	34	7	20	4	7.00	15.00	4.00	103.41	88.41	84.41



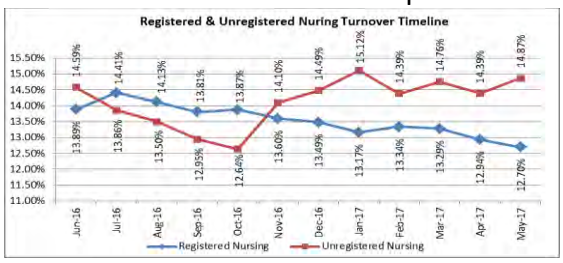
Comparison with NHSI Model Hospital benchmarking data in December 2016 (which is the most recent information available) indicates that our Consultant retention rate at that time was 90.1% compared to 93.8% nationally, 93% in our Region and 91.2% within our STP footprint. Consultant retention is a key area for improvement.

Nursing Vacancies

Nurse recruitment continues to be a national challenge and local Trusts are reporting that they are unable to recruit sufficient registered nurses to fill current vacancies. NHSI Model Hospital benchmarking from December 2016 (which is the latest information available) indicates that our retention rate for Registered Nurses, Midwives and Healthcare Support Workers is better than the national average which correlates with our reducing Nurse turnover since July 2016.

People, Management & Culture: Well-led	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Staff Retention Rate - Nursing & Health Visitors	Dec 2016	87.4%	0.0%	87.3%			
Staff Retention Rate - Midwifery	Dec 2016	90.3%	0.0%	88.3%			
Staff Retention Rate - Healthcare Support Workers	Dec 2016	87.5%	0.0%	84.5%			

Nursing recruitment needs additional focus as the current strategy, whilst bringing in numbers, leaves us in an almost static position. The registered nurse turnover rate had peaked at over 14.41% in July 2016 but has been showing a steady month on month improvement since July 2016 which will help to stabilise the vacancy position. Turnover for the 12 months up to May 2017 has reduced again to 12.7% from 12.94% last month which is a positive trend.



Recruitment continues and new starters have been recruited but have not yet commenced with the Trust. However, despite reduced turnover our recruitment is currently not keeping abreast of our attrition. We had 16.71 wte registered nurse leavers and 13.59 wte new starters in May 2017 (-3.12 wte).

We currently have 159.45 wte registered nurse vacancies with 40.57 wte appointed but not started. Active steps are being taken to recruit to the remaining 118.88 vacancies including regular assessment centres, attendance at recruitment events, and appointment of Mental Health and Learning Disability Nurses where appropriate. Our total vacancies have reduced by 12.37 wte since last month.

Registered Nurse Vacancies excluding Additional Capacity as at 31.5.17						
Division	**Funded WTE**	**Contracted WTE**	**Total WTE vacancies**	**Appointed Not Started**	**Remaining vacancies**	**Vacancy rate**
Medicine	629.38	535.6	93.78	23.58	70.2	11%
S.C.S.D.	587.99	535.38	52.61	4.99	47.62	8%
Surgery	271.54	264.8	6.74	12	-5.26	
Women & Children	343.74	337.42	6.32	0	6.32	2%
Trust Total	**1832.65**	**1673.2**	**159.45**	**40.57**	**118.88**	**6%**
Additional Capacity Ward	0	7.13				

We have counteracted some of the effects of registered nurse vacancies by recruiting additional Health Care Support Workers with 33.33 wte additional posts in Medicine and 17.05 wte in Surgery.

Unregistered Nurse Vacancies excluding Additional Capacity as at 31.5.17						
Division	**Funded WTE**	**Contracted WTE**	**Total WTE of Dept-vacancies**	**Appointed Not Started**	**Remaining Vacancies**	**Vacancy rate (% of establishment)**
Medicine	296.07	313.66	-17.59	15.74	-33.33	
S.C.S.D.	185.71	164.15	21.56	2.96	18.60	10%
Surgery	161.48	174.02	-12.54	4.51	-17.05	
Women & Children	104.13	93.41	10.72	1.80	8.92	8%
Trust Total	**747.39**	**745.24**	**2.15**	**25.01**	**-22.86**	
Additional Capacity Ward	0.00	15.62				

We have 49.76 wte vacancies across the Allied Health Professions (The group of concern is Radiographers with 27.59 wte vacancies which are hard to fill and regularly re-advertised.

AHP/Scientists and Prof and Tech Staff Month 1 Vacancy Position		Funded	Contracted	Vacant	Vacancy rate
AHPs	Dietician	18.42	17.81	0.61	
	Occupational Therapists	42.54	41.09	1.45	3%
	Orthoptists	9.21	9.21	0	
	Physiotherapists	94.04	93.02	1.02	
	Radiographers	198.93	171.34	27.59	14%
	Scientific, Technical & Therapeutic - Agency	0	0	0	
Scientists	Clinical Scientists	11.79	11.3	0.49	
	MLSO	104.45	95.56	8.89	8%
	Non Theatre MTO	137.81	128.68	9.13	7%

	Theatre MTO	0.53	3.33	-2.8	
Other ST&T	Chaplains	2.8	2.6	0.2	
	Clinical Scientists	0.87	1.4	-0.53	
	MLSO	1.16	0.36	0.8	
	Pharmacists	55.28	52.37	2.91	5%
	Scientific, Technical & Therapeutic - Agency	0	0	0	
Grand Total		**677.83**	**628.07**	**49.76**	**7%**

From the remaining staff groups we have 96.49 wte vacancies. 23.46 wte are in Estates and Asset Management, 20.66 wte are Senior Manager vacancies, and the remainder are Administrative and Clerical posts.

Asset Management and IT and Corporate Posts Month 1 Vacancy Position		Funded	Contracted	Vacant	Vacancy rate
NHS Infrastructure support	Admin & Clerical	847.92	801.97	45.95	5%
	Ancillary	199.35	177.52	21.83	11%
	Estates Officer	11.73	10.1	1.63	14%
	Maintenance	17	12	5	30%
	Non Clinical - Agency	0	0	0	
	Senior Managers	193.93	173.27	20.66	11%
	Trust Board	11	9.58	1.42	13%
Seconded - Administrative & Clerical	Admin & Clerical	0	0	0	
Grand Total		**1280.93**	**1184.44**	**96.49**	**8%**

Corrective Actions Log

	Staff Group	Actions	Progress	Lead	Deadline
1	Medical	Progressing medical recruitment through Skype interviews	Appointments made	Di Pugh	On-going
2	Medical	International Recruitment event to India 7 July 2017 with HCL Clarity	Event organised and supported by 2 panels for Medicine and Surgery	Di Pugh	July 2017
3	Nursing	Revised Nursing Strategy to be developed between Nursing and HR Directorates	Away Day took place in June 2017	Sarah Needham/ Di Pugh	July 2017

Impact on Trajectories

Medical Vacancies	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Current Trajectory		110.40	103.41	88.41	84.41							
New Trajectory		110.40										

Nursing Vacancies	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Current Trajectory	131.25	159.45	118.88									
New Trajectory												

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: May 2017

*** PLEASE NOTE THIS IS A DRAFT VERSION WITH PRE-VALIDATED FIGURES WHICH ARE SUBJECT TO CHANGE ***

Area	Indicator Type		Indicator	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Current YTD	Prev Year	Tolerance Type	2017/18 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Waits	National	PW1.1.3	6 Week Wait Diagnostics (Proportion of waiting list)	5.90%	2.70%	2.03%	3.16%	2.36%	3.36%	2.75%	4.56%	3.98%	2.24%	3.73%	6.80%	6.07%		3.55%	National	<1%	-	>1%	COO	
	National	CW3.0	RTT - Incomplete 92% in 18 Weeks	88.80%	88.26%	87.80%	87.36%	86.79%	86.60%	85.00%	83.58%	83.90%	83.59%	83.51%	83.04%	84.07%		83.51%	National	>=92%	-	<92%	COO	
	Local	PO1.1	Cancelled Outpatient Appointments (Patient Led)	7,494	8,564	7,488	7,880	8,235	7,535	7,747	7,282	7,469	6,727	7,599	6,102	7,739		90,866	-	-	-	-	COO	
Outpatients	Local	PO2.0	DNA Rate - New Appointments	7.1%	7.5%	7.9%	8.2%	7.5%	7.6%	7.7%	7.6%	6.9%	6.3%	7.1%	7.6%	7.6%		7.3%	-	-	-	-	COO	
	Local	PO3.0	DNA Rate - Follow-up Appointments	8.9%	9.2%	8.5%	9.0%	9.2%	8.4%	7.9%	8.1%	8.3%	7.7%	8.0%	8.4%	8.4%		8.5%	-	-	-	-	COO	
Theatres	Local	PT1.1	Utilisation - ALX	66.00%	72.00%	66.00%	73.00%	69.00%	42.00%	69.00%	71.00%	29.00%	67.00%	72.00%	72.00%	69.00%		-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT1.2	Utilisation - WRH	68.00%	72.00%	76.00%	75.00%	75.00%	78.00%	78.00%	71.00%	75.00%	71.00%	76.00%	73.00%	75.00%		-	Local				COO	
	Local	PT1.3	Utilisation - KGH	70.00%	71.00%	66.00%	70.00%	64.00%	65.00%	66.00%	67.00%	69.00%	70.00%	71.00%	67.00%	67.00%		-	Local				COO	
A & E	National	CAE1.1a	4 Hour Waits (%) - Trust inc. MIU - from September 14	82.20%	84.70%	85.70%	83.70%	82.80%	80.90%	78.90%	75.30%	76.80%	77.90%	82.57%	81.3%	82.67%		81.50%	National	>=95%	-	<95%	COO	
	National	CAE1.2	4 Hour Waits (%) - WRH	68.30%	68.10%	73.00%	69.90%	70.20%	68.40%	65.70%	59.40%	61.00%	61.00%	65.95%	66.94%	65.70%		67.20%	National	>=95%	-	<95%	COO	
	National	CAE1.3	4 Hour Waits (%) - ALX	81.10%	88.20%	85.20%	83.00%	77.80%	75.60%	71.90%	69.20%	73.30%	75.80%	83.79%	78.97%	85.41%		79.40%	National	>=95%	-	<95%	COO	
	National	CAE1.4	4 Hour Waits (%) - KGH	100.00%	100.00%	99.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.00%	100.00%	100.00%		99.97%	National	>=95%	-	<95%	COO	
	Local	CAE1.6	A&E Attendances (Trust inc.MIU) - from September 14	16,861	15,938	17,215	15,792	15,787	15,870	14,802	13,769	13,663	13,388	15,558	15,499	15,458		183,601	-	-	-	-	COO	
	National	CAE2.0	Overall Time in Department (Hrs) - 95th Percentile ^ (inc Kidd MIU)	11.9	11.9	10.8	12.7	12.3	14.1	13.7	12.8	15.1	15.6	12.4	12.1	13.9		-	National	<=4hrs	-	>4hrs	COO	
	Local	CAE2.1	12 hour trolley breaches	0	5	1	13	4	4	37	88	177	55	14	4	6			Local	0		0	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile	33	22	24	32	23	37	36	41	44	43	27	31	44		-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment for All Patients (Mins) - 95th Percentile	35	28	30	40	35	31	34	34	35	34	27	28	57		-	National	<=15mins	-	>15mins	COO	
	National	CAE4.0	Time from Arrival to Treatment (Mins) – Median ^ (inc Kidd MIU)	68	64	64	59	59	61	60	62	52	52	49	57	57		-	National	<=60mins	-	>60mins	COO	
	National	CAE5.0	Unplanned Reattendance within 7 days of original Attendance (%) (inc Kidd MIU)	5.30%	6.00%	5.50%	5.70%	5.40%	5.60%	5.50%	5.60%	5.70%	5.40%	5.10%	5.20%	5.70%		5.40%	National	<=5%	-	>5%	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	56.10%	57.30%	59.10%	60.70%	57.40%	54.70%	53.90%	39.20%	39.70%	35.90%	47.70%	51.30%	52.50%		53.20%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	90.20%	91.70%	93.00%	90.30%	90.80%	87.69%	87.70%	78.70%	79.50%	74.90%	86.40%	86.10%	86.80%		88.10%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes - WMAS data	51	34	26	70	43	97	81	157	141	129	60	70	95		731	Local	0		>0	COO	

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Area	Indicator Type	Indicator		May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Current YTD	Prev Year	Tolerance Type	2017/18 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Cancer *	National	CCAN1.0	31 Days: Wait For First Treatment: All Cancers	96.90%	96.58%	99.23%	98.13%	97.25%	98.32%	94.60%	97.63%	95.08%	97.39%	97.64%	97.69%	96.10%		97.06%	National	>=96%	-	<96%	COO	
	National	CCAN2.0	31 Days: Wait For Second Or Subsequent Treatment: Surgery	90.48%	82.50%	83.78%	97.14%	93.02%	79.59%	77.14%	91.43%	82.93%	84.21%	77.78%	92.00%	87.80%		85.43%	National	>=94%	-	<94%	COO	
	National	CCAN3.0	31 Days: Wait For Second Or Subsequent Treatment: Radiotherapy	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		99.70%	National	>=94%	-	<94%	COO	
	National	CCAN4.0	31 Days: Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.40%	100.00%		100.00%	National	>=98%	-	<98%	COO	
	National	CCAN5.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	79.34%	68.07%	66.44%	66.15%	72.20%	74.35%	75.25%	73.85%	57.49%	76.40%	76.70%	70.70%	61.40%		71.80%	National	>=85%	-	<85%	COO	
	Local	CCAN5.2	62 Days: Wait For First Treatment From Urgent GP Referral: Breast*	96.20%	83.30%	85.70%	94.70%	84.60%	96.30%	100.00%	90.90%	93.30%	100.00%	94.70%	83.30%	84.20%		92.70%	National	>=97%	-	<97%	COO	
	Local	CCAN5.3	62 Days: Wait For First Treatment From Urgent GP Referral: Gynae*	85.70%	75.00%	60.00%	55.60%	60.00%	33.30%	100.00%	66.70%	71.40%	66.70%	100.00%	50.00%	100.00%		63.60%	National	>=83%	-	<83%	COO	
	Local	CCAN5.4	62 Days: Wait For First Treatment From Urgent GP Referral: Haemotological*	72.70%	91.70%	86.70%	60.00%	88.90%	83.30%	85.70%	100.00%	100.00%	93.30%	71.40%	87.50%	83.30%		83.20%	National	>=86%	-	<86%	COO	
	Local	CCAN5.5	62 Days: Wait For First Treatment From Urgent GP Referral: Head & Neck*	22.20%	66.70%	0.00%	66.70%	40.00%	90.90%	100.00%	80.00%	30.00%	61.50%	-	28.60%	33.30%		58.10%	National	>=74%	-	<74%	COO	
	Local	CCAN5.6	62 Days: Wait For First Treatment From Urgent GP Referral: Lower Gastro*	85.70%	59.30%	26.70%	40.00%	36.40%	41.70%	48.50%	30.80%	37.20%	54.50%	40.00%	33.30%	38.30%		45.70%	National	>=77%	-	<77%	COO	
	Local	CCAN5.7	62 Days: Wait For First Treatment From Urgent GP Referral: Lung*	72.70%	100.00%	80.00%	41.70%	70.60%	76.90%	53.80%	69.00%	62.50%	100.00%	57.90%	83.30%	43.80%		69.80%	National	>=81%	-	<81%	COO	
	Local	CCAN5.8	62 Days: Wait For First Treatment From Urgent GP Referral: Skin*	95.20%	100.00%	82.00%	88.50%	94.80%	97.80%	94.70%	100.00%	100.00%	89.70%	100.00%	95.80%	88.90%		95.00%	National	>=96%	-	<96%	COO	
	Local	CCAN5.9	62 Days: Wait For First Treatment From Urgent GP Referral: Upper Gastro*	76.90%	50.00%	88.90%	75.90%	66.70%	59.10%	90.60%	83.30%	40.00%	75.00%	100.00%	62.50%	72.70%		72.50%	National	>=80%	-	<80%	COO	
	Local	CCAN5.10	62 Days: Wait For First Treatment From Urgent GP Referral: Urological*	56.50%	30.80%	47.40%	42.60%	55.20%	49.40%	51.40%	37.30%	31.30%	53.70%	63.30%	59.30%	37.50%		46.30%	National	>=81%	-	<81%	COO	
	Local	CCAN5.11	62 Days: Wait For First Treatment From Urgent GP Referral: Other*	40.00%	100.00%	-	100.00%	0.00%	100.00%	33.30%	-	0.00%	100.00%	-	0.00%	0%		66.70%	National	-	-	-	COO	
	National	CCAN6.0	62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers (Small numbers)	95.00%	100.00%	95.50%	88.00%	89.50%	93.10%	79.00%	78.30%	80.00%	81.80%	100.00%	90.90%	95.20%		89.20%	National	>=90%	-	<90%	COO	
	National	CCAN8.0	2WW: All Cancer Two Week Wait (Suspected cancer)	63.70%	69.20%	75.50%	65.90%	71.00%	86.30%	82.50%	90.40%	86.60%	86.30%	83.90%	64.90%	66.00%		74.70%	National	>=93%	-	<93%	COO	
	National	CCAN9.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	28.00%	55.70%	74.50%	52.00%	76.10%	93.40%	94.10%	95.60%	86.60%	80.50%	51.80%	34.40%	27.37%		66.60%	National	>=93%	-	<93%	COO	
	National		Cancer Long Waiters (104 Day +) includes suspected and diagnosed	31	39	33	41	40	48	41	45	41	42	30	25	21								
	National	CCAN10.1	Cancer Long Waiters (104 Day +) includes suspected and diagnosed - treated in month - NEW			12	12	11	12	14	11	20	7	13	6	13			-	-	-	-	COO	
Stroke	Local	CST1.1	80% of Patients spend 90% of time on a Stroke Ward (National Definition - from April 2016)									21.80%	53.80%	42.40%	71.70%	75.40%			Local	>=80%	-	<80%	COO	
	Local	CST2.1	Direct Admission (via A&E) to a Stroke Ward (National Definition - from April 2016)									14.50%	4.70%	23.00%	41.00%	30.00%			Local	>=90%	-	<90%	COO	
	Local	CST3.1	TIA (National Definition - from April 2016)		31.80%	5.60%	6.40%	4.60%	4.50%	8.00%	35.00%			8.02%	3.88%				Local	>=60%	-	<60%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH **	101%	99%	100%	100%	100%	100%	99%	99%	99%	99%	99%	96%	98%		100%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX **	87%	84%	87%	86%	93%	96%	96%	90%	91%	90%	86%	87%	83%		89%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN2.3	Beds Occupied by NEL Stranded Patients (>7 days) - last week of month								45.60%	45.60%	48.90%	40.94%	38.75%	38.46%		48.90%	Local	<=45%	-	>45%		
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute***	33	33	22	26	39	34	45	25	23	34	33	38	32		383	Local	<30	-	>=30	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute***	788	1063	704	514	1145	1005	1225	1,068	706	878	1,186	686	819		11021	-	-	-	-	COO	
	Local	PIN4.2	Bed Days Lost Due To Acute Bed No Longer Required (Days)	3,252	3,106	2,409	2,459	2,899	3,387	3,402	2,933	3,068	3,117	3,428	3,000	3,204	6,204	36,498	-	-	-	-	COO	
Day Case	Local	PDC1.0	Day Case Admissions	6,099	6,525	5,951	6,085	6,191	6,260	6,715	5,611	6,416	6,300	6,927	5,800	6,588		74,666	-	-	-	-	COO	
	Local	PDC2.0	Day Case Rates	89.9%	89.4%	89.1%	90.0%	89.0%	88.9%	89.0%	88.8%	91.7%	91.2%	89.7%	89.7%	89.91%		89.7%	-	-	-	-	COO	
Elective	Local	PEL1.0	Elective Admissions	684	803	698	700	776	795	841	647	617	615	804	629	770		8,641	-	-	-	-	COO	
	Local	PEL2.0	Elective Length of Stay (Exclude Day Case)	3.0	2.6	2.5	2.7	2.5	2.7	2.9	3.2	3.0	2.9	2.7	2.8	2.82		2.8	-	-	-	-	COO	
	National	PEL3.0	28 Day Breaches as a % of Cancellations****	15.3%	20.0%	17.7%	22.9%	10.1%	7.1%	40.2%	28.4%	39.0%	13.4%	51.4%	12.5%	22.45%		25.7%	TBC	<=5%	6 - 15%	>15%	COO	
	National	PEL3.1	Number of patients - 28 Day Breaches (cancelled operations)	13	15	11	11	7	7	39	25	39	9	18	4	11	15	-	TBC	-	-	-	COO	
	Local	PEL4.1	Cancellations (Patients)	85	75	62	48	69	99	97	88	61	67	35	32	49		846	-	-	-	-	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	1	4	1	1	0	0	1	1	0	1	0	1	1		10	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	4.4	4.8	4.3	4.7	4.8	4.6	4.6	5.0	5.0	5.0	4.6	4.4	4.43		4.7	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	6.1	6.6	5.9	6.4	6.9	6.6	6.8	7.1	7.0	7.3	6.8	6.4	6.41		6.6	-	-	-	-	COO	
Clinical Coding	National	PCC1.0	% of Discharged FCEs not coded by SUS Submissions (approx. 5th working) ****	2.2%	3.2%	2.8%	0.0%	0.0%	0.8%	0.3%	6.2%	0.6%	29.0%	76.7%		50.1%			National	<=5%	-	>5%	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.*
*****April data unavailable*

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

Quality Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Patient Safety

Area	Indicator Type		Indicator	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Current YTD	Prev Year	2017/18 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	4	1	4	4	1	2	4	1	0	0	3	11		-	0	-	>0	CMO	
	National	QPS4.1	Never Events	0	0	0	1	0	0	0	0	1	0	0	0	0		2	0	-	>0	CMO	
	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	1	1	1	1	2	2	1	4	2	5	0	2	1		23	<=1	-	>=2	CNO	
	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	0	2	1	2	3	2	0	4	2	1	0	0	1		18	0	1 - 3	>=4	CNO	
	Contractual	QPS7.7	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 4 Avoidable (Monthly)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	-	>=1	CNO	
Mortality*	National	QPS9.1	Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge - rolling 12 months	110	110	111	110	108	109	108	108	107	107					-	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months*	107	109	110	109	108	109	108	106	109	109	107				-	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.21	% Primary Mortality Reviews completed**	51%	61%	59%	64%	59%	59%	54%	55%	54%	52%	45%	46%				>=60		<60	DPS	
	National	QPS.9.22	% Secondary Mortality Reviews completed**	0%	17%	11%	0%	22%	10%	33%	29%	17%	0%	0%	0%				>=20		<20	DPS	
Safety Thermometer	National	QPS10.1	Safety Thermometer - Harm Free Care Score	93.33%	92.86%	94.47%	93.10%	91.78%	91.51%	89.91%	91.79%	94.63%	93.39%	93.63%	90.20%	91.33%	-	-	>=95%	90% - 94%	<90%	CMO	
VTE	National	QPS11.1	VTE Risk Assessment	96.19%	95.43%	95.64%	93.80%	93.89%	92.84%	93.46%	93.40%	93.48%	93.27%	94.20%	94.51%	94.74%		94.27%	>=95%	94% - 94.9%	<94%	CMO	
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	4	2	3	0	6	4	5	6	3	3	3	2			41	16/17 Threshold < = 32 17/18 Threshold < = 32			CNO	
	National	QPS12.4	MRSA Bacteremia - Hospital Attributable (Monthly)	0	0	0	0	0	0	1	1	0	1	1	0	0		4	0	-	>0	CNO	
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective	95.00%	95.40%	95.80%	95.90%	92.70%	97.10%	96.60%	93.80%	97.00%	96.70%	95.50%	96.40%	97.40%		-	>=95	-	<95%	CNO	

Patient Experience

Area	Indicator Type		Indicator	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Current YTD	Prev Year	2017/18 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Complaints & Compliments ****	Local	QEX1.1	Category 2 Complaints - Numbers (In Month) - WHAT	58	65	55	70	59	63	68	60	55	51	61	#N/A			724				CNO	
	Local	QEX1.14	Category 2 Complaints - % responded within 25 days (closed in month) - WHAT	73.0%	68.0%	67.0%	65.0%	51.0%	47.0%	63.0%	70.0%	71.0%	55.0%	56.0%				63.0%	>=90	80-90%	<=79%	CNO	
	Local	QEX1.24	Formal Complaints - Numbers (In Month)												34	64			-	-	-	CNO	
	Local	QEX1.26	Formal Complaints - Number per 10,000 Bed Days (YTD)												14.93	21.07			-	-	-	CNO	
	Local	QEX1.37	Formal Complaints - % responded within 25 days (closed in month) - WAHT												46.9%	34.6%			>=80	70-79%	<=69%	CNO	
Friends & Family****	National	QEX2.1	Friends & Family - A&E (Score)	57.4	63.8	74.7	82.1	64.1	66.8	69.1	77.5	69.0	67.8	71.9	55.4	70.1		70.2	>=71	67-<71	<67	CNO	
	National	QEX2.61	Friends & Family - Acute Wards (Score)	80.1	79.7	79.2	82.1	78.0	80.0	80.9	78.0	83.0	81.0	80.0	82.4	84.6		-	>=71	67-<71	<67	CNO	
	National	QEX2.7	Friends & Family - Maternity (Score)	87.6	87.6	83.2	86.0	85.8	79.0	83.0	81.4	87.1	81.6	83.5	85.6	85.0		84.0	>=71	67-<71	<67	CNO	
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	0	0	0	0	0	0	0	15	0	9	40	36	34		64	0	-	>0	CNO	

Effectiveness of Care

Area	Indicator Type		Indicator	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Current YTD	Prev Year	2017/18 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Hip Fracture*****	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	65.9%	69.6%	47.7%	47.9%	53.4%	66.1%	61.4%	61.2%	63.7%	63.5%	70.5%	91.0%	91.0%		60.0%	>=85%	-	<85%	CMO	
	Local	QEF3.1i	Hip Fracture - Time to Theatre <=36 hours (%) - WRH	68.0%	64.0%	40.0%	46.0%	40.0%	67.0%	50.0%	68.0%	59.0%	59.0%	55.0%	85.0%	88.0%		55.7%	>=85%	-	>=85%	CMO	
	Local	QEF 3.1ii	Hip Fracture - Time to Theatre <=36 hours (%) - ALX	61.0%	86.0%	60.0%	52.0%	69.0%	66.0%	78.0%	48.0%	71.0%	70.0%	89.0%	100.0%	95.0%		67.2%	>=85%	-	>=85%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Treatment Pts	79.0%	81.0%	65.0%	77.0%	63.0%	80.0%	67.0%	69.5%	78.7%	76.7%	76.8%	97.0%	94.0%		70.2%	>=85%	-	<85%	CMO	

Risk Register Activity

Area	Indicator Type		Indicator	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Current YTD	Prev Year	2017/18 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Effectiveness	Local	QR1.4	% of National Audits with an action plan												72.0%				>80%	50%-79%	<50%	CNO	
	Local	QR1.6	% of Local Audits with an action plan									100.0%	100.0%	100.0%	100.0%				>80%	50% - 79%	<50%	CNO	

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

Workforce Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: May 2017

***** PLEASE NOTE THIS IS A DRAFT VERSION WITH PRE-VALIDATED FIGURES WHICH ARE SUBJECT TO CHANGE *****

Area	Indicator Type	Indicator		May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Current YTD	Prev Year	Tolerance Type	2017/18 Tolerances			SRO
																				On Target	Of Concern	Action Required	
Vacancies & Recruitment	Local	WVR1.0	Number of Vacancies - Total	440	406	461	524	499	486	497	512	502	471	437	476.83	502.40		437	Local	<=200	201-229	>=230	DCE
Turnover	Local	WT1.0	Staff Turnover WTE %	12.9%	12.8%	12.7%	12.6%	12.5%	12.6%	13.0%	12.8%	12.8%	12.7%	12.6%	12.5%	12.5%		12.57%	Local	<>10-12%	<>12-14%	>14%	DoHR
	Local	WT1.3	Nursing Staff Turnover - Qualified	14.4%	13.9%	14.4%	14.1%	13.8%	13.9%	13.6%	13.5%	13.2%	13.3%	13.3%	12.9%	12.7%		13.3%	Local	<>10-12%	<>12-14%	>14%	DoHR
	Local	WT1.4	Nursing Staff Turnover - Unqualified	14.3%	14.6%	13.9%	13.5%	13.0%	12.6%	14.1%	14.5%	15.1%	14.4%	14.8%	14.4%	14.9%		14.8%	Local	<>10-12%	<>12-14%	>14%	DoHR
Sickness & Absence	Local	WSA1.0	Sickness Absence Rate Monthly (Total %)	4.11%	3.73%	4.13%	3.99%	3.90%	4.55%	4.81%	4.96%	5.06%	4.17%	4.04%	3.98%	3.83%		4.04%	Local	<= 3.50%	>=3.51% & <=3.99%	>= 4.00%	DoHR
Induction	Contractual	WIN1.0	Staff Eligible to attend induction	47			185			59	56			57				458	-	-	-	-	DoHR
	Contractual	WIN1.2	Staff Who Attended Induction	44			172			57	46			70				443	-	-	-	-	DoHR
	Contractual	WIN1.3	% of eligible staff attended Induction	93.6%			93.0%			96.6%	82.1%			122.8%				96.7%	Contractual	>= 90%	80 - 89%	< 80%	DoHR
Statutory and Mandatory	Contractual	WSMT10.2	% Of Eligible Staff completed Training	85.3%	82.1%	84.5%	81.6%	81.3%	109.0%	107.9%	109.7%	108.2%	104.6%	80.5%	93.0%	92.7%	92.8%	84.8%	Contractual	>= 90%	60.1-89.9%	<=60%	DoHR
Appraisals	Contractual	WAPP1.2	% Of Eligible non-medical Staff Completed Appraisal	84.9%	79.4%	78.9%	82.1%	83.4%	84.6%	86.8%	85.3%	83.8%	80.5%	75.8%	73.9%	75.6%	74.7%	82.2%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP2.2	% Of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	83.6%	82.9%	82.6%	81.4%	81.1%	82.3%	83.4%	83.1%	82.1%	80.2%	81.9%	83.7%	88.6%	86.2%	82.1%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP3.2	% Of Eligible Consultants Who Have Had An Appraisal	85.7%	85.8%	86.4%	85.9%	86.0%	85.7%	85.7%	85.8%	83.7%	83.1%	84.4%	86.3%	92.3%	89.3%	85.2%	Contractual	>= 85%	71 - 84%	< 71%	DoHR

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

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healthwatch Worcestershire

Care in the Corridor at the Worcestershire Royal Hospital

Survey Report

May 2017

Healthwatch Worcestershire,
Civic Centre, Queen Elizabeth Drive,
Pershore,
Worcestershire,

WR10 1PT
Tel. 01386 550 264
Email: info@healthwatchworcestershire.co.uk

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Acknowledgments

HWW acknowledge the co-operation of the Trust's leadership, the matrons of the A&E Departments and A&E staff throughout the visit programme.

EXECUTIVE SUMMARY

Introduction

1. Healthwatch Worcestershire (HWW) provides an independent voice for people who use publicly funded health and social care services. Our role is to ensure that people's views are listened to and fed back to service providers and commissioners in order to improve services.
2. Patients have reported to Healthwatch Worcestershire their experience of long waits at the Accident & Emergency Department (A&E) at Worcestershire Royal Hospital, some of which took place on trolleys in corridor areas at the hospital.
3. Health and Care organisations in Worcestershire have stated that nursing patients on trolleys is not an acceptable practice[1]. Figures published by NHS England[2] in March 2017 however identified Worcestershire Acute Hospitals Trust as the worst in the country for "trolley waits" of over 12 hours during January 2017.
4. Healthwatch Worcestershire agrees that patients being cared for in corridors is unacceptable and does not endorse this in any way. Nevertheless this situation is being experienced by patients.
5. We undertook the Care in the Corridor Survey to directly gather patient's experience of being cared for in corridors at A&E and the Medical Assessment Unit. From 13th February 2017 – 26th March 2017 HWW completed 31 unannounced visits to Worcestershire Royal Hospital and 13 unannounced visits to Alexandra Hospital using our powers to Enter & View[3] premises. The WAHT has been fully cooperative with our Visit programme.
6. *Awaiting contextual information from CCGs re attendance figures and performance during the time period of our visits.*

What we did

7. Our survey asked patients about information provided to them about being in the corridor area; their care; the environment; privacy and dignity; waiting times; and their overall experience of being in the corridor area of the hospital. We have already reported urgent issues that emerged from our visits to the WAHT.
8. There were no patients in the corridor at the Alexandra Hospital during any of our visits.
9. We spoke with 119 patients at the WRH, 96 in the corridor areas at A&E and 23 in the corridor of the Medical Assessment Unit, of whom 51% were female and 49% male.

What we found out

10. In the Report we have provided further information & commentary about our findings. The main headlines are set out below.
11. We found that the majority of respondents had not been given any information about being in the corridor area and 43% did not know the name of the person looking after them.

[1] Risk Summit meeting 18th January 2017

[2] Monthly A&E Timeseries January 17, NHS England, published March 2017

[3] Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

12. Most patients knew how to call for attention from staff but had not needed to do so. Of those (27%) that had called for attention 46% reported that they had waited over 5 minutes for help or had not received the help that they needed. We also observed patients who appeared confused or distressed, had communication difficulties or sensory impairments in the corridor areas. We question whether a corridor is ever the right environment for these patients.
13. The majority of patients had been provided with a drink (88%) or food (62%) since being in the corridor area. When cross referencing patients who had been offered food by the time patients had waited we found 1 patient who had waited 8 – 12 hours and 3 patients who had waited over 12 hours who reported they had not been offered any food since being in the corridor area. We noticed that food and drink was sometimes placed at a distance to patients. A refreshment trolley was available in the MAU, but needed to be clearly signed with instructions available for patients and visitors.
14. Half of the patients that we spoke to had been in pain since being in the corridor area, 60% of these patients felt that staff were doing what they could to control their pain, whilst 19% thought this was true to some extent and 21% did not. A patient reported that they had not been given their prescribed medication during nearly 24 hrs in A&E.
15. We asked patients whether, in their opinion, there were enough staff on duty in the corridor area of the hospital to care for them. 65% said that yes there were enough staff, 19% said that there were not enough staff and 16% did not know.
16. Patients reported that it was difficult to sleep and rest in the corridor areas. We received negative comments about people & equipment moving around, noise, doors opening and closing and bright lighting. We observed staff leaning across patients on trolleys to use the electronic fob to open doors to another part of the hospital. We also observed staff coming through these doors into A&E.
17. 75% of patients reported that there was nowhere to safely keep their personal belongings in the corridor area of the hospital, or they did not know where this was (18%).
18. Whilst 30% of patients reported that they had definitely been given enough privacy when discussing their personal information; condition or treatment in the corridor area, 19% of patients agreed to some extent, however 28% disagreed. Despite moving away from patients to complete our observations we overheard patient's personal information, treatment and condition being discussed on 21 of our visits to the A&E corridor areas. We twice heard test results and diagnosis being given to patients by doctors in the corridor.
19. When asked whether patients had been given enough privacy when being examined or treated 31% reported that this was definitely the case, 19% agree to some extent and 12% disagreed. On three occasions we observed a mobile screen in use in the corridor when a patient was being examined. The screen was insufficient to completely shield the patient from view of other patients and passers-by.
20. Most patients (85%) had not been told how long they might be waiting in the corridor area for, and 16% did not know the reason that they were waiting.

Most patients told us they were waiting to be admitted to a ward or MAU (48%), or were awaiting scans, tests or a decision about next steps (34%).

21. We asked patients how long they had ACTUALLY been waiting in the corridor area of the hospital. 47% (55) of respondents had been waiting for less than four hours. 19% (23) had been waiting 4 – 8 hours, 16% (19) had been waiting eight – twelve hours, 15% (18) had been waiting over 12 hours and 3% (3) didn't know or could not remember
22. Patients reported that overall they had been well looked after by hospital staff, with 74% saying that this was always the case, 18% sometimes the case and 9% disagreeing. The answers varied by age, with people over 50 more often saying that they had been well looked after than those under 50.
23. We asked patients "Overall do you feel that you have been treated with respect and dignity while you have been in this area of the hospital?" 76% reported this was always the case, 15% sometimes the case and 9% disagreed. Again people over 50 more often reported that they had been treated with respect and dignity than those under 50.
24. We asked patients to rate their overall experience of being nursed in the corridor by giving it a number between 1 – 10, where 0 was very poor and 10 was very good. 8% of patients rated their experience between 0 – 3; 46% rated their experience between 4 – 7 and 46% rated their experience between 8 –10. Most (79%) of patients who rated their experience 8 – 10 were over 50, and many had given negative response to other questions in the Survey.
25. From our observations and the comments we received patients appear to be making a distinction between the staff in the A&E Department and the situation that they find themselves in of being cared for in the corridor area. Patients appear to empathise with the pressure on staff in the Department, whilst being unhappy about some aspects of the experience of being cared for in the corridor.
26. We observed that facilities for visitors can be very limited. On 16 occasions there was nowhere for at least one visitor to sit down. Visitors are not routinely offered drinks even after waiting with patients for some hours.
27. On three occasions patients reported to us inaccuracies in their records, and on four occasions we noted equipment partially obstructing fire exits.
28. We have made 38 recommendations based on the findings which can be found at 1. below.
29. Implementation of the Recommendations set out in this Report should ensure that patients experience and views are given proper consideration in the improvement process and assist with improving the patient experience in what are acknowledged as being extremely difficult circumstances.

1. RECOMMENDATIONS

(Numbers in brackets refer to the section of the Report where the recommendations originate)

Information (5.1)

1. All patients being cared for in the corridor of the A&E Department to be given the letter prepared by WRH explaining about being in the corridor.
2. The WRH letter should be amended to briefly explain HWW role. The text for this can be supplied by HWW.
3. All patients should be given a HWW leaflet so they are aware they can report their experiences to us independently of the hospital.
4. The designated corridor nurse to be identified by wearing a specific coloured badge (similar to the Nurse in Charge badge) to clearly identify them to patients.
5. All staff to introduce themselves to patients by name, in line with the #hellomynameis campaign.
6. Photos of A&E/MAU staff making this pledge could be shared in the A&E areas, subject to Health & Safety considerations.

Patient Care (5.2)

7. WAHT to ensure it is explained to all patients how to call for attention in corridor areas of the hospital, including the MAU where there are no call bells available.
8. WAHT to consider whether patients who appear to be confused or living with dementia, or who have specific communication difficulties or sensory impairments should be nursed in corridor areas of the hospital.
9. WAHT to provide reassurance that best practice on nutrition and hydration of patients on wards is being followed in corridor areas when patients are waiting for lengthy periods.
10. Staff to check patients are able to reach food and drink placed at the end of the trolley and whether any assistance with this is required.
11. Consideration to be given to reinstating a refreshment trolley in the A&E corridor area similar to that in the MAU for patients and visitors.
12. Refreshment trolleys to be easily identifiable to patients and visitors with clear instructions about their use.
13. WAHT to consider how signage could be improved to make this more visible to patients.
14. Patients to be routinely offered pillows and blankets when waiting on trolleys in the corridor areas.
15. Patients to be asked as part of “Care & Comfort” rounds if there is anything that can be done to make their wait more comfortable.
16. Patients to be told the location of the toilets and how to ask for assistance if they require it.
17. WAHT to provide reassurance that procedures are in place to control patient’s pain whilst they are being nursed in corridor areas of the hospital.

18. WAHT to provide reassurance that procedures are in place to provide patients with their prescription medication when they are subject to extended waits in the A&E Department.
19. WAHT to provide information about how A&E and MAU staff will be clearly identified so that patients know who they can ask for assistance.
20. WAHT to consider, in light of the findings and recommendations from this Survey, whether there are sufficient staff to care for patients in the corridor areas in A&E and the MAU throughout the 24hr period.

The Environment (5.3)

21. Consider whether doors to the A&E Assessment corridor need to remain open throughout the day, accepting that this may be the least disruptive option for patients.
22. Consider whether doors to the staff toilets can be modified to prevent them from banging.
23. Relocate the electronic fob in the side corridor to the opposite wall to ensure patients are not disturbed by staff operating the doors into the hospital.
24. Monitor staff movement from the hospital side of the doors into A&E to reinforce the message that this should not be used as a short cut.
25. Dim the lights in the corridor areas earlier at night to allow patients to rest and sleep.
26. WAHT to provide information about how noise will be controlled in corridor areas, particularly at night.
27. Provide secure storage space for patient valuables and belongings when they are being nursed for extended periods in the corridor area of the hospital.

Privacy & Dignity (5.4)

28. Consistently use private areas when providing patients with diagnosis or test results.
29. Consistently use the reserved curtained cubicles within the A&E Department when examining or treating patients.
30. When it is unavoidable to discuss patient's personal information in the corridor areas ensure patients are screened and voices are kept as low as practicable.
31. When it is unavoidable to examine or treat patients in the corridor areas ensure patients are screened sufficiently to protect their privacy and dignity.

Waiting Times (5.5)

32. Provide patients with an indication of how long they might be waiting in the corridor area and provide reassurance to patients whilst they are being nursed in the corridor.
33. Provide patients with a clear reason why they are waiting in the corridor area.

34. WAHT to provide information and reassurance to the public about the specific actions that are planned to ensure that WAHT is able to meet national standards for trolley waits, and the timetable for implementation.

Other Recommendations (6)

35. Provide basic facilities for relatives and visitors, including a seat and access to drinks.
36. Visitors who are staying overnight should be informed of where hospital facilities can be found and offered blankets.
37. WAHT to provide reassurance that processes are in place to ensure patient records are accurate.
38. Ensure that health and safety requirements in respect of the corridors are always complied with.

2. ABOUT HEALTHWATCH WORCESTERSHIRE

Healthwatch Worcestershire (HWW) provides an independent voice for people who use publicly funded health and social care services. Our role is to ensure that people's views are listened to and fed back to service providers and commissioners in order to improve services.

3. WHY DID WE UNDERTAKE THE "CARE IN THE CORRIDOR" SURVEY?

Worcestershire Acute Hospitals NHS Trust (WAHT) is responsible for the provision of acute hospital services in the County. The Trust run two Accident & Emergency (A&E) Departments.

One is located at the Worcestershire Royal Hospital (WRH) in Worcester. The Department is responsible for all emergency care for children in the County. It also sees patients who have had a suspected Stroke. The WRH has a Medical Assessment Unit (MAU). Patients are admitted to the MAU for observation or for further tests to see whether admission to a ward is required.

The other A&E Department is located at the Alexandra Hospital (the Alex) in Redditch. This is for adults requiring emergency care. During 13 visits to the Alex we did not observe any patients being cared for in the corridor area. This Report is therefore focused on the Worcestershire Royal Hospital.

Patients have reported to Healthwatch Worcestershire their experience of long waits at A&E at Worcestershire Royal Hospital, some of which took place on trolleys in corridor areas at the hospital. Figures published by NHS England in March 2017 identified Worcestershire Acute Hospitals Trust as the worst in the country for "trolley waits" of over 12 hours during January 2017. In the same period 65% of patients were seen within 4 hours of arriving at A&E, the national average was 77% and the government target is 95%[4].

The WAHT has identified pressure on the A&E Department at WRH is due to:

- high demand – number of patients coming to A&E in person or by ambulance
- overcrowding – not enough cubicles/ beds available in the department for the number of patients attending
- lack of available beds in the main hospital to transfer patients into, often due to delays in patients leaving hospital when they are medically fit to do so

[4] Monthly A&E Timeseries January 2017, NHS England, Type 1 A&E, published March 2017

As a result patients at Worcestershire Royal Hospital are being cared for on trolleys in the corridor areas of the A&E Department or on chairs, trolleys or beds in the corridor area of the Medical Assessment Unit (MAU), as all other spaces in the Departments are occupied. The situation occurs regularly, to the extent that 6 "call bells" have been installed in the A&E corridor areas where the trolleys are placed at the request of the WAHT Patients Public Forum in an attempt to improve patient experience.

WAHT has been in special measures since December 2015 after being rated inadequate by Care Quality Commission (CQC) Inspectors. In December 2016 the Trust was re-inspected. At a Risk Summit held on 18th January 2017 health and care organisations in Worcestershire, including the WAHT, stated that nursing patients on trolleys is not an acceptable practice. There is a lot of work going on both within WAHT and from other health and social care agencies in Worcestershire with the aim of improving performance across the Trust.

Healthwatch Worcestershire agrees that patients being cared for in corridors is unacceptable and does not endorse this in any way. Nevertheless this situation is being experienced by patients. It is recognised that this is unsatisfactory for both patients and hospital staff.

Healthwatch Worcestershire has been involved in both Quality Monitoring and Risk Summit meetings relating to the Trust and has regularly highlighted the implications for patients of the difficulties being experienced, including through local and national media.

HWW undertook the Care in the Corridor Survey to directly gather patient's experience of being cared for in these areas. One of the roles of Healthwatch is to make recommendations about how local health & care services could or ought to be improved.

Implementation of the Recommendations set out in this Report should ensure that patients' experience and views are given proper consideration in the improvement process and assist with improving the patient experience in what are acknowledged as being extremely difficult circumstances.

4. HOW DID WE UNDERTAKE THE SURVEY?

4.1 Unannounced Enter and View Visits

HWW wrote to WAHT and informed them of our intention to carry out a series of unannounced Enter and View visits to the A&E Departments during the period 13th February 2017 – 26th March 2017.

Healthwatch has the power to "Enter and View" [5] premises where health or social care services are being provided, speak with patients and to observe for ourselves how care is being delivered.

Over the 6 week period Healthwatch Worcestershire completed 44 visits. Of these 31 were to Worcestershire Royal Hospital and 13 to the Alexandra Hospital. We decided to visit the WRH more frequently than the Alexandra Hospital as statistical data and information from the Care Quality Commission (who are responsible for regulating and inspecting hospitals), indicated that corridor waits were more frequent at the WRH.

Visits were carried out at different times in the day and in the evening on weekdays and weekends. The hospital staff did not know when we would be visiting. For further details of the visit programme see Appendix One.

4.2 The Corridor Areas

Worcestershire Royal Hospital

a. Accident & Emergency

The corridor areas that we visited are in two parts. Both are relatively narrow, brightly lit spaces. When there are patients waiting on trolleys in the corridors areas it is difficult for beds, trollies or other equipment to get through the corridor.

Main Corridor

This is located just outside the main A&E area and separated from the assessment area corridor where patients arrive by ambulance by double doors. On one side of the corridor there is space for three trolleys. There are call bells fitted to the wall on this side. Further along there is another set of doors into the main A&E area and a door to a staff only area. On the other side of the corridor there is a unisex patient toilet, double doors to a lab area and 3 staff only doors to sluice, drugs and storage areas. Further along there is a door to an office. The corridor is a busy thoroughfare, with people (staff, patients and visitors) and equipment coming and going through the corridor.

Side Corridor

The second is a shorter corridor leading off from the main corridor area. On one side of the corridor there is space for three trolleys. There are call bells fitted to

[5] Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

the wall on this side. There is also a door to a staff changing area which is located between the second and third trolley area. On the other side of the corridor are separate female and male staff toilets and 2 further doors labelled as staff changing rooms.

At the end of this corridor there are double doors into another part the hospital. On the A&E side of the door there is an electronic pad which staff swipe with cards to open the doors. This is located on the wall behind one of the trolley bays. Although this corridor is generally quieter than the main corridor areas it can be particularly busy at staff handover times.

b. Medical Assessment Unit (MAU)

There is a short corridor area through double doors at the entrance to the main MAU. We observed that chairs, trolleys and on 2 occasions beds are placed on the left hand side of the corridor for patients who are waiting either to be admitted to the MAU or for test results. We also observed a refreshment trolley here on occasions. On the other side of the corridor are 3 doors labelled as offices. There are boards displaying useful information for patients and visitors on both sides of the corridor and photographs of staff receiving awards and thank you cards on display. The unisex toilet, waste room and staff room are located just outside of this area, further along the corridor.

Alexandra Hospital

The corridor area is in the main body of the A&E Department, along from the area where patients arrive by ambulance. We did not observe any patients being nursed in this area. Staff drew to our attention that the area is cold and heating inadequate. We have passed on these observations to WAHT.

4.3 Survey and Observations

We developed a survey focusing on different aspects of patient care. Some of the questions were based on the CQC National Inpatient Questionnaire. We piloted the Survey with patients at WRH and made some revisions based on the pilot.

The Survey asked patients about their care; the environment; privacy and dignity and the information that had been provided to them. We also asked patients to rate their overall experience. The Survey can be found at Appendix Two.

Where we have received comments from patients these have been coded as neutral, positive and negative and then themed. Themes identified are presented in order of frequency. Anonymised quotes from patients are also used to highlight issues within the Report.

We also carried out observations and recorded what we saw during our visits using prompt sheets. Findings drawn from observations are reported where relevant in the Commentary sections below.

4.4 Total Respondents

A total of 119 surveys were completed face to face by HWW at Worcestershire Royal Hospital.

- 96 took place in the corridors in the A&E Department
- 23 took place in the corridors in the Medical Assessment Unit

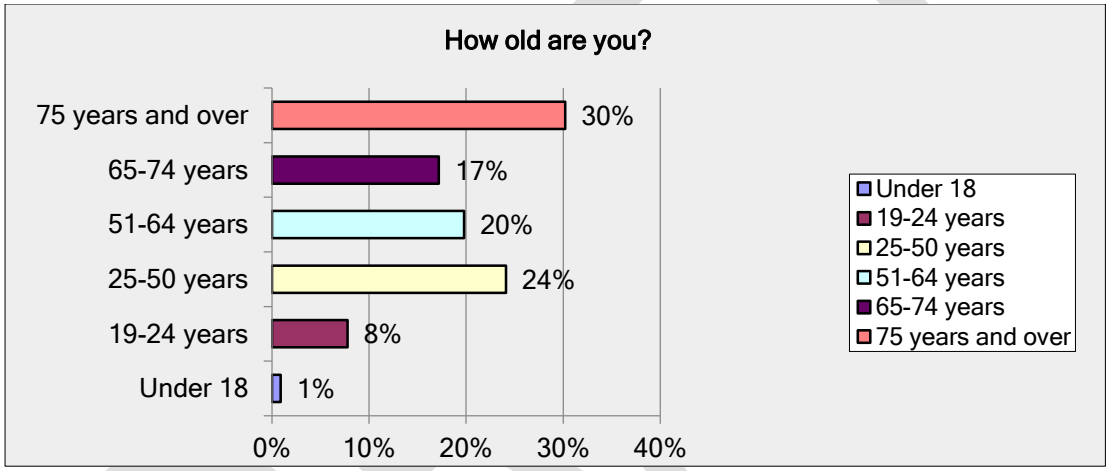
92% (108) of the surveys were completed with the patient, 6% (7) were completed with the patient and a friend or relative and 3% (3) were completed with a friend or relative of the patient.

4.4.1 Respondents by gender

- 51% (61) of respondents are female
- 49% (58) of respondents are male

4.4.2 Respondents by Age

The chart below shows that of the people who answered this question 30% are aged 75+, 24% are aged 25 -50, 20% are aged 51 - 64, 17% are aged 65 - 74, 8% are aged 19 - 24 and 1% are aged Under 18.



4.4.3 Respondents by Ethnicity

97% of the people who answered this question identified themselves as White British. The 3% of respondents who gave a different response identified themselves as Any Other Background (White European)

NOTE

Not all questions were answered by all respondents. When non-response is present, percentages are reported based on the numbers answering the question. The number of respondents to each question can be found at Appendix Two.

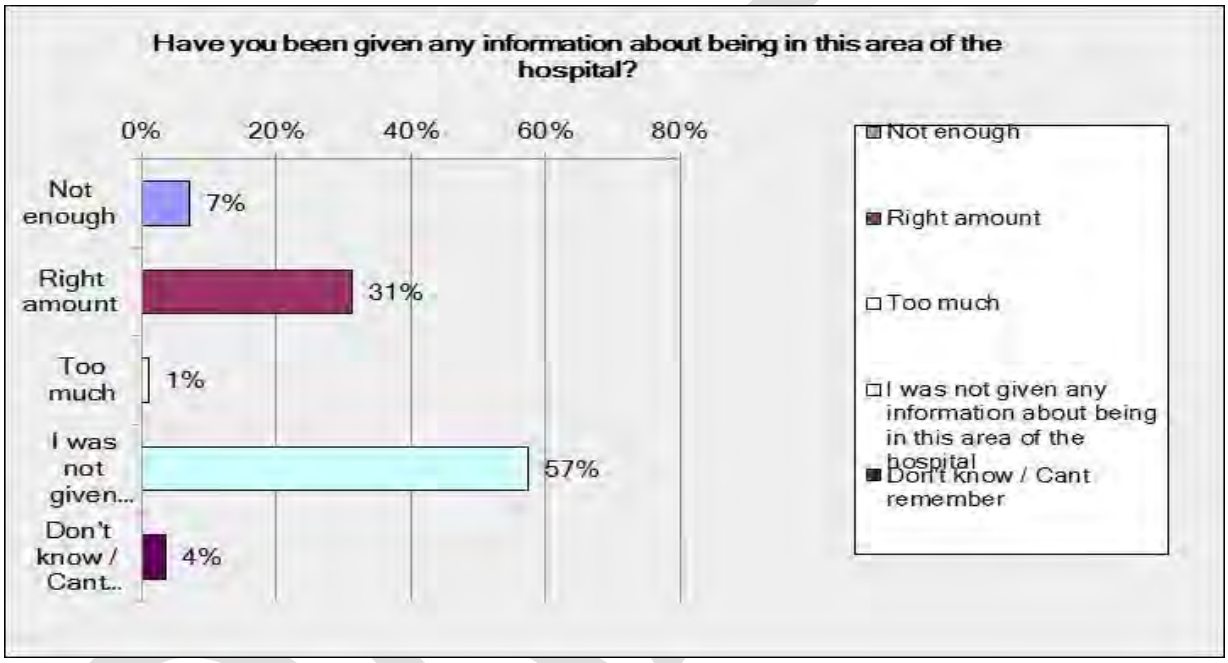
Results have been rounded to the nearest whole number, therefore will not always sum to 100%.

5. SURVEY RESULTS

5.1 INFORMATION

5.1. a. Have you been given any information about being in this area of the hospital?

The chart below shows that the majority of respondents (57%) reported that they had not been given any information about being in the corridor area of the hospital. 31% felt they had received the right amount of information, 7% had not had enough information and 1% too much and 4% did not know or could not remember.



Commentary

HWW observed that some patients have been given an explanatory letter prepared by the Emergency Department "Worcestershire Royal Hospital Emergency Department Patient Information Being in the Corridor". The letter does not seem to be provided consistently to every patient.

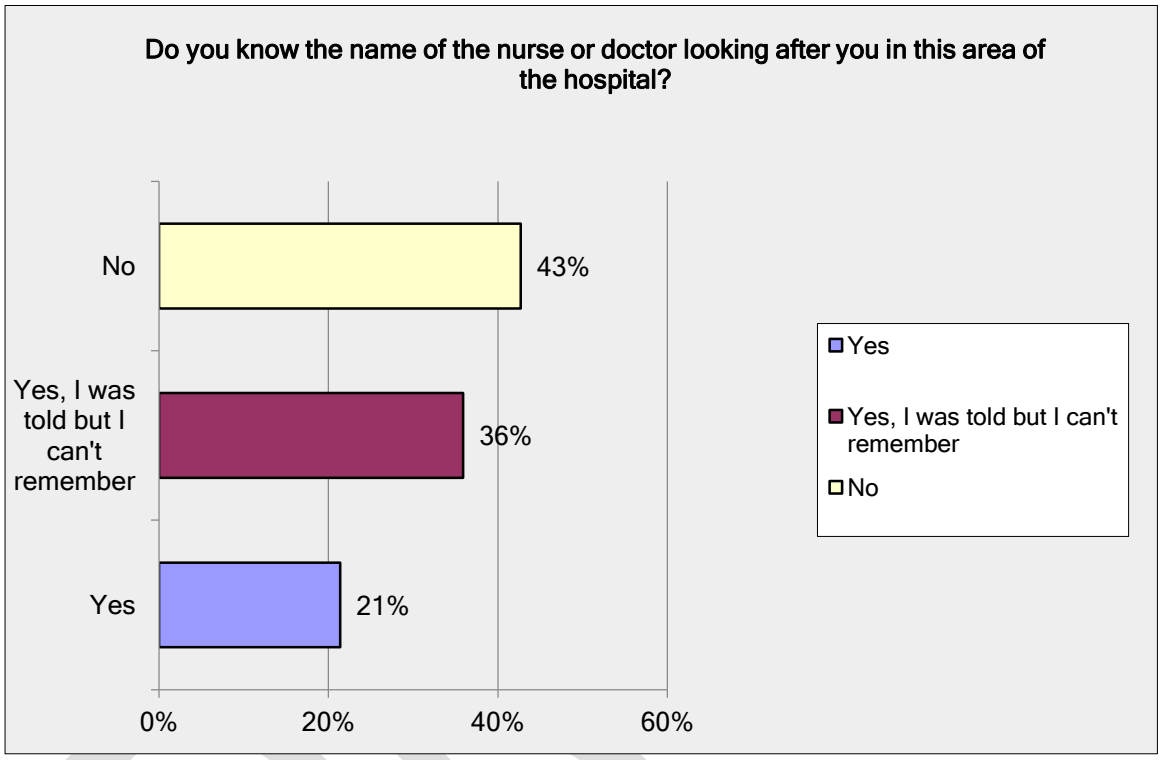
Recommendations

i. All patients in the corridor of the A&E Department to be given the letter prepared by WRH explaining about being in the corridor.
ii. The WRH letter should be amended to briefly explain HWW role. The text for this can be supplied by HWW.
iii. All patients should be given a HWW leaflet so they are aware they can report their experiences to us independently of the hospital.

5.1. b. Do you know the name of the nurse or doctor looking after you in this area of the hospital?

WAHT is a supporter of the #hellomynameis campaign, which aims to encourage staff to introduce themselves to patients, ensuring patients feel respected and welcomed and to improve their quality of care.

57% of the respondents to this question had been told the name of the nurse or doctor looking after them, however of these 36% were unable to remember the person's name. 43% of respondents reported that they did not know the name of the person looking after them.



Patients Said ….

"I would have liked someone to come and introduce themselves I feel a bit cut off here" (A&E)

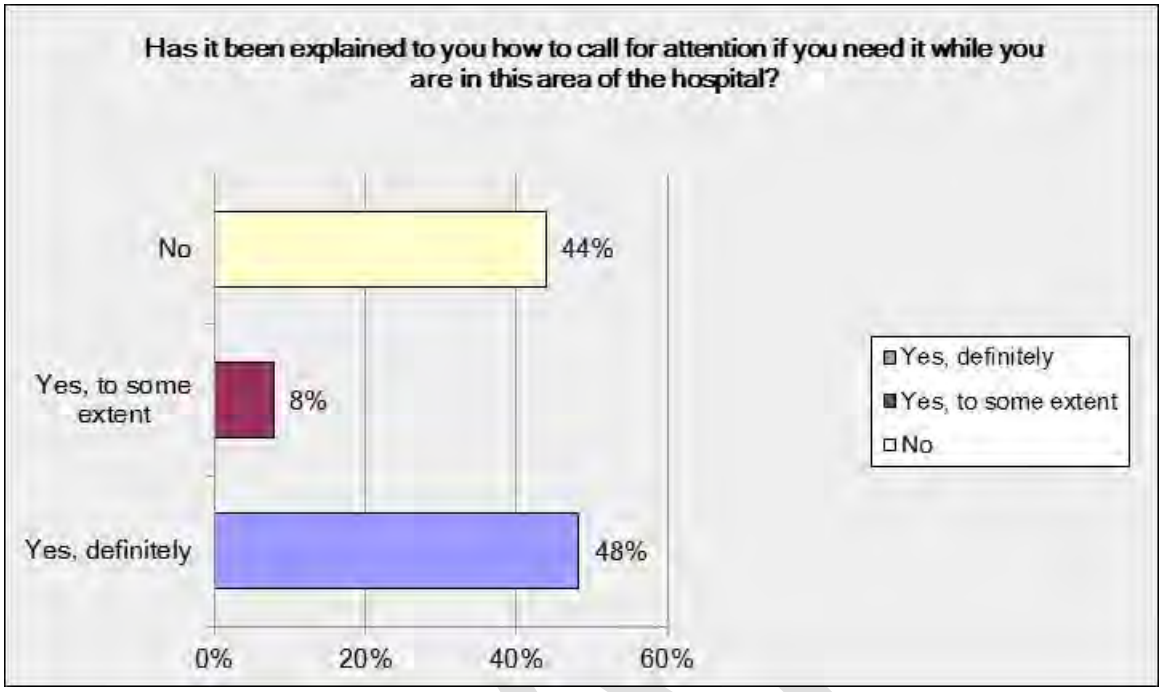
Recommendations

i. The designated corridor nurse to be identified by wearing a specific coloured badge (similar to the Nurse in Charge badge) to clearly identify them to patients
ii. All staff to introduce themselves to patients by name, in line with the #hellomynameis campaign.
iii. Photos of A&E /MAU staff making this pledge could be shared in the A&E areas, subject to Health & Safety considerations.

5.2 PATIENT CARE

We asked a series of questions about the care received by patients in the corridor area of the hospital.

5.2.a. Getting Help – Calling for Attention and Response Times

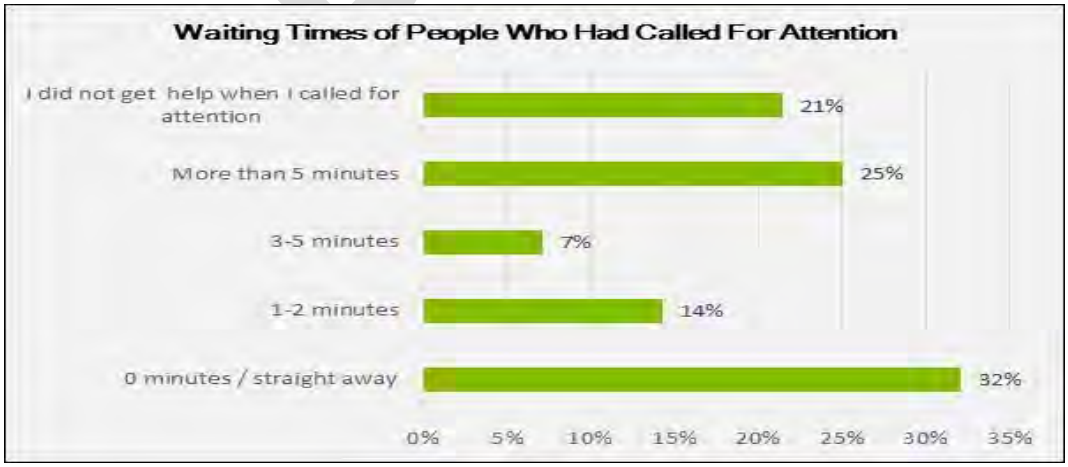


The chart shows that 48% of patients reported that it had definitely been explained to them how to call for attention if they needed it in the corridor area of the hospital, whilst 8% felt this had been explained to some extent. 44% had not had this explained to them.

We asked patients how many minutes it took after they had called for attention before they got the help they needed.

27% of patients had called for attention, whilst 74% had not.

The chart below shows the time that patients who had called for attention reported they waited to get help. 46% of patients waited more than 5 minutes to get help or had not received the help that they needed.



Patients Said ….

We received 7 comments from patients about getting help. These have all been coded as Negative Comments

Negative Comments

- Have not got a bell – 2
- Have a bell but cannot access it – 2
- Delays in answering the bells – 2
- Broken call bell – 1

"There are staff but you can never find them when you need them. I was in pain & I was crying. Staff walked past me when I was crying. It took 20 minutes for someone to come" (A&E)	*"It's a matter of getting hold of staff when I need them. I don't want to run them down, they are lovely" (A&E)*
"I've seen the buzzer, but I've not been shown how to use it" (A&E)	*"Have not got a bell, nurse said to shout for help" (MAU)*

Commentary

On 5 of our visits to WRH we observed older patients, who appeared to be confused or distressed, waiting on trolleys in the corridor areas.

We also observed one patient who was unable to communicate and a patient who was blind in the corridor (both were accompanied by a visitor).

We question whether a corridor is ever the right environment for these patients.

It is also concerning that, although the actual numbers are low, of the patients who had called for attention 21% (6) reported that they did not get the help they needed and 25% (7) waited for more than 5 minutes before they got help.

Recommendations

i. WAHT to ensure it is explained to all patients how to call for attention in corridor areas of the hospital, including the MAU where there are no call bells available

ii. WAHT to consider whether patients who appear to be confused or living with dementia, or who have specific communication difficulties or sensory impairments should be nursed in corridor areas of the hospital.

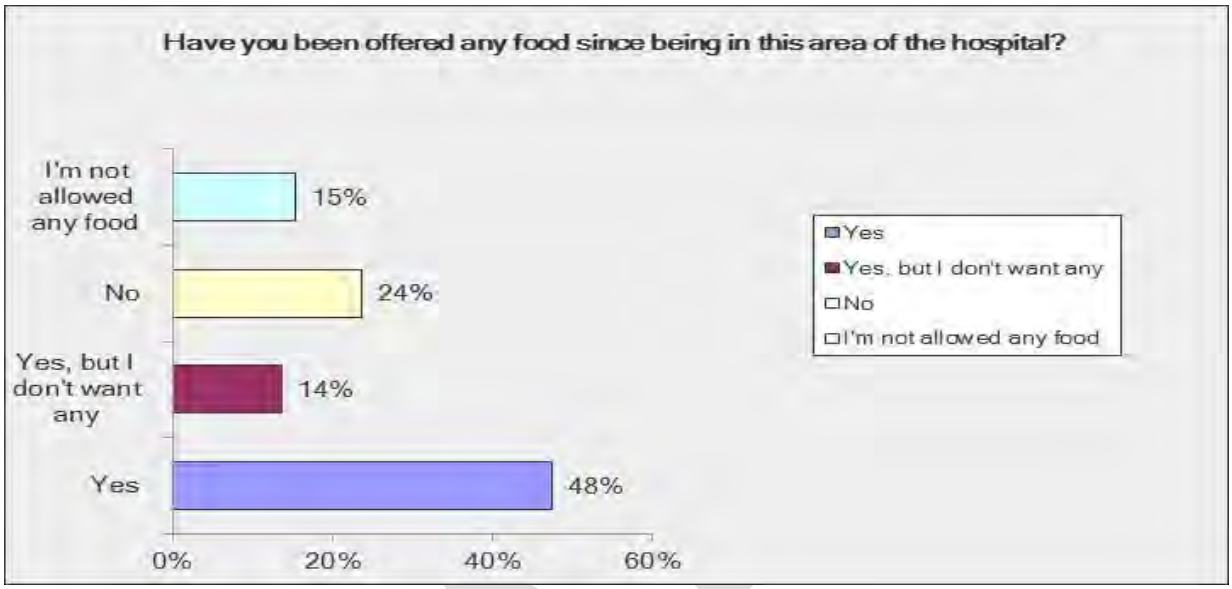
5.2.b. Food and Drink

We asked if patients had been able to get a **drink** since being in the corridor areas of the hospital. 88% of respondents had been able to get a drink, 7% had not been able to get a drink and 5% were not allowed a drink.

Of the patients who had been able to get a drink 88% had been provided with a drink by staff, 7% by a friend or relative and 5% had got a drink themselves.

Most of our respondents (75%) did not need help from staff to have their drink, 16% reported that they definitely got enough help from staff to have their drink, 3% reported that they had help from staff to some extent and 6% reported that they did not get the help that they needed from staff to have their drink.

We asked if patients had been offered any **food** since being in the corridor area.



62% of patients had been offered food, 15% were not allowed any food and 24% of patients had not been offered any food.

Of the patients who had been offered food 62% had been offered a sandwich or savoury snack; 15% had a cold meal (usually breakfast); 5% had a biscuit, cake or sweet snack; 2% a hot meal and 16% reported they had another food option (usually the patient had a sandwich and a cold meal e.g. breakfast).

We asked if patients had enough help from staff to eat their food. 86% (51) reported that they did not need any help, 7% (4) had definitely had the help they needed, 3% (2) had help form staff to eat their food to some extent whilst 3% (2) reported that they did not get the help they needed.

Patients Said ….

We received 14 comments from patients about food and drink. Of these 2 were positive and 12 were negative. Themes identified in order of frequency are:

Positive Comments

- Food was nice/meals of good quality (2)

Negative Comments

- Can't reach/No table (3)
- Waiting for staff to respond to request for a drink (3)
- Not offered food or drink (3)
- Not enough food or drink provided (1)
- Support not provided to eat or drink (1)
- Easier Access to drinks (1)

"I asked for a cup of coffee at least 4 times. No drink for 7 hours" (A&E)	*"Food was nice" (A&E)*
"Only two cups of tea within 16 hours" (A&E)	*"Meals of good quality" (A&E)*
"Unsure if supposed to drink, nurse said she would return and tell me. No one returned after 20 minutes, so I drank it as I had not had one all day" (A&E)	
"It's a bit far away, I can't reach it" (A&E)	
"Cold, burnt toast for breakfast" (A&E)	

Commentary

Whilst the numbers of patients who reported they did not get the help that they needed with food and drink are small hydration & nutrition are obviously important areas.

When cross referencing patients who had been offered food by the time patients had waited we found 1 patient who had waited 8 – 12 hours and 3 patients who had waited over 12 hours who reported they had not been offered any food since being in the corridor area.

We observed on our visits that patients had been provided with small bottles of water. We are not clear of the frequency at which these are provided to patients.

We also observed the trays on which drink and food are placed are fixed to the end of the trolleys. This means that for some patient's food and drink is placed at a distance from them.

On our preliminary visit to the A&E Department prior to the start of the E&V programme we observed that there was a drinks trolley available in the corridor, although this did appear to be causing an obstruction when beds / trolleys were passing through. We did not observe this trolley on any subsequent E&V visits.

In the Medical Assessment Unit we observed that there was sometimes a trolley in the waiting area that contained magazines, water and biscuits. We welcome the initiative to provide these for patients and visitors, however the trolley is not clearly identified as a refreshment trolley. We did not observe anyone helping themselves from the trolley. On one occasion on the top of the trolley we observed two laminated A4 notices. One said "Help yourself to food and drink". The other said "Please ask a member of staff if you can eat or drink".

In the A&E corridors we observed, following some initial feedback to the WAHT from our E&V visits, laminated A4 notices have been placed above the trolley bays

and on the wall in the corridor area. These say "Meal rounds begin at 08:00; 12:30; 18:00 and 22:00 – if you require refreshments outside of these times please ask a member of staff to assist you". On a number of occasions we pointed out these notices to patients who did not appear to have noticed them.

Recommendations

i. WAHT to provide reassurance that best practice on nutrition and hydration of patients on wards is being followed in corridor areas when patients are waiting for lengthy periods
ii. Staff to check patients are able to reach food and drink placed at the end of the trolley and whether any assistance with this is required
iii. Consideration to be given to reinstating a refreshment trolley in the A&E corridor area similar to MAU for patients and visitors
iv. Refreshment trolleys to be easily identifiable to patients and visitors with clear instructions about their use
v. WAHT to consider how signage could be improved to make this more visible to patients

5.2.c. Patient comfort

We asked patients if anything more could be done (excluding pain relief) to make them more **comfortable on the trolley**.

65% answered No, 16% would have liked more pillows and 14% more blankets. 4% did not know.

It should be noted that the majority of patients that we saw in the MAU were seated on chairs rather than on trolleys or beds.

We asked patients did they get enough help from staff to **use the toilet**. 65% of respondents reported that they did not need any help from staff to do this; 29% reported that they had definitely got the help that they needed; 1% reported that they had been helped to some extent, and 5% reported that they did not get the help they needed from staff to use the toilet.

Patients Said …

We received 46 comments about patient comfort (going to the toilet and being comfortable on the trolley). 5 were positive and 41 were negative.

<u>Positive Comments</u>

- Help received from staff to go to the toilet (3)
- Have been provided with pillows (2)

<u>Negative Comments</u>

- Discomfort – Needed more pillows/blankets (13)
- Discomfort – trolley (12)
- Couldn't access the toilet/found the toilet myself (7)
- Sides up on the trolley (5)
- A friend/relative helped me to the toilet (3)

- Length of time for staff to take to toilet (1)

"A longer trolley, my feet are jammed against the end of the trolley. If I did not have a friend I would not be able to get out because the bars were up. When had to go to the toilet a friend lowered the bars." (A&E)	*"Staff moved the trolley to right in front of the toilet door and then waited outside for me" (A&E)*
"It would be nice if the trolley was softer" (A&E)	*"Staff pushed me to the toilet in a chair" (A&E)*
"Pillows are very hard" (A&E)	*"Nurse walked with me to the toilet" (A&E)*
"The chair is uncomfortable. I could have done with a cushion" (MAU)	
"I had to wait 15 minutes for them to put the side down so I could go to the toilet" (A&E)	

Commentary

7 patients reported they did not know where the toilets were or had found them by themselves.

5 patients reported they could not get off their trolley because the rails on the trolley had been put in the raised position. We raised this issue with WAHT following which laminated notices were put up on the walls in the A&E area which state: "Trolley sides are for your safety. If you wish to have them down please ask a member of staff to assist you".

In the MAU one patient reported that it was difficult to manoeuvre a wheelchair into the toilet. Another reported that another patient had got stuck in the toilet cubicle and they had called staff for help. The patient who got stuck was told by a member of staff to ask for help next time as it causes problems.

Recommendations

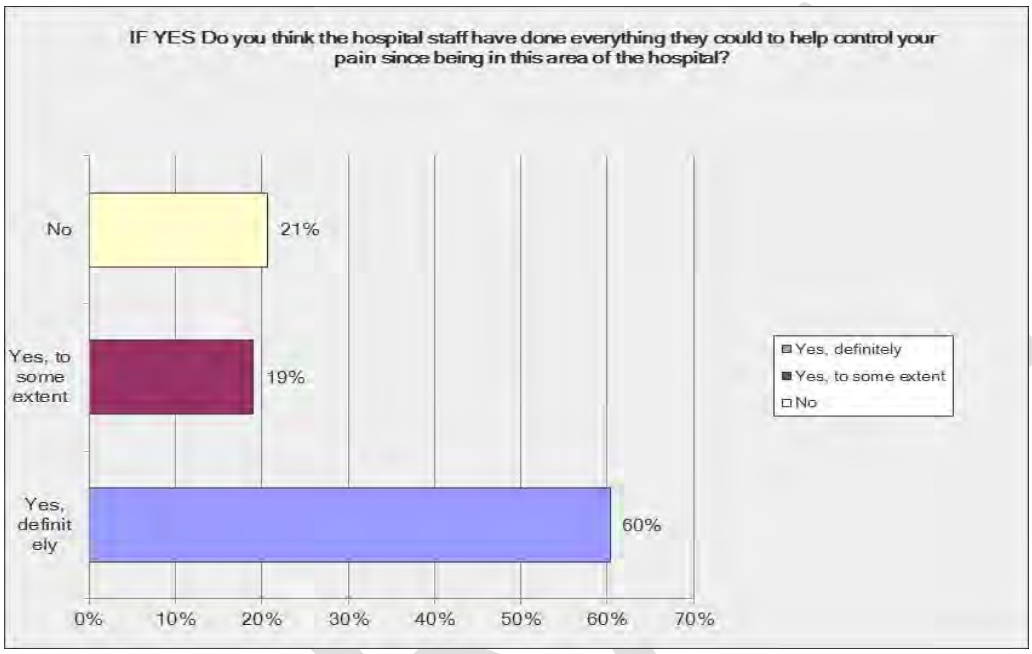
i. Patients to be routinely offered pillows and blankets when waiting on trolleys in the corridor areas
ii. Patients to be asked as part of "Care & Comfort" round if there is anything that can be done to make their wait more comfortable
iii. Patients to be told the location of the toilets and how to ask for assistance if they require it

5.2.d. Managing Pain

We asked patients if they had been in pain since being in the corridor area of the hospital. 50% of patient's reported that they had been in pain and 50% reported they had not.

We asked those patients **who had been in pain** if they thought that hospital staff had done everything they could to help control their pain since being in the corridor area.

The chart below shows that 60% answered Yes definitely to this question, 19% said Yes, some extent and 21% said No.



Patients Said ….

We received 11 comments about managing pain. 3 of these were positive and 8 were negative.

<u>Positive Comments</u>

- Received pain relief (2)
- Staff were supportive (1)

<u>Negative Comments</u>

- Time patients spent waiting for pain relief (4)
- Not being offered pain relief (3)
- Pain relief ineffective (1)

"Had to wait quite a long time for pain relief. Also have not had my prescribed meds" (A&E)	*"Been very supportive" (A&E)*
"Been waiting 1 hour for pain medication, not received" (A&E)	*"Given paracetamol" (A&E)*

Commentary

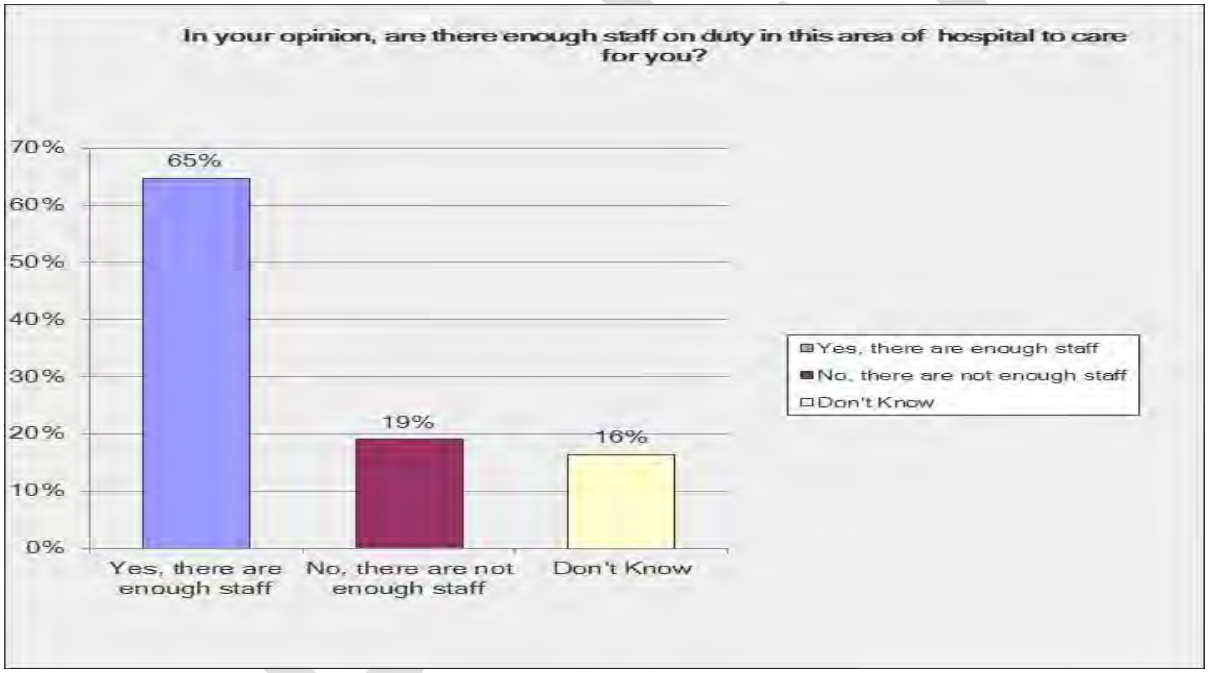
A patient reported that he/she had not been given prescribed medicines during the nearly 24 hours they had been in A&E, including 8 hours whilst being nursed on a trolley in the corridor and that no explanation for this had been provided. We have made the WAHT aware of this issue.

Recommendations

i. WAHT to provide reassurance that procedures are in place to control patients pain whilst they are being nursed in corridor areas of the hospital
ii. WAHT to provide reassurance that procedures are in place to provide patients with their prescription medication when they are subject to extended waits in the A&E Department

5.2.e. Staffing levels

We asked patients whether, in their opinion, there were enough staff on duty in the corridor area of the hospital to care for them. 65% said that yes there were enough staff, 19% said that there were not enough staff and 16% did not know



Patients Said ….

We received 21 comments in total about staffing levels. 2 were neutral, 2 of the comments were positive and 17 were negative.

<u>Positive comments</u>

- Staff walking about (1)
- Last night 1 nurse between 3 (1)

<u>Negative comments</u>

- Lots of staff but they are all busy (9)
- Not enough staff (5)

- Don't see nurses / feel out of the way (3)

"There are lots of staff constantly passing me but I have not had a lot of attention" (A&E)	*"Last night there was 1 nurse between 3 patients" (A&E)*
"Barely, staff are very busy" (A&E)	*"Staff appear to have too many people to look after, so I am alright but were they?" (A&E)*
"They are stretched" (MAU)	*"There seems to be staff but how they are allocated I don't know" (A&E)*
"They appear run off their feet" (MAU)	

Commentary

A number of patients commented that there are lots of staff coming and going along the corridors, but they are not always sure which staff are part of the A&E or MAU and can therefore be asked to help them.

Recommendations

i. WAHT to provide information about how A&E and MAU staff will be clearly identified to patients so that patients know who they can ask for assistance
ii. WAHT to consider, in light of the findings and recommendations from this Survey, whether there are sufficient staff to care for patients in the corridor areas in A&E and the MAU throughout the 24hr period

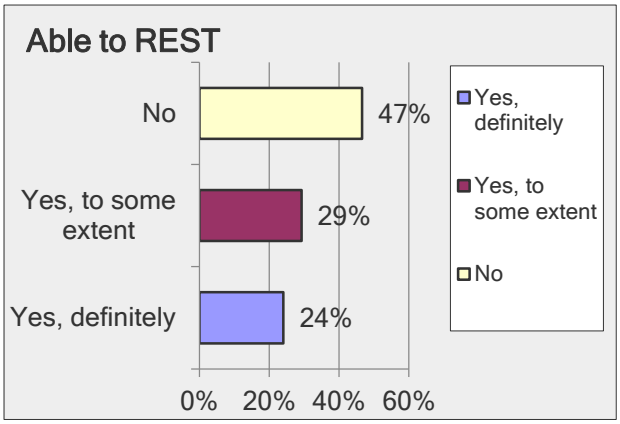
5.3 THE ENVIRONMENT

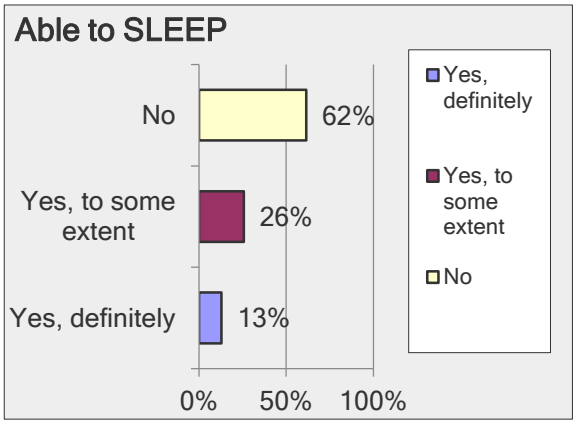
5.3.a. Noise, Rest and Sleep

We asked patients whether they had been bothered by **noise** since being in the corridor area of the hospital. 42% reported that they had been bothered by noise whilst 58% had not.

We asked patients if they were able to **rest** in corridor areas of the hospital. 47% of patients did not feel able to rest in the corridor area, 29% could rest to some extent and 24% were definitely able to rest.

We also asked if patients were able to **sleep** in corridor areas of the hospital. Fewer patients felt able to sleep than to rest. 62% reported that they would not be able to sleep, 26% said they could sleep to some extent and 13% said they could definitely sleep in the corridor area.





Patients Said ….

We received 89 comments relating to noise, rest and sleep. 9 comments were neutral; 5 were positive and 75 were negative.

Positive Comments

- Staff turned lights off (2)
- Moved to a warmer part of corridor (1)
- Better than a cubicle (1)
- Not noisy (1)

Negative Comments

- People/equipment moving (23)
- Noise (22)
- Doors opening/closing/key pads (9)
- Too bright (9)
- Buzzers/beeping/printer (6)
- Discomfort (3)
- Strange environment (2)
- Unhygienic (1)

"Noisy, trolleys moving. Bleeps going off all the time" (A&E)	*"Noise does not bother me. I know they are busy. They are all working*

	hard" (A&E)
"It's like the M5, everything and everybody coming past you" (MAU)	*"Quite noisy but I did manage to get some rest" (A&E)*
"I am right by the doors with the fob scanner above my right shoulder. The corridor is busy, including with waste bins. I would rather be here than by the toilet though" (A&E)	*" I find it better out here than in a cubicle with the curtain closed, at least there is stuff going on" (A&E)*
"Bright lights - didn't go off until early hours of the morning" (A&E)	*"They turned the lights off at one point which really helped me [sleep] (A&E)*
"It's difficult to sleep at night because of all the banging going on. Particularly difficult because staff are using the loos during the night and the doors bang" (A&E)	
"It is noisy. The floor moves when people walk up and down" (MAU)	

Commentary

On 20 of our 31 visits we observed the main corridor area in the A&E Department was especially busy, with lots of people (staff, patients and visitors) and equipment coming and going through the corridor.

On 16 occasions we described the A&E corridor areas as noisy.

We observed that the double doors to the corridor area where patients who have arrived by ambulance are sometimes assessed were often open during our visits.

The side corridor in the A&E Department was generally quieter but could be particularly busy at staff handover times when the changing rooms are in use. Patients also reported being disturbed through the night by staff using the toilets located in this corridor.

On 2 occasions we observed Trust staff leaning over patients on trolleys to use the electronic fob to open the doors into the hospital. Patients (5) also reported to us that Trust staff leaned over them to access the fob. We also observed staff from the hospital coming through these doors into the A&E corridor area. We observed a sign on the hospital side of the door instructing that the corridors should not be used as a "short cut" as patients are being nursed on the other side of the doors. We have already passed on these observations to WAHT.

Patients reported noise at night time. Two examples were a printer being used at 03:00 a.m. and staff holding non work related conversations at night in the corridor areas by patients on trolleys.

We observed that the lighting in the corridor areas is bright, with lights located above the trolley areas. Patients told us the lighting was sometimes not dimmed until the early hours of the morning.

Patients in MAU observed the floor shudders when people walk through the corridor area.

Recommendations

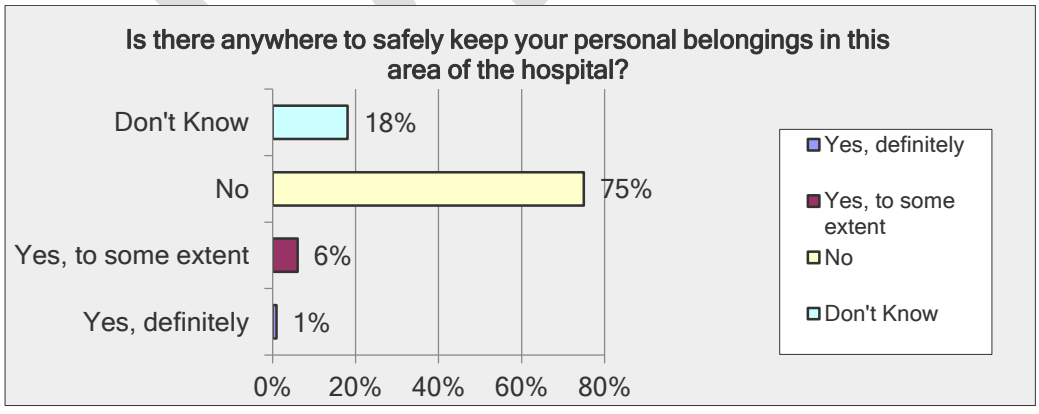
i. Consider whether doors to the A&E Assessment corridor need to remain open throughout the day, accepting that this may be the least disruptive option for patients
ii. Consider whether doors to the staff toilets can be modified to prevent them from banging
iii. Relocate the electronic fob in the side corridor to the opposite wall to ensure patients are not disturbed by staff operating the doors into the hospital
iv. Monitor staff movement from the hospital side of the doors into A&E to reinforce the message that this should not be used as a short cut
v. Dim the lights in the corridor areas earlier at night to allow patients to rest and sleep
vi. WAHT to provide information about how noise will be controlled in corridor areas, particularly at night

5.3. b. Temperature

Most patients (66%) found the temperature in the corridor area of the hospital about right. 15% reported that it was hot (7%) or too hot (8%) or, whilst 20% found it cold (17%) or too cold (3%)

5.3. c. Personal belongings

75% of patients reported that there was nowhere to safely keep their personal belongings in the corridor area of the hospital or they did not know where this was (18%).



Patients Said ….

We received 6 comments about personal belongings. All were negative.

- Fear of losing belongings (3)
- Don't know where belongings are (2)
- Nowhere safe for belongings (1)

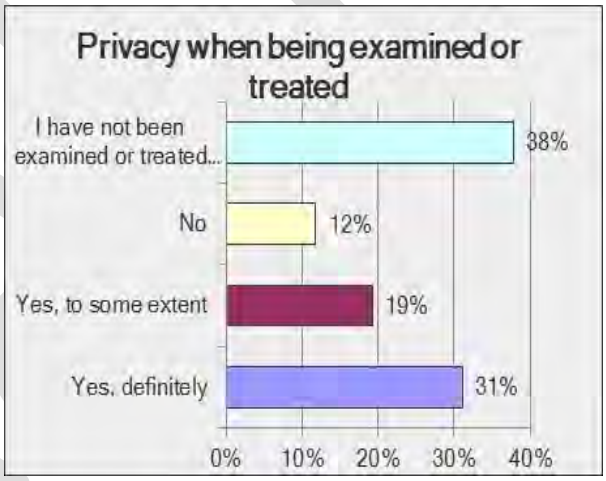
"I took my shoes off when I was admitted but no one knows where they are" (A&E)	*"I had my arm on my bag all night just in case" (A&E)*	*"I was panicking because I couldn't find my bag" (A&E)*

Recommendations

i. Provide secure storage space for patient valuables and belongings when they are being nursed for extended periods in the corridor area of the hospital.

5.4 PRIVACY AND DIGNITY

We asked patients whether they had been given enough privacy when discussing



personal information, your condition or your treatment since being in the corridor area of the hospital. The chart shows that 30% of respondents reported this was definitely the case, 19% agreed to some extent, 28% did not agree that they had been given enough privacy and 22% had not discussed these subjects since being in the corridor area.

We asked patients whether they had been given enough privacy when being **examined or treated** since being in the corridor area of the hospital. The chart shows that 31% of respondents reported this was definitely the case, 19% agreed to some extent, 12% did not agree they had been given enough privacy and 38% had not been examined or treated since being in the corridor area.

Patients Said ….

We received 30 comments relating to privacy and dignity. 2 comments were neutral; 7 were positive and 21 were negative.

<u>Positive Comments</u>

- Taken to a cubicle or private area for discussion or treatment (4)

- Screen used to provide privacy (3).

Negative Comments

- Lack of privacy during examination/consultation (5)
- No privacy/the situation is not right for privacy (5)
- Can overhear/be overheard (4)
- Feel watched/people walking past (4)
- No screens (1)
- Curtains needed for privacy (1)
- Could be treated with more dignity (1)

"None whatsoever [privacy] when discussing personal information and completely opposite to privacy when being examined" (A&E)	*"They put a screen around me" (A&E)*
"The location doesn't make being treated with dignity and respect easy - especially if you are worried about being overheard" (A&E)	*"Wheeled screen, staff tried, to the best of their ability" (A&E)*
"I feel a bit watched. There is no privacy. I can overhear everything the doctors are saying" (A&E)	*"I was pushed into a cubicle when they needed to look at my leg" (A&E)*
"I overheard all the details of a consultation with a lady who was on the trolley next to me, also had to avoid looking through the screen that was around her" (A&E)	*"When in the corridor the doctor examined me but he was quickly put right by a nurse who suggested he should move me into a cubicle which he did" (A&E)*
"I was examined in hallway where everyone can see including personal areas, I am not happy about that" (A&E)	
"A lady was examined by the doctor in the corridor and I could see her stomach and breasts, she laughed but I felt it was not right" (A&E)	

Commentary

Despite moving away from patients to complete our observations we overheard patient's personal information, treatment and condition being discussed on 21 of our visits to the A&E corridor areas.

We twice overheard test results and diagnosis being given to patients by doctors in the corridor. Other patients in the corridor at the time would also have heard this

information. On one other occasion we observed a screen was being used and efforts were being made to speak softly and maintain patient privacy.

On three occasions we observed a mobile screen in use in the corridor when a patient was being examined. The screen was insufficient to completely shield the patient. Other patients and people walking past could see the patient being examined.

We also observed patient's blood being taken; a cannula fitted and bandages being removed. More routine checks such as blood pressure were also undertaken in the corridor area.

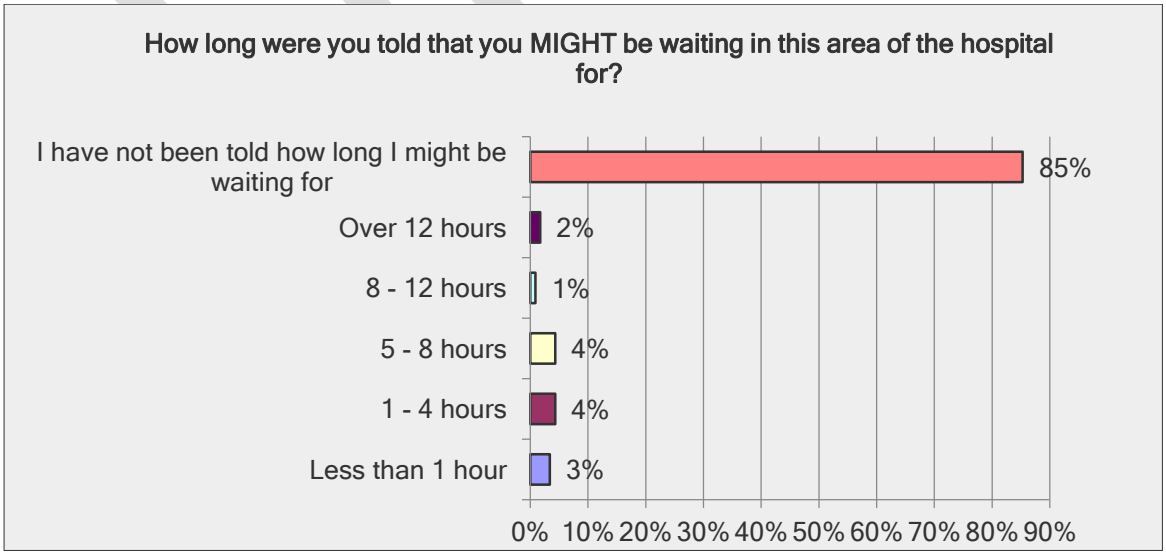
Recommendations

i. Consistently use private areas when providing patients with diagnosis or test results
ii. Consistently use the reserved curtained cubicles within the A&E Department when examining or treating patients
iii. When it is unavoidable to discuss patient's personal information in the corridor areas ensure patients are screened and voices are kept as low as practicable
iv. When it is unavoidable to examine or treat patients in the corridor areas ensure patients are screened sufficiently to protect their privacy and dignity

5.5 WAITING TIMES

5.5.a. Informing patients about how long they MIGHT be waiting

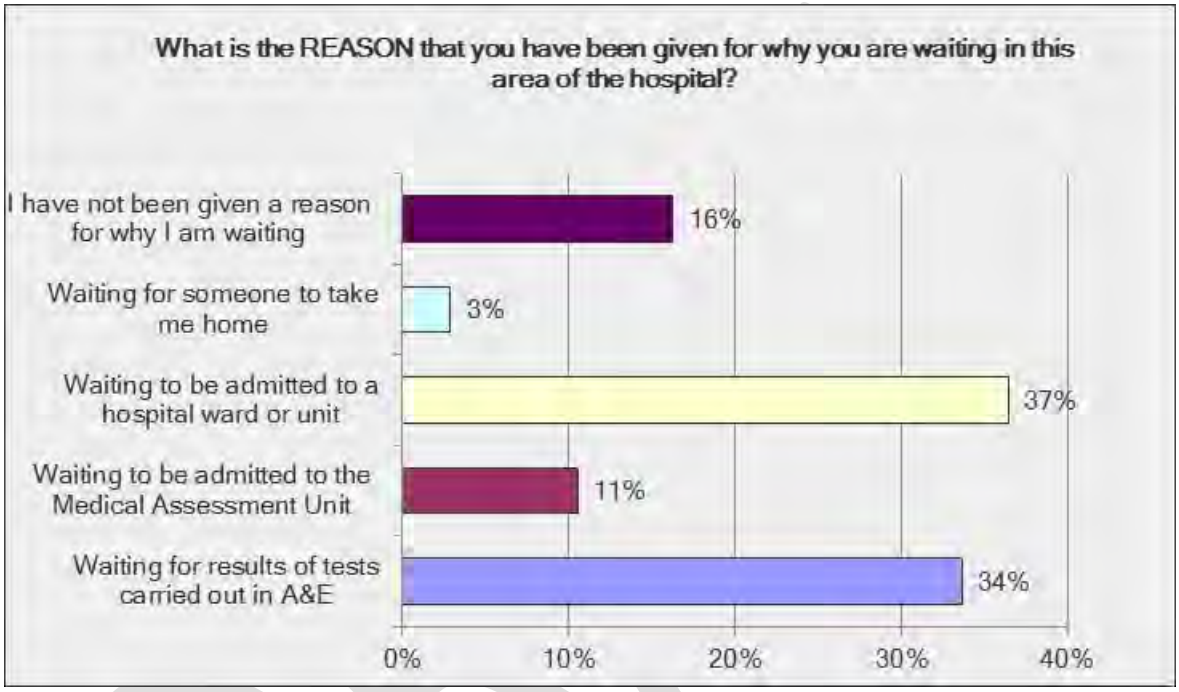
We asked patients if they had been told **how long they MIGHT be waiting** in the corridor area. 85% of respondents had not been told how long they might be waiting, the chart below gives the distribution of remaining answers. Patients who had been told they would be waiting more than 12 hours had usually been informed they would be in hospital overnight.



5.5.b Informing patients about the reason they are waiting

We asked patients what was the **reason** they had been given for why they were waiting in the corridor area of the hospital.

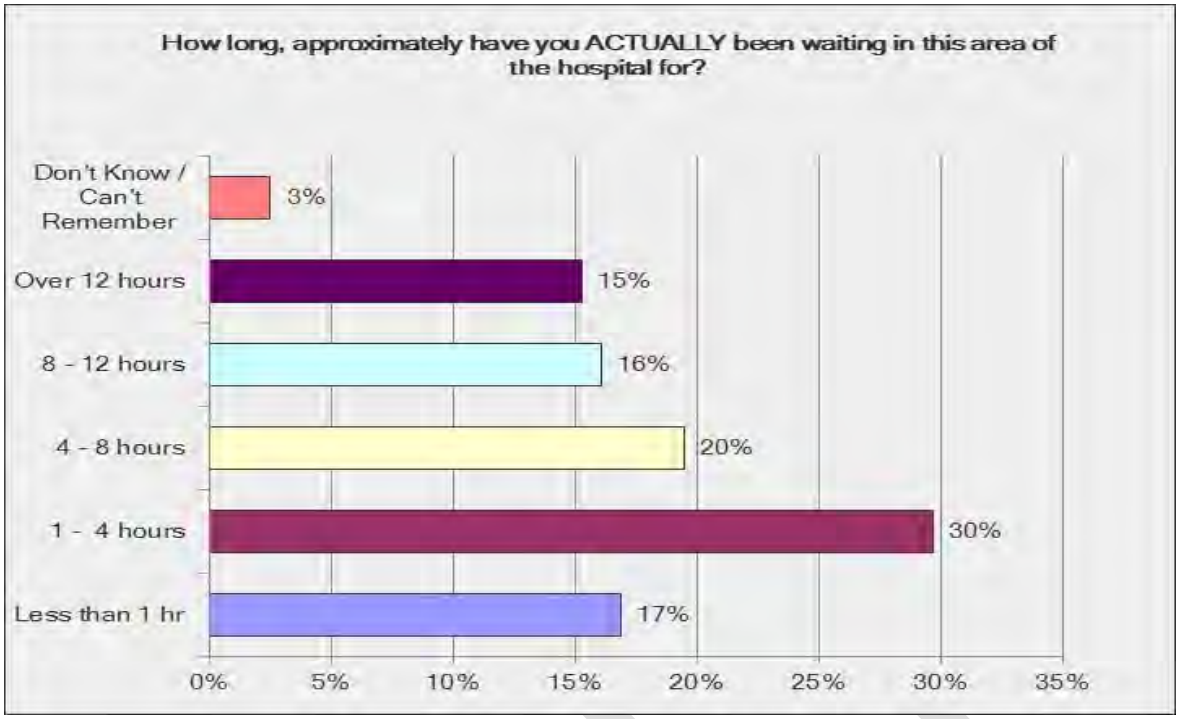
The chart shows that 37% of patients were waiting to be admitted to a hospital ward or unit, and a further 11% were waiting to be admitted to the Medical Assessment Unit. 34% of patients were waiting for results of tests carried out in A&E. It should be noted that patients who told us they were waiting to go for scans or tests, or who were waiting to speak with doctors or consultants so a decision could be made about next steps have been included in this category. 3% of patients were waiting for someone to take them home. 16% of patients had not been given a reason for why they were waiting in the corridor area of the hospital.



5.5.c. How long patients had ACTUALLY been waiting

We asked patients how long approximately have you ACTUALLY been waiting in the corridor area of the hospital. We were clear with patients that we were not asking about when they had first arrived in the Emergency Department, we were asking about time spent waiting in the corridor.

17% (20) of respondents reported they had been waiting for less than an hour, 30% (35) had been waiting between one – four hours; 19% (23) had been waiting 4 – 8 hours, 16% (19) had been waiting eight – twelve hours, 15% (18) had been waiting over 12 hours and 3% (3) didn't know or could not remember.



The table below shows waiting time by age.

Age	Waiting time				
	Under 1 hour	1-4 hours	4 - 8 hours	8 - 12 hours	Over 12 hours
Under 18	0%	0%	0%	5%	0%
19 - 24	0%	12%	9%	16%	0%
25 - 50	30%	15%	36%	26%	22%
51 - 64	20%	21%	18%	21%	11%
65 - 74	20%	15%	14%	11%	28%
75 +	30%	36%	23%	21%	39%

The table shows that the highest percentage of patients waiting over 12 hours are aged 65+, this could be due to patients who are older having multiple medical conditions.

Patients Said ….

We received 7 comments relating to waiting times all of these were negative and referred to length of wait.

"At first I was told I was waiting for a bed. I was offered a trolley about 8pm. I thought there will be a bed soon so I refused. I finally got a bed at midnight. I am in bed but I am still in the corridor" (MAU)	*"Staff have been brilliant, but could keep you better informed about how long you have to wait" (A&E)*
"I wish treatment would happen quicker" (A&E)	*"Had to wait 7 hours to see a doctor" (A&E)*

Commentary

There are a number of national targets relating to A&E. These include:

- Attendances – patients being seen in under 4 hours from arrival at A&E to admission, transfer or discharge
- Number of patients spending over 4 hours from decision to admit to admission,
- Number of patients spending over 12 hours from decision to admit to admission.

The latter 2 targets are referred to as "trolley waits". A trolley wait of over 12 hours is classed as a "serious incident" which should never happen.

During the period of our visits:

Awaiting contextual information from CCG's

We were specifically asking patients how long they had been waiting in the corridor, we did not ask patients about the total time they had spent in the A&E Department. 35% of our sample reported they had been waiting in the corridor over 4 hours and 15% over 12 hours at WRH. During this project we made 13 visits to the Alexandra Hospital but we did not see any patients in corridor areas at the hospital. There may be learning or practice from the Alexandra Hospital or elsewhere that could help the situation at the WRH.

On one occasion we heard staff apologise to a patient for the long wait and provide reassurance that they had not been forgotten and would be seeing a doctor.

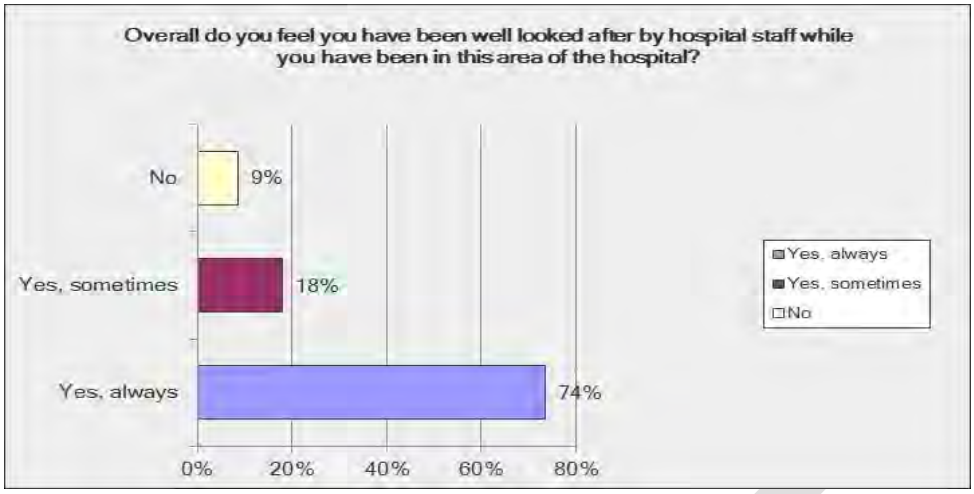
Recommendations / Points to Consider

i. Provide patients with an indication of how long they might be waiting in the corridor area and provide reassurance to patients whilst they are waiting
ii. Provide patients with a clear reason why they are waiting in the corridor area
iii. WAHT to provide information and reassurance to the public about the specific actions that are planned to ensure that WAHT is able to meet national standards for trolley waits, and the timetable for implementation

5.6 PATIENTS OVERALL EXPERIENCE

5.6.1. Have patients been well looked after by hospital staff

We asked patients "Overall do you feel you have been well looked after by hospital staff while you have been in this area of the hospital?" 74% replied they had always been well looked after, 18% had sometimes been well looked after and 9% answered no to this question.



There is a variation in responses to this question according to the age of the respondent, with 80% of those over 50 reporting they had always been well looked after compared to 58% of those under 50. More under 50's (18%) answered no to this question than over 50's (4%).

By Age - Well looked after by hospital staff

	Under 50	Over 50	All
Yes, Always	58%	80%	74%
Yes, Sometimes	24%	16%	18%
No	18%	4%	9%

This may be because, in HWW experience, people in the 50+ age group are more reluctant to complain about their care than younger respondents.

Patients Said ….

We received 23 comments about staff (as opposed to staffing levels which were reported at 4.2.e.). 18 comments were positive and 5 were negative.

Positive Comments

- Staff are kind/helpful/excellent (14)
- Staff have looked after me/care was good (4)

Negative Comments

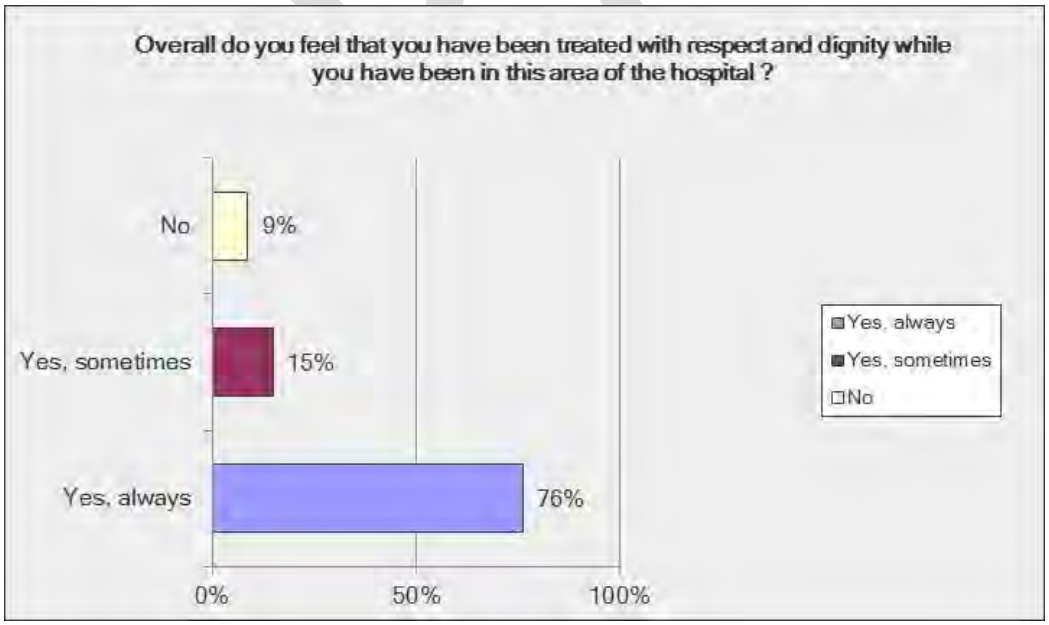
- Attitude and care provided by doctors (2)
- Lack of respect and compassion (3)

"Can't fault the staff, lucky to have	*"As hospital staff pushed past me, no*

the service and treatment" (A&E)	*one said "Excuse me". No one asked me how I was feeling for about 8 hours" (A&E)*
"I couldn't wish for anything better. If you are on a trolley there are other people worse than you. I have had very bad experiences at this hospital before but not here today" (A&E)	*"Some orderlies walked past when I was crying, I asked for help and they said you'd have to see a nurse. It took a member of the public visiting another patient to get me a nurse … there has got to be a bit of compassion" (A&E)*
"I am very satisfied, they cannot do enough for you. I have had two doctors, they have explained things to me and the nurse has been popping back" (A&E)	*"I repeatedly asked for someone to contact my wife. I left home seven and a half hours ago. Eventually a visitor to another patient let me use her mobile phone" (A&E)*
"Everyone has been extremely kind and thoughtful"	

5.6.2. Have patients been treated with respect and dignity

We asked patients "Overall do you feel you have been treated with respect and dignity while you have been in this area of the hospital?" 76% responded they had always been treated with respect and dignity, 15% they had sometimes been treated with respect and dignity and 9% answered no to this question.



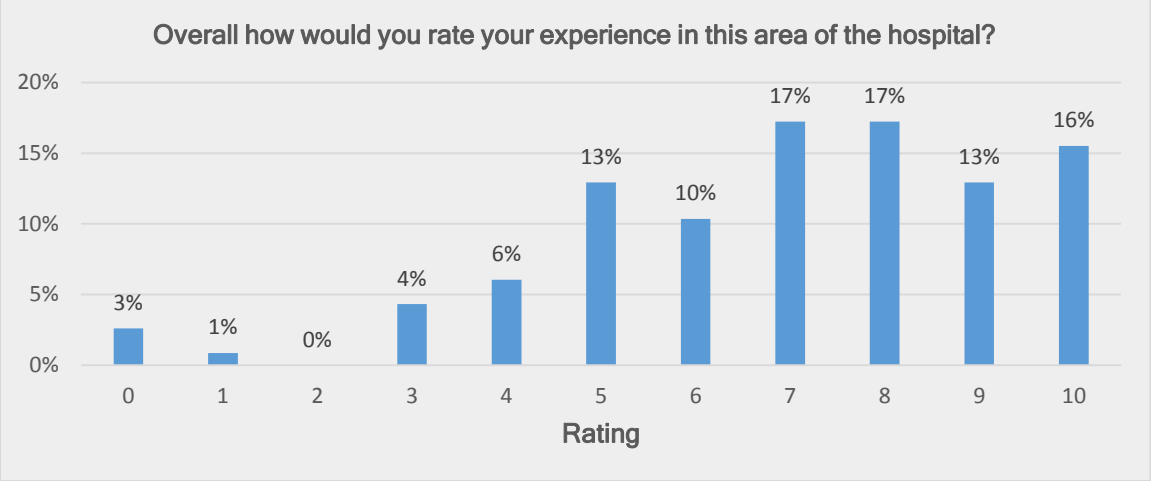
There is a variation in responses to this question according to the age of the respondent with 81% of those over 50 reporting they had always been treated with respect and dignity compared to 65% of those under 50. More under 50's (14%) answered no to this question than over 50's (7%).

By Age - Treated with respect and dignity

	Under 50	Over 50	All
Yes, Always	65%	81%	76%
Yes, Sometimes	22%	12%	15%
No	14%	7%	9%

5.6.2. Overall Rating

We asked patients to rate their overall experience in the corridor area of the hospital, where 0 = I had a very poor experience and 10 = I had a very good experience.



The chart shows that:

8% of patients rated their experience between 0-3

46% of patients rated their experience between 4-7

46% of patients rated their experience between 8-10

The table below shows **rating by Age**

Age	**Rating**		
No of respondents	**0 - 3**	**4 - 7**	**8 - 10**
Under 18 (No. 1)	0%	0%	100%
19 - 24 (No. 9)	11%	66%	22%
25 - 50 (No. 28)	22%	57%	22%
51 - 64 (No. 21)	5%	58%	38%
65 - 74 (No. 20)	0%	45%	55%
75+ (No. 34)	3%	30%	67%
All	**8%**	**46%**	**46%**

Of the patients who gave a rating of between 8 - 10 of their experience those aged under 18 and those aged 65+ gave the highest ratings.

The table below shows **rating by waiting times**

	Rating		
Waiting Times	**0 - 3**	**4 - 7**	**8 - 10**
Under 1hr	5%	65%	30%
1 - 4 hrs	3%	30%	67%
4 - 8 hrs	13%	66%	22%
8 - 12 hrs	15%	45%	39%
12+ hrs	6%	34%	61%
All	**8%**	**46%**	**46%**

Although there is no clear pattern between ratings and waiting times the findings suggest that patients waiting between 4 – 8 hrs rate their experiences lower (0 -7) than other patients (79%). The comparatively high number of patients who are waiting over 12 hrs and have rated their experience between 8 – 10 may be related to the age group of these patients.

Patient Said ….

We asked patients whether there was anything else they would like to tell us about their experiences in the corridor areas of the hospital. We received 33 comments. 3 were positive, 12 were neutral and 24 were negative

Positive Comment

- Being in corridor has been managed well / not a problem (3)

Neutral Comments

- Statements of appreciation for care provided, but unhappy about the situation of being in the corridor (10)
- Practical issues of being in corridor (no clock or phone charger available) (2)

Negative Comments

- Feeling left / forgotten / isolated (9)
- Situation of being nursed in the corridor poor / not acceptable (9)
- Poor environment for patients (4)
- Staff did not contact relatives (2)

"Annoying that I am here but people	*"If no beds then I cannot be moved*

have looked after me. I cannot give them a gold star for putting me in a corridor. I think it is a sorry state of affairs to be in a bed in a corridor all night …. this is my first experience of being out in the cold" (MAU)	*from the corridor and I have accepted it. It's not the staffs fault" (A&E)*
"I understand the pressure for beds but it's not ideal for elderly people, or for anybody. You would only find this in third world countries" (A&E)	*" I think they have worked well in how they have managed this, being in the corridor" (A&E)*
"No one really comes to me out here in the corridor" (A&E)	*" I have been quite happy here, it's not been a problem at all" (A&E)*
"Not nice being on a walkway. People going up and down. No privacy. Feel a bit forgotten round the corner (A&E)	*"The staff have been brilliant, but the corridor situation is not good!" (A&E)*
"From a staff point of view I would put 10, from a corridor point of view I would put 5" (A&E)	*"Care very good but the situation is not ideal" (MAU)*
"Care was fantastic until I was moved into the corridor. I was very upset for an hour and nobody came. I had to phone Mum. I had no pain relief and was crying. Around the corner I can hear others laughing and chatting while I am crying" (A&E)	*"I have heard a lot of things about trolleys being used in corridors. This is my first experience. I sympathise, if you can't fit everyone in what can you do? I can see the dilemma" (A&E)*
"I don't think anyone can be treated with respect in a corridor" (A&E)	*" It's not the staff, it's the environment" (A&E)*
"Don't know why I'm in the corridor. I just hate it. I feel like I am living here" (A&E)	*"Just need more beds …. situation, not the care that is the issue" (MAU)*

Commentary

In HWW experience patients, particularly older patients, are grateful for the NHS and the care they are receiving.

It is interesting to note that of the patients who gave an overall rating of 8, 9 or 10 in answer to survey questions these patients reported that 29% did not know the name of the person who was looking after them; 43% had not had it explained to them how to call for help; 6% had reported they did not think there were enough staff on duty to care for them and 15% were not sure about this. These patients also made 28 comments which have been themed as negative in response to questions on the survey. This suggests that patients are reluctant to give lower overall ratings and are taking other factors into consideration.

As can be seen from some of the "Patients Said" comments above patients appear to be making a distinction between the staff in the A&E Department and the situation they find themselves in of being nursed in the corridor area.

Patients appear to empathise with the pressure on staff in the Department whilst being unhappy about some aspects of the experience of being nursed on the corridor.

We also observed that patients seemed more reluctant to provide negative feedback than visitors. For example we received a follow up telephone call from a patient's relative saying the patient "didn't want to get anyone in trouble" and was reluctant to say anything bad about her care. The patient had been in A&E for a total of 28hrs (not all spent on the corridor).

6. FURTHER POINTS FROM OUR OBSERVATIONS NOT COVERED IN THE SURVEY

During our visits patients reported or we were told about the following issues that are not reported elsewhere in the Survey.

6.1 Relatives and Visitors

On 26 of our visits at least one patient in A&E had a relative or visitor with them. On 16 occasions there was nowhere for at least one relative or visitor to sit down. We observed 6 visitors sitting on the end of patient trolleys as there was nowhere else to sit down.

On at least three occasions we spoke with relatives or visitors who had remained with a patient overnight. One mentioned being unsure of the "rules" about visitors e.g. was it acceptable to stay overnight with a patient. We also noted that some of the relatives / carers we saw appeared themselves to be older people, but were reluctant to leave the patient unaccompanied overnight. We are concerned about the lack of facilities for people staying overnight.

There did not appear to be a clear policy about whether relatives / visitors, particularly of patients who have lengthy stays in A&E, were offered drinks, chairs or blankets.

"As a visitor I have been standing most of the day. It would have been nice if someone had offered me a chair" (A&E)	*"Porter offered Mum a chair" (A&E)*
"I am not sure what the rules are about being here or not. I don't want to go to the café in case I am not allowed back in or xx was moved" (A&E)	*"The nurse gave me a couple of blankets" (A&E)*

Recommendations

i. Provide basic facilities for relatives and visitors, including a seat and access to drinks
ii. Visitors who are staying overnight should be informed of where hospital facilities can be found and offered blankets

6.2. Record Keeping

On 3 occasions patients reported inaccuracies in their records. These related to:

- Patient challenging the accuracy of the record in relation to pain relief and hydration – this issue has already been raised with WAHT
- Patient reported being recorded as the wrong gender on their record – the patient pointed this out and the record was changed
- Patient reported their records showed they had allergies which they did not have

One patient reported being asked for the same information on a number of occasions

Recommendations

i. WAHT to provide reassurance that processes are in place to ensure records are accurate

6.3 Health and Safety

On 2 occasions we noted there was equipment in the A&E corridor area next to the sign: "No trolleys or equipment at this location. Caution fire evacuation route. No trollies or equipment".

On 2 occasions we observed trolleys outside the MAU corridor that were partially blocking the evacuation route.

Recommendations

i. Ensure that health and safety requirements in respect of the corridors are always complied with

7 CONCLUSION

It is widely recognised, and accepted by the Trust, that caring for patients in corridors does not provide the privacy and dignity that patients deserve.

Our Survey has identified that, whilst staff are doing their best to manage the situation of patients routinely being cared for in corridor areas, there are areas where patients experience indicates that care could be improved.

We have therefore made 38 recommendations which could and should improve the situation of patients who find themselves being cared for in corridor areas.

However this situation is not acceptable and rapid action needs to be taken to ensure that patients no longer find themselves being cared for in corridors.

To be completed following feedback on draft. To include work of A&E delivery board

APPENDICES

APPENDIX ONE – The Visit Programme

The table below summarises the number of visits that we undertook each week, the total number of patients that we observed in the corridor areas and the number of patients that we spoke with. Please note that the numbers of patients in the corridor could be fluid over the course of a visit as patients were taken for tests, allocated a bed or discharged. The total number of patients below is the maximum number that we observed during our visits.

Visit Summary

	WRH			ALEX		
Week	**Visits by HWW**	**Total Patients observed in corridors (A&E / MAU)**	**No of patients HWW spoke with**	**Visits by HWW**	**Total Patients observed in corridor**	**No of patients HWW spoke with**
1	4	25	15	1	0	0
2	5	38	26	2	0	0
3	6	44	23	2	0	0
4	6	34	17	2	0	0
5	5	35	24	3	0	0
6	5	24	14	3	0	0
TOTAL	**31**	**200**	**119**	**13**	**0**	**0**

The table below shows the **distribution of the visits over days of the week** across the two hospital sites.

Visits

Day	Visit	WRH	ALEX
Monday	AM	2	1
	PM	1	1
	EVE	2	1
Tuesday	AM	1	1
	PM	3	1
	EVE	2	0
Wednesday	AM	2	0
	PM	1	1
	EVE	2	0
Thursday	AM	2	0
	PM	0	2
	EVE	1	1
Friday	AM	1	1
	PM	1	0
	EVE	2	2
Saturday	AM	1	1
	PM	1	0
	EVE	1	0
Sunday	AM	2	0
	PM	1	0
	EVE	2	0
TOTAL		**31**	**13**

APPENDIX TWO - SURVEY QUESTIONS AND NUMBER OF RESPONDENTS (n =) TO EACH QUESTION

1. Have you been given any information about being in this area of the hospital? (n = 115)
2. Do you know the name of the nurse looking after you in this area of the hospital? (n = 117)
3. Has it been explained to you how to call for attention if you need it in this area of the hospital? (n = 116)
4. How many minutes did it take after you called for attention before you got the help you needed? (n = 106)
5. Have you been able to get a drink since being in this area of the hospital? (n = 118)
6. If YES how did you get a drink? (n = 104)
7. Did you get enough help from staff to have your drink? (n = 96)
8. Have you been offered any food since being in this area of the hospital? (n = 118)
9. IF YES what food have you been offered (n = 61)
10. Did you get enough help from staff to eat your food? (n = 59)
11. Did you get enough help from staff to use the toilet? (n = 104)
12. Have you been in pain since being in this area of the hospital? (n = 119)
13. If YES do you think the hospital staff have done everything they could to help control your pain since being in this area of the hospital? (n = 58)
14. Is there anything that could be done (excluding giving you pain relief) to make you more comfortable on this trolley? (n = 98)
15. In your opinion, are there enough staff on duty in this area of the hospital to care for you? (n = 116)
16. Do you feel that you are able to rest in this area of the hospital? (n = 116)
17. Do you feel that you are able to sleep in this area of the hospital? (n = 117)
18. Have you been bothered by noise since being in this area of the hospital? (n = 119)
19. How comfortable do you find the temperature in this area of the hospital? (n = 119)
20. Is there anywhere to safely keep your personal belongings in this area? (n = 116)
21. Were you given enough privacy when discussing your personal information, your condition or your treatment since being in this area of the hospital? (n = 116)
22. Were you given enough privacy when being examined or treated since being in this area of the hospital? (n = 119)
23. How long were you told you MIGHT be waiting in this area of the hospital for? (n = 116)
24. What is the REASON you have been given for why you are waiting in this area of the hospital? (n = 104)
25. How long, approximately have you ACTUALLY been waiting in this area of the hospital for? (n = 118)
26. Overall do you feel that you have been well looked after by hospital staff while you have been in this area of the hospital? (n = 117)

27. Overall do you feel that you have been treated with respect and dignity while you have been in this area of the hospital? (n = 114)
28. Overall how would you rate your experience in this area of the hospital? (n = 116)
29. Is there anything else you would like to tell us about your experience in this area of the hospital? (n = 33)

Herefordshire & Worcestershire
Sustainability and Transformation Plan

5th July 2017 - Publication

www.yourconversationhw.nhs.uk

Your Health & Wellbeing
#YourConversation

Worcestershire Acute Hospitals NHS Trust

Herefordshire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Wyre Forest Clinical Commissioning Group

Wye Valley NHS Trust

Worcestershire Health and Care NHS

2gether NHS Foundation Trust

Taurus Healthcare

worcestershire county council

Herefordshire Council

Herefordshire and Worcestershire

Sustainability and Transformation Plan

5th July 2017

Name of footprint	Herefordshire and Worcestershire
Region	Midlands and East
Nominated Lead	Sarah Dugan, Chief Executive Worcestershire Health and Care NHS Trust
Contact Email	whcnhs.yourconversationhw@nhs.net

Partners involved	
GP Practices	90
CCGs	4
Acute Trusts	1
Combined Acute and Community Trusts	1
Combined Community and Mental Health Trusts	1
Mental Health Trusts	1
HealthWatch bodies	2
District and Borough Councils	6
Councils with Health & Well Being Boards	2

Key Statistics	
Population	780,000
Area	1,500sq m
Annual NHS Allocation – 2016/17	£1.168bn
Annual NHS Allocation – 2020/21	£1.327bn
STF allocation in 2020/21	£50m
NHS "Do Nothing" financial gap to 2020/21	£288.1m
NHS Residual Gap after applying national planning assumptions	£61.3m

Redditch and Bromsgrove CCG
South Worcestershire CCG
Wyre Forest CCG
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council

Herefordshire CCG
Wye Valley NHS Trust
2gether NHS Foundation Trust
Taurus GP Federation (representing 24 practices)
Herefordshire Council

#yourconversationHW

Contents and foreword

Foreword by Mark Yates, Independent STP Chair

Herefordshire and Worcestershire have some unusual challenges compared to many of the other STP areas. We are one of the largest STP areas in terms of geography – covering 1,500 sq miles, but one of the smallest in terms of population – covering about 780,000 people. By way of example the distance between Hereford County Hospital and Worcestershire Royal Hospital is more than 30 miles and typically takes more than an hour to drive on single carriageway roads.

Our counties are also unusual in that they provide hospital services for 40,000 people from the Welsh health system who are external to the area. Powys has no district general hospitals and the people of mid-Powys rely on the County Hospital in Hereford and with Powys being even more sparsely populated than Herefordshire, for some residents, the nearest acute hospital after Hereford is some considerable distance away in Aberystwyth. Service provision in this area is characterised by long travel times for patients and staff and we have the challenge of achieving a balance of what can be provided locally in Wales and centrally in England.

Partners across the two counties recognise that the solution to the sustainability and efficiency challenges facing health and social care cannot be dealt with by partners nor organisations working alone. Individuals, families, local communities, Voluntary and Community Sector Partners all have a core role to play in developing solutions. We need to place equal if not greater focus on helping communities and individuals to live healthily, be resilient and avoid the need to access organised services for things that many people are able to deal with themselves. Carers play a vital role in this vision and are a hugely important asset to the NHS and social care system. We need to do more to help identify, support and recognise their vital roles. We will do this by working towards achieving system wide agreement to implement the "Commitment to Carers – Carers Toolkit". Helping carers to provide better care and to stay well themselves will contribute to better lives for those needing care and more effective use of NHS and social care resources.

These are just a few of the many challenges faced by the two counties, but all partners continue to be equally committed to providing the best and most cost effective services to our communities and patients. We've been working very closely together throughout 2016 and this commitment to the STP process will see our collective journey forge well into the future. However, partners also recognise the magnitude of the difficulty of providing health and social care services to a very diverse and widespread population within a very tight cost envelope. We recognise that this submission is not an end point – it is merely a stage in our collective journey towards a better health and social care system for the population of Herefordshire and Worcestershire and we are committed to engaging with our communities to ensure this is the case going forward.

What has changed since we published our draft plan in November 2016?

On 22nd November the Herefordshire and Worcestershire Sustainability and Transformation Plan was published for the first time. The document was an "umbrella" plan bringing together all the current changes happening across the two health and social care systems. It started by outlining the gap that health and social care services in the two counties face, using the triple aim mantra of (i) Health and well being, (ii) Care and quality and (iii) Finance and efficiency.

The document incorporated 12 proposed programmes of work across four priority change areas, supported by three key enabling processes. These programmes and processes each contained a series of first ideas and outline proposals for how local partners and stakeholders felt we could begin to tackle the challenges we face.

At the time of publication we were acutely aware of the public's nervousness around the plan and how it would affect local communities and services that they rely on. We also recognised that due to the process and timelines we were working to, the opportunities for public engagement before publication in November were fairly limited.

For these reasons we specifically chose to enter a period of public engagement and discussion on the contents of the plan post publication of the draft in November. This was **not a consultation** because we were not seeking views on specific worked up service changes.

Consultations will be undertaken for specific service changes that are made under the guise of the STP in the coming months and years where appropriate.

The "***Your Conversation***" engagement began in November 2016 and ran through to the end of February 2017. Unfortunately due to the restrictions of pre-election Purdah, firstly for Worcestershire's Local Authority Elections in May and subsequently for the General Election in June, we have been unable to publish our refreshed plan until July 2017.

We are pleased to be able to do so now and we welcome further feedback from the public and local stakeholders to help us inform and develop our delivery plans. Please provide further comments to whcnhs.yourconersationhw.nhs.net

Further information and supporting information is available at our website:

www.yourconversationhw.nhs.uk

The public engagement identified broad support for the direction of travel that we outlined in the draft plan. However, there were a number of areas that were highlighted as requiring further consideration as we develop further detail.

The vision and key priorities remain the same, however we have updated some parts of this document. The more significant changes made during the refresh process include:

- **Public engagement - pages 5 to 9** - A whole new section to preface the original plan which outlines the key themes arising from the engagement and how we intend to address these as we develop more detailed proposals.
- **Financial context – page 22** – As people would expect, the financial landscape has changed over the last 6 months. The finance section has been refreshed to reflect this.
- **Programme Management and Governance arrangements – pages 26** – We have refined our processes to oversee delivery of the STP and ensure that we use existing forums to take ownership for delivery of the plan.
- **Prevention , self care and promoting independence– pages 41 to 45** – We have updated the section to reflect emerging changes in the two counties health and well being strategies.
- **Urgent Care – Pages 61 to 71** – following a challenging winter and the emergence of A&E Delivery Boards to oversee improvements in urgent care, we have refreshed this section to reflect the revised priorities and delivery arrangements. We have also refreshed the bed numbers for Worcestershire to reflect agreed changes that were implemented during 2016/17.
- **Mental health – pages 55 to 60** – Whilst the shared ambition to invest in mental health services and parity of esteem has not changed, partners have recognised that that financial conditions have meant we are not going to be able to achieve as much as we originally intended in the early years of the plan. The refreshed version reflects this and the revised timelines.

Other than these areas and points of factual accuracy this document is broadly unchanged from the version published in November 2016.

Communications and Engagement

Our STP priorities are not new; they have been central to our engagement for a number of years and include extensive engagement around our strategies for Urgent Care, the reconfiguration of acute hospitals services, increasing out of hospital delivery and the promotion of self care and prevention. The collaborative focus of the STP process has enabled us to bring the learning from these activities together to develop a consistent approach to our future work, namely to effectively scale up the engagement and interaction with our local communities, clinicians and staff.

Throughout the STP process we have engaged on the direction of travel and post publication on the 21st November 2016 we have undertaken a period of formal public engagement on the full plan. This concluded at the end of February 2017 with ongoing further engagement with our workforce. Overall the engagement has focused on some high level ideas and concepts, to ascertain initial views on the suggested direction of travel and key priorities identified. The engagement has been supported by a dedicated website (www.yourconversationhw.nhs.uk) where a number of documents have been made available including the full plan and a summary document, plus an online questionnaire. In addition to online information, events and drop in sessions have been held across the two counties where patients, carers and members of the public have been able to meet with members of the communications and engagement work stream to discuss thoughts, concerns and ideas and to complete a questionnaire.

A further opportunity to engage with the community has been presented by the consultation events on the Future of the Acute Hospital Services in Worcestershire. Across the two counties, presentations have also been made at a number of community, voluntary and statutory sector meetings, groups and forums. Attendance at these groups has allowed us to share information, promote discussion and gather the views of various health and care groups/patient and carer groups, and also to gather the views of those considered seldom heard. Other comments have been received through letters, emails and enquiries.

By the end of the engagement period, 1195 public and patient engagement questionnaires had been completed and over 165 events had been attended. There were 10,769 hits to the website supported by social media activity. The final STP engagement report is available at (www.yourconversationhw.nhs.uk
A review of feedback half way through the engagement period indicated the need to enquire more deeply into two areas that respondents seemed concerned about – notably transport and the use of technology. To this end, a focused piece of work with a number of groups and individuals has allowed us to explore these issues in more detail. This work is continuing and recommendations will embedded in the specific workstreams and subsequent proposals where appropriate.

Specific engagement with staff around the STP began in February 2017 and by the end of April we had 372 survey responses that highlighted staff understanding about the STP and early views around the general direction of travel. The next phase of engagement will scale up internal communications around our delivery plans and widen the involvement with STP developments with our workforce.

#YOURCONVERSATION

YOUR HEALTH AND WELLBEING IN HEREFORDSHIRE AND WORCESTERSHIRE

1195

surveys completed in Worcestershire

478

surveys completed in Herefordshire

165 engagement events and attended VCS group meetings in Worcestershire and **25** in Herefordshire

10,769

hits to our dedicated STP webpage from November.

6 'STP launch' articles in the local papers across Herefordshire and Worcestershire

25 STP related articles
– most relating to bed reductions

2,567

people viewed the STP summary document.

46

retweets on our Twitter posts

12,607

impressions

2567

people reached through our Facebook posts

Current engagement activity paused at the end of February 2017.

Key themes from our engagement activity:

The engagement that has been undertaken has indicated general support for the direction of travel:

Out of hospital care

Many respondents support the idea of having well-publicised, local services provided by a range of health care professionals who are available at known community bases/health hubs. Decisions around which service/professional a patient should access should be made by clinical, not administrative staff. There is strong support for much routine, non-urgent and non-specialist care to be provided at home/in the community/out of hospital. Many respondents would like to see many more services provided locally and support the idea of local health teams caring for patients at home.

General Practice

Access to services at present is not straightforward and is more complex for particular groups. Many respondents believe that access to GP services needs to be changed with good support for the idea that some might see a professional other than a GP, and the proposal that GP appointments should be kept for those who really need them. Respondents support the suggestion that GPs should support local health teams and believe that more professional time should be allocated to those who need it. However, many do not support the idea of Skype being used for routine appointments.

Accident and Emergency services

A lack of 24/7 local options and out of hours GP services are seen as key contributors to the challenges being faced by A&E. Respondents want A&E to only treat those who need to be in A&E and many people support the proposal to re-direct people to more appropriate sources of treatment. Whilst some respondents feel that information could help in this regard and offer suggestions where and how this could be provided, others believe that the issue is more about education that needs to be provided at the point of access so that people start to learn what is provided where.

Prevention , self-care and promoting independence

Most people recognise they have a responsibility to look after their own health but currently, information about health and services and what people can do for themselves is difficult to access, sometimes contradictory, and often confusing. Respondents want clear information about all services/conditions provided in one trusted place or by trusted individuals or organisations that are known to them and their community. Some respondents recognise that information is not enough for those with entrenched or habitual behaviour, calling for health coaching/motivational interviewing support. Much more prevention and self-care information should be communicated through schools and workplaces.

Key themes from our engagement activity:

Technology

Views on technology are mixed; some people like it, some do not, and this engagement would suggest that preferences do not reflect gender or age variables. However, in Worcestershire, it would suggest that preferences are linked to ethnicity, with minority ethnic groups much less supportive of technology than White British groups. The feedback across the two counties indicates that overall, different people like different IT solutions. The perception of whether or not it is useful, often depends on the service/groups it is being proposed for and many respondents felt they had insufficient detail at this stage to comment more fully.

Transport and Travel

For the majority of people who responded through the Your Conversation engagement transport and travel was not a issue but the data does suggest that transport remains a challenge for some particular groups. In Worcestershire this seems to include some patients in the North of the county, as well as some carers, both of whom indicate that they do not have access to transport options. Similar concerns were expressed by some Herefordshire residents who are concerned that they will not be able to access appointments when they no longer drive as there are reduced or no public transport options in some places. It is suggested that greater flexibility and a broader system response is taken to address the issues identified around travel and transport challenges and that these are considered early in relation to specific STP proposals.

Bed reductions

There is concern about reducing the number of beds, based on the view that beds are still needed and a lack of knowledge/understanding about the alternatives on offer. This was mainly relating to Community Hospital bed reductions and limited detail around the skills and capacity required to support and care for people in their home.

Carers

If carers are going to be asked to do more and to become care partners, more work is required to identify, support, train and involve them. Many carers asked for breaks or respite periods.

Better use of resources

Many respondents were keen to offer views around how services could be made more efficient; including better use of resources like pharmacists, mobile units and community venues.

Communications and Engagement: Next Steps

To date, the patients and public we have engaged with have expressed their appreciation for the opportunity to be involved. It is important that as our plan becomes more detailed we scale up our communication and engagement activity accordingly, with a focus on specific changes that are being considered and how people can engage with these. Therefore, each workstream is developing a bespoke approach to communication and engagement, reflecting the themes from the engagement activity to date and involving key stakeholders to develop the detail around priorities and proposals. There is a dedicated Communication/Engagement Officer on each workstream – they provide advice around best practice and ensure links are made to the established structures across our system. The Communications and Engagement workstream meets monthly, aggregating the workstream activity to advise Partnership Board around the ongoing system wide messages/context setting to support the overall direction of travel. This workstream is also supported by NHSE to develop and embed models of enhancing system wide approaches Community Citizenship and co-production.

Next Steps:

- A Communication and Engagement Plan is in development which outlines the expected activity across all the workstreams including an early assessment on equality impact, areas for formal consultation and the timelines for these. This focused work will be supported by ongoing overarching engagement around the content of our Summary Document, ie the case for change, the scaling up of out of hospital models and prevention, self care and promoting independence.
- Through current public sector partnerships we will seek to align our ambitions and developments to maximise wider place based delivery where possible. This will include modelling around impact across the wider determinants of health including housing, employment, community safety etc
- A key part of our work around carers is about involving them as expert care partners but our engagement has shown that carers need support and training to step fully into this role. To help us with this we applied for, and were successful in being selected, to receive support from the Building Health Partnerships scheme. This year-long project will see voluntary and statutory sector working together to establish a Carers Reference Group that will help ensure existing initiatives are mapped and good practice around carers (including support for carers to participate as experts in the care planning process) embedded within work streams and across the two counties.
- Targeted engagement work will continue around transport, travel and digital to further understand the issues and explore the opportunities to work differently with partners. Responding to our Your Conversation feedback this will also scope out the varying approaches that maybe developed for different communities, including younger and older people as well as black and ethnic minority groups and rural communities.
- We will continue to work with NHSE as a STP exemplar site for Communication and Engagement to strengthen our approach to Community Citizenship. We anticipate that our Building Health Partnerships work will provide us with an opportunity to test ideas around Lay Reference Groups and VCS involvement which can then be extended and adapted to support all the activities outlined in our STP.
- We will continue to work with Communication and Engagement colleagues from neighbouring STPs and beyond to align messages (especially at our county's borders) and adopt best practice and innovation where possible.

Our vision for 2020/21

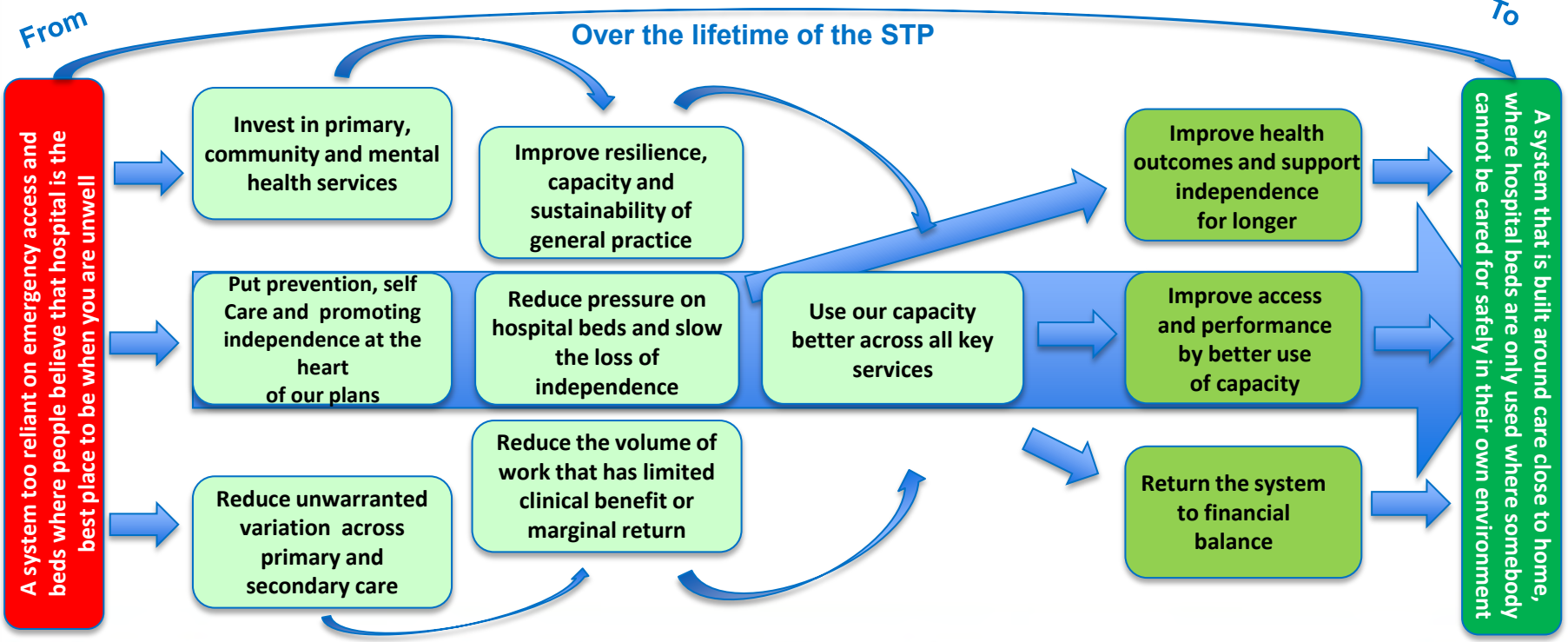
"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people".

What we mean	
Live well in a supportive community…	There is collective agreement across the wider public and voluntary/community sector that one of the most effective ways to improve health is for people to live well within supportive resilient communities taking ownership of their own health and well-being. We will be better at helping residents to draw on the support available from their local communities and voluntary groups, and we will help those communities and groups develop the capacity to meet these needs. We will use social impact bonds and social prescribing to support this. This will apply across all age groups.
…with joined up care…	Where individuals have a health or care need this will be delivered in an integrated way, with a single plan developed with and owned by the individual in true partnership and available wherever people access the system. Local integrated delivery teams will be in place which recognise the central role of the GP and reflect a broad range of skills and expertise from across the organisations. We will make care boundaries invisible to people using our services by removing operational boundaries between organisations and we will ensure that co-production is embedded in everything we do.
…underpinned by specialists…	Specialist care will always be needed, but there are times when care could be safely provided under the remote supervision of a specialist across a digital solution. For example, by developing better digital links between practices and hospitals we believe that more care can be provided locally by GPs and other health or social care staff based in the community. This is particularly important given our rurality challenge. Our workforce, organisational development and recruitment plans will focus on making sure that we make Herefordshire and Worcestershire an attractive place to work so we have a stable and committed workforce, with much less reliance on agency employment.

What we mean	
…delivered in the best place…	We will have completely adopted and embraced the principle of "home first" and will deliver as many services as possible close to home. We will carefully balance the need and benefit of local access against that of service consolidation for quality, safety and cost effectiveness. We will reduce as far as possible the need for people to travel out of their area to access most services. Some services will be brought out into communities and delivered in GP surgeries, community hospitals or other local premises. Equally some services will be consolidated where clinical sustainability or quality of care is significantly improved by doing so. Joined up transport planning will enable us to support people in planning their travel arrangements where this is the case. We will involve the public in any decisions and provide the information needed to understand how and why things need to change.
…by the most appropriate person.	We need to create the capacity and resilience to enable GPs to be clinical navigators and senior clinical decision makers in the out of hospital care setting. This will be with a particular emphasis on people who are frail and those at risk of emergency admission. We will develop extended roles such as physician assistants and advanced practitioners in areas such as physiotherapy, dermatology and pharmacy and review the skill mix to free up the GP time needed to focus on patients with the most complex needs. Equally there are times when the demarcations in roles are too prohibitive and result in the need for additional roles that add more cost than value. This will change with alignment of pathways of care. Over time we have introduced a degree of complexity and cost that is not sustainable. The work we do to implement this plan will mean that people will be seen by the right person in the right place at the right time. This will mean change to the way in which services are delivered.

The essence of our Sustainability and Transformation Plan

Our health and care economy has become too dependent on reactive bed based care that results in reduced wellbeing, a poor patient experience and higher cost of services. There remains a public perception that being in hospital is the best place to be when people are unwell. This is despite there being considerable evidence to the contrary, particularly for people who are frail. The essence of our STP is to change this by keeping people well and enabling them to remain in their own homes. We will achieve this by focusing our efforts more on what happens in our communities, not just in hospitals. We will build our system around resilient and properly resourced general practice, that has community services wrapped around them. This will relieve pressure on our hospitals, which will be freed up to focus on efficiently dealing with complex elective and emergency care. Waiting times and outcomes for patients will be better. For the system it will enable us to live within the financial means available by the end of the 5 year period. To achieve this change we will require all partners to commit to this approach and to deliver this through their operational planning and delivery work. It will also require change from the population. We will need local residents and citizens to take more control of their own health and well being, to take more responsibility for supporting others in their communities. Building strong and resilient communities, through wider work around employment, housing and education, will be an essential foundation for this. As a result, people will no longer need the historic range and level of public services, and will be sensible consumers of the services we do need to provide.



A single page summary of the big priorities for this STP

Sustainable General Practice

- Prioritise investment to ensure delivery of the General Practice Forward View – developing primary care at scale "bottom-up" with practices , community pharmacy, third sector and health and care services.
- Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity.
- Adopt an anticipatory model of provision – with proactive identification, case management and an MDT approach for those at risk of ill-health.
- Share information across practices and other providers to enable seamless care.
- Move to "big system management" – with real time data collection and analysis providing the intelligence to support continuous quality improvement and demand management.

Primary & Community Services

- During 2018/19, organise and provide services from locality based Multi-Speciality Community Providers (Worcestershire) and similarly formed alliance model (Herefordshire).
- Through the One Herefordshire Alliance and the Worcestershire Alliance Boards, develop population based integrated teams wrapped around general practice covering physical and mental health, wider primary and social care services and engage with the population to deliver services close to home.
- Support patients and carers to self-manage their own conditions, harnessing voluntary sector partners and communities to support independence and reduce loneliness.
- Develop plans which integrate specialist support, reducing the time taken to access specialist input and reducing the steps in the pathway. Initially focussed on supporting people living with frailty and end of life care, but adopting principles and learning quickly to a range of other priority pathways.

Prevention, self care and promoting independence

- Embed at scale delivery of evidence based prevention interventions across all providers of health and social care, achieving population behaviour change.
- Put long term life outcomes for children, young people and their families' needs at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future.
- Support people to manage their own health, linking them with social support systems in their communities and identify when a non-clinical intervention will produce the best experience and outcomes for patients.

MH & LD

- Deliver the requirements of the national taskforce.
- Work with NHS specialised services to increase local child mental health services to reduce demand for complex out of county services and enable repatriation of complex cases back to their local areas.
- With local authorities, develop joint outcomes and shared care for people with learning disabilities.

Urgent Care

- Reduce the number of individual physical access points to urgent care services across the two counties by 2020/21.
- Retain 3 units with an A&E function across the two counties. Explore the need for the number of MIUs and the Walk in Centre as we move to 7 day primary care services, and the opportunity for standardised opening hours for MIUs in Worcestershire.
- Shift to home based care – explore whether we should reduce the number of community based beds across the system and shift resources to primary and community services.

Maternity

- Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme.
- Develop a Local Maternity system across Herefordshire and Worcestershire delivering the Better Births strategy.
- Establish a single service with specialist teams working under a common management structure, delivered locally within both counties.

Elective Care

- Develop 4 key prevention programmes to reduce demand for surgery delivered at scale and improve the likelihood of positive clinical outcomes following surgery.
- Across Worcestershire undertake a greater proportion routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes.
- Develop strategic partnerships with external partners to secure organised access to elective surge capacity in a planned and managed way.
- Expand pan STP working on cancer services and deliver the requirements of the national taskforce.

Infrastructure

- Explore the benefits from integration in pathology, radiology and pharmacy services across the two counties.
- Develop robotic pharmacy functions and maximise the use of technology.
- Develop a single strategy and implementation plan for a joined up place based back office across all local government and NHS partners.
- Develop a place based estates strategy and a place based transport strategy.

Our biggest challenges – health and well-being

Overall, health outcomes in Herefordshire and Worcestershire are good but we face significant challenges now and into the future. We recognise that radically scaling up prevention activities across all our health and care interactions with the population will be a vital element of securing improvements, we also recognise the need to work closely with wider system partners to ensure that a healthy place is created by all those who shape it, addressing the social, economic and environmental determinants of health. These partners will include police, fire and rescue, housing, and the VCS, as well as economic partners who can influence the overall wealth and inequality of our place.

The gap between life expectancy (LE) and healthy life expectancy (HLE)
There are large numbers of people living in poor health in our older population and this is one of the most significant gaps to reduce. In Herefordshire the gap at 65 years of age is 7.8 years for men and 9.4 years for women. In Worcestershire 7.1 and 9.1 years respectively. Closing these gaps is essential to improving the quality of life for the population.

- **Premature mortality rates vary significantly between the two Counties** Worcestershire mortality rates are most concerning – the county ranks 55th out of 150 Authorities nationally (where 1st is best) for premature mortality rate per 100,000 population. Herefordshire ranks 21st out of 150. In comparison with its statistical neighbours, Worcs ranks 12th out of 15, with a premature death rate of 320 per 100,000, compared with 256 for the 1st ranked. This is equivalent to around 370 additional premature deaths a year. Herefordshire ranks best for its comparative group, with a premature death rate of only 287 per 100,000

- **There are some condition specific premature mortality concerns** - In Herefordshire, colorectal cancer, heart disease and stroke are slightly higher than expected (but not significantly), whereas in Worcestershire, premature mortality in some of these areas is amongst the worst or actually is the worst for its comparator group (for example colo-rectal cancers and heart disease)

Gap between life expectancy & healthy life expectancy

	Men	Women
Herefordshire	7.8 yrs	9.4 yrs
Worcestershire	7.1 yrs	9.1 yrs

Premature mortality rates compared to other areas (1 is best performing)

	England	Statistical Neighbours
Herefordshire	21st of 150	1st of 15
Worcestershire	55th of 150	12th of 15

Our biggest challenges – health and well-being

There is a gap in mortality rates between advantaged and disadvantaged communities, particularly in Worcestershire – Our health and well-being strategies identify approaches to tackle this gap, and these are reflected throughout the STP. The range of years of life expectancy across the social gradient at birth is 7.8 years in Worcs and 4.9 in Herefordshire. In our rural areas, health inequalities can be masked by sparsity of population but we know differences exist which need to be tackled, including issues of access.

Some outcomes for children and young people which are lower than expected:

- **School readiness** - In Herefordshire only 40% of Children receiving free school meals reach a good level of development at the end of the reception school year. In Worcestershire the figure is 46%. Both are worse than the England average of 51%
- **Neonatal mortality and stillbirth rates** – These are amongst the worst in the comparative groups for both counties. In Herefordshire it is 9.7 per 1,000 live births and Worcestershire 7.5 per 1,000
- **Obesity** – In Herefordshire 22% and in Worcestershire 23% of reception class children are obese or overweight
- **Alcohol admissions under 18s –** In Herefordshire the figure of 56 per 100,000 population and in Worcestershire 46.5 per 100,000 are both significantly higher than the England average of 40. This equates to an additional 30 admissions in Herefordshire and 37 in Worcestershire per annum
- **Breast-feeding initiation rates** are both below the national average (68% in Herefordshire and 70% in Worcestershire with a national figure of 74%).
- **Occurrence of low birth weight** in both counties is amongst the worst of their comparator groups
- **Teenage conceptions** - 24 per 1,000 in Herefordshire and 25 per 1,000 in Worcestershire are the highest rates amongst their comparator groups

Mortality variation between different social groups

Difference between less deprived and more deprived areas

Herefordshire	4.9 yrs
Worcestershire	7.8 yrs

Areas of concern regarding poor outcomes for children and young people across both counties

Older ---------- Younger

- **Neonatal mortality and still births**
- **Low birth weight**
- **Breastfeeding rates**
- **School readiness**
- **School age obesity**
- **Under 18 alcohol admissions**
- **Teenage conception rate**

Our biggest challenges – health and well-being

Mental health and well-being - This is a theme that cuts across and impacts on all the outcomes and is a priority in our health and well-being strategies**.** On average, men and women in contact with mental health services have a life expectancy 17.5 and 14 years less than the rest of the population of Herefordshire and Worcestershire, this is a highest figure compared to similar STP areas. On the Integrated Household Survey 21% of residents in Herefordshire and 18% in Worcestershire reported an anxiety score of over 5/10. In addition, we know that people suffering from mental health conditions suffer higher levels of health inequality and outcomes across an array of measures. We will focus on improving mental health and well-being which will in turn impact on individual behaviour change and physical health.

To narrow the gaps identified above, our plans for mental health will include improved access to early help as soon as problems start. we will also focus on living healthily, knowing that good physical health is inextricably linked to good mental health. We will focus on changing the lifestyle behaviours that increase risks of poor health outcomes**.** We want to reduce:

- **The numbers of people eating too many high fat, salt and sugar foods** - In Herefordshire 65.2% of adults are overweight or obese and in Worcestershire 66.6%
- **Alcohol consumption** - in both counties about 27% of the drinking population drink at increasing or higher risk levels
- **Smoking** - 14% of adults in Herefordshire and 17% in Worcestershire still smoke
- **Physical inactivity** - 22% of adults in Herefordshire and 25% in Worcestershire are inactive

Although we are generally at national average in terms of these behaviours, the national figures themselves give rise for concern and average performance should not be allowed to provide false comfort. If unchecked, these issues will mean that the rising burden of avoidable disease will continue. Furthermore, there are marked differences between deprived and non-deprived areas which will require careful referral and targeting (for example smoking prevalence among routine and manual workers is 25% in Herefordshire and 32% in Worcestershire). The biggest single staff group across the two counties is employed by the NHS and local government. We will focus on implementing local strategies to support our own workforces to lead the way in changing behaviour for others.

Life expectancy for mental health service users compared to non-mental health service users

Gap in life expectancy in years

Men	17.5 yrs
Women	14 yrs

Unhealthy lifestyles

% of the population who:

	Here'd	Worcs
Are obese or overweight	65.2%	66.6%
Drink too much	27%	27%
Smoke	14%	17%
Are physically inactive	22%	25%

Our biggest challenges – care and quality

In addition to our health and well being challenges, we also have a number of areas where our performance on care and quality can be significantly improved. We know there are significant workforce challenges in a number of areas leaving services too reliant and locums and agency staff to meet demand.

Our biggest challenges include:

- Lack of capacity and resilience in primary care and general practice.
- Social care provider capacity & quality (domiciliary and residential care capacity is stretched). The entirety of population growth in Herefordshire over the next 15 years is in the over-75s (with major implications for demand).
- One Trust in the CQC special measures regime and one that has recently emerged from it, having been re-categorised as "requires improvement".
- Poor Urgent Care performance on a number of measures including ambulance measures, 4 hour waits in A&E, long trolley waits and challenges around including stroke performance.
- Poor performance against elective care referral to treatment times (18 week waits) and access to mental health services such as psychological therapies.
- Poor performance of cancer waiting times.
- Low dementia diagnosis rates.
- Poor performance in parts of the STP area on a number of maternity indicators such as uptake of flu vaccinations, smoking at the time of delivery, low birth weight and breastfeeding initiation.

May 2017 Highest risk areas for key NHS Constitutional standards

Urgent Care	• 4 hour A&E standards across all sites • Poor patient flow resulting in 12 Hour Trolley breaches (WAHT) • Stroke TIA (WVT) • Ambulance Handovers
Planned Care	• Referral to treatment 18 week (WVT & WAHT) • Cancer 62 day wait • Cancer all 2 week wait referrals • Cancer 2 week wait – Breast Symptomatic • Cancelled operations (WAHT)
Mental Health	• Dementia Diagnosis • IAPT Access (Improved access to psychological therapies) • IAPT Recovery

Our biggest challenges – finance and efficiency

In October 2016 the STP developed a financial model that set out a 'do nothing' scenario for the health and care economy. The model was calculated showing the impact of increases in demography, inflation and other factors. The model also included those investments required to deliver the priority areas set out in the Five Year Forward View. The STP is in the process of refreshing its financial model, and the scale of the financial challenge is set out below. The Partnership Board has reiterated the importance of the investment in delivering the programmes set out in the General Practice Forward View. The financial model has been refreshed to include 2016/17 outturn, the 2017/19 contractual agreements and organisational control totals. The financial model will be continually refined as we move forward. The refreshed 'Do Nothing' base case for Herefordshire and Worcestershire split by sector is:

includes a £23.0m new requirement to deliver the NHS Five Year Forward View.

Area	Herefordshire	Worcestershire	Do nothing gap
NHS Commissioners	£34.4m	£99.6m	£311.1m*
NHS Providers	£74.8m	£102.3m	

In addition to this, the financial modelling shows that the two local authorities combined have a "do nothing" gap of circa £84m that are being addressed through local efficiency savings alongside the STP– taking the system gap to £395m.

NHS £311.1m gap by area	2020/21 'Do Nothing'	Population	Per head
Herefordshire *Including net import from Wales*	*-£109.2*	*225,000*	*£485*
	-£109.2m	185,000	£590
Worcestershire	-£201.9m	595,000	£339

We recognise the importance of addressing this position as quickly and effectively as possible. Based on published allocations for 2017/19 and advised inflationary uplifts spending allocations will increase from £1.168bn to £1.327bn (this includes NHS England priorities including MH Parity of Esteem). If the population continues to access services in the same way as now, and we continue to provide them in the same way, then our spending will be likely to increase by an additional £175m over and above this increase. When added to our opening gap and the social care gap, this results in the total financial challenge for the system by the end of 2020/21 of £395m.

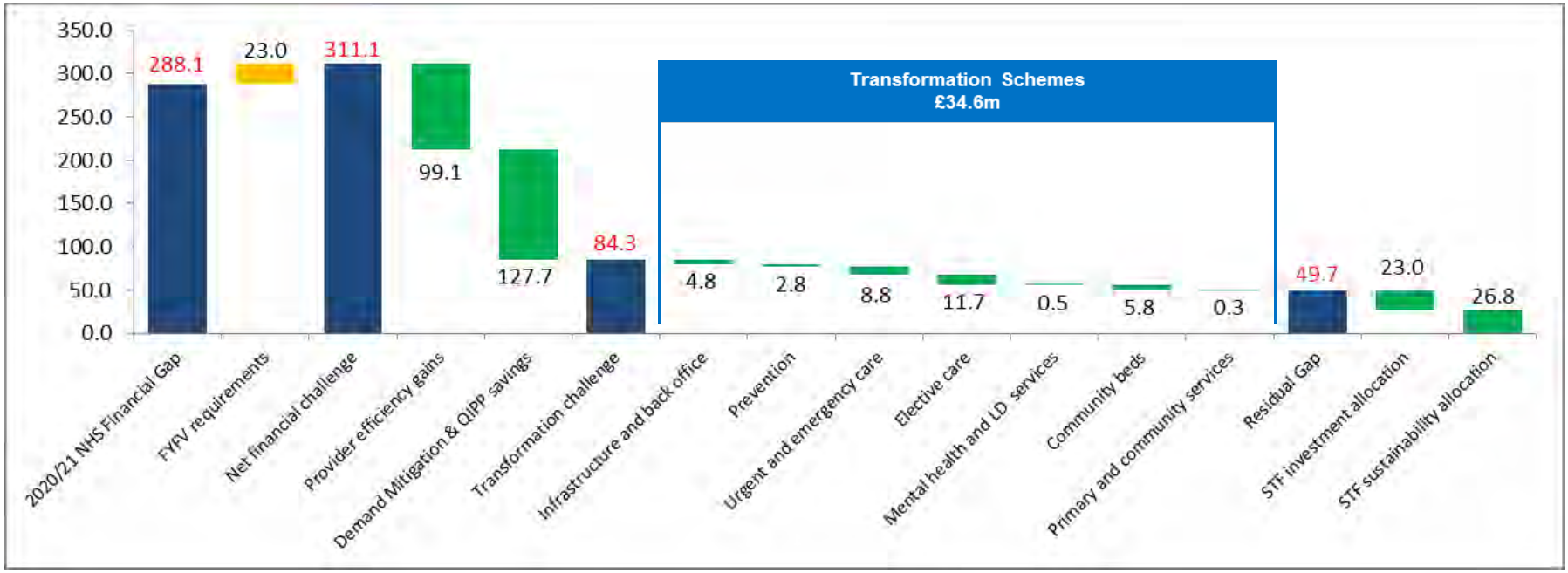
We are very conscious of the challenge between the need to live within individual control totals in the short term and the delivery of a balanced and sustainable system in the long term. In seeking to meet both challenges, we recognise the need to take radical steps, but equally will be careful not to compromise long term sustainability with rash steps towards short-term financial savings.

There is a significant disparity in the scale of the financial challenge across the two counties. The additional challenge in Herefordshire, in part, stems from the inherent additional costs resulting from serving a very dispersed rural population where there is limited access to the internet. These challenges are not fully reflected in the national funding formula. The current model assumes these financial challenges can be met through efficiency savings which are very challenging.

Our biggest challenges – finance and efficiency

Closing the NHS Gap by 2020/21

If we achieve the national planning assumptions of 1% demand mitigation and 2% provider efficiency gains, and deliver additional QIPP savings and efficiency gains, then our local modelling suggests that the financial challenge we will reduce to £84.3m (£311.1m - £226.8m demand management & efficiency gains) this is the gap before the transformation schemes and proposed use of the STF investments is allocated. We have currently identified transformational schemes totalling £34.6m that could begin to bridge the gap, leaving £26.8m to be covered by the STF money after covering the investment requirement from our STF allocation. Delivering this scale of transformation will be challenging without access to sufficient transformation resource to support change (see page 24 for plans). This is one of the key risks that the system will need to address as part of the next phase of development. In implementing any changes to services, all partners have agreed to the principle that we must not take decisions in one part of the system that have an adverse effect or shunt costs into another part of the system, without this being part of an agreed and organised approach. We are very conscious that there may be a tension between the need to live within the control totals of individual organisations in the short term and the delivery of a balanced and sustainable system in 2021. In seeking to meet both challenges, we are ready to take radical steps, but we will not be foolhardy, in taking rash steps towards short-term financial savings that undermine outcomes in the longer term.'



Opportunities identified using Right Care to support demand mitigation

In order to deliver our commissioner QIPP and provider CIP challenge we intend to apply the NHS Right Care approach and the wider efficiency work recommended by national reviews such as *Carter* . The CCG Right Care Commissioning for Value packs show that there are significant opportunities for demand mitigation compared to other areas in both elective and non-elective care. Other sources of analysis show opportunities in Continuing Healthcare and variation in GP prescribing. These savings opportunities are included with the CCG QIPP plans mainly within Acute Contracts for 2017/18 and 2018/19.

Elective Admissions

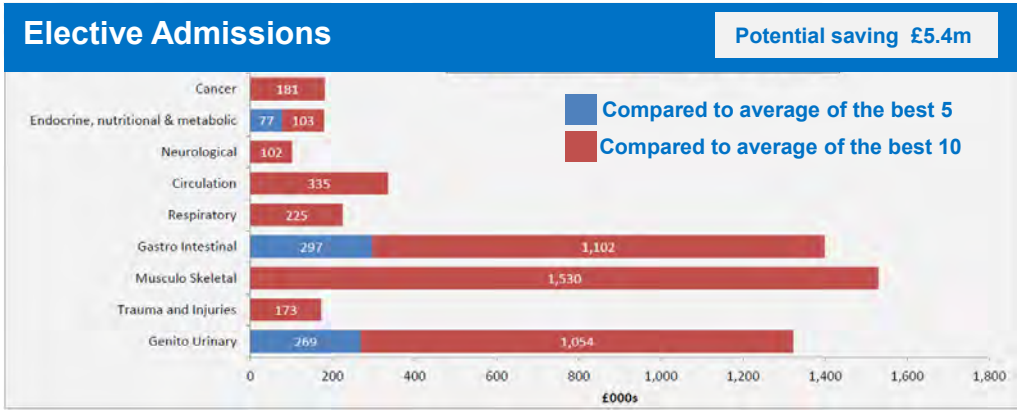
- There are significant opportunities to deliver efficiencies in this area, most notably in Gastro-Intestinal and Musco-skeletal
- Total saving opportunity =
  - £643k against the top 10 comparators
  - £5.4m against the top 5 comparators

Non Elective Admissions

- There are also significant opportunities to be pursued in the non-elective admissions, but in a smaller number of areas. The most significant being Neurological.
- Total saving opportunity =
  - £186k against the top 10 comparators
  - £2.5m against the top 5 comparators

Other areas (not shown in charts)

- In addition to these areas CCGs have also identified CHC and GP Prescribing as areas to target for demand mitigation strategies with savings of £2.1m and £3.7m targeted.



In addition to existing schemes, jointly developed QIPP/CIP schemes will be developed through the operational planning process to support delivery of these savings, alongside the additional requirements to support control total compliant spend in 2017/18 and 2018/19.

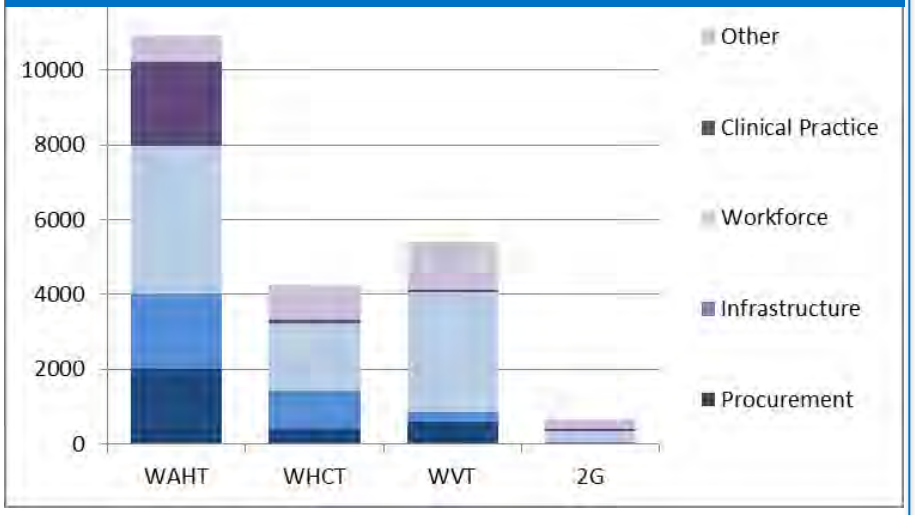
Identification of provider cost improvement plans – 2017/18 and 2018/19

Providers are developing plans to deliver the 2% cost improvement requirements outlined on page 18. These plans are consistent with the areas set out in the Carter review and include the following elements:

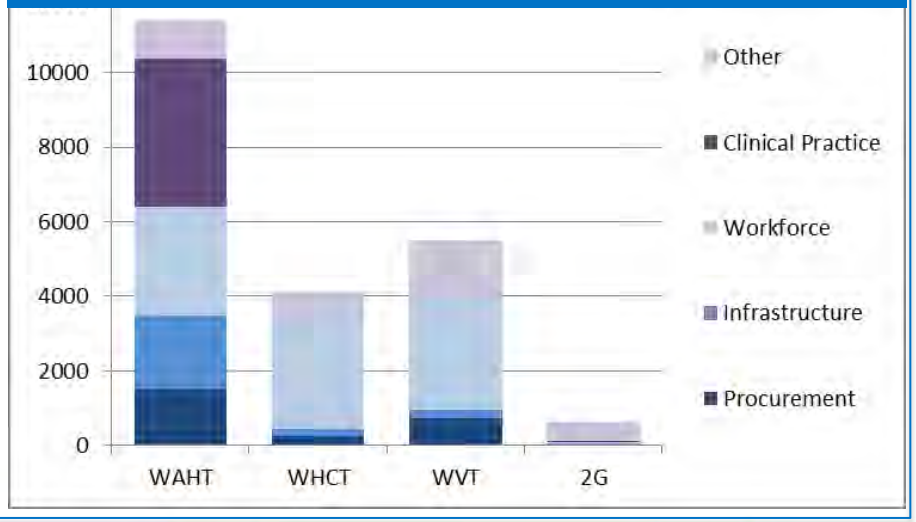
- **Procurement** – a total of £3.0m savings across the 4 providers in 2017/18 and a further £2.5m in 2018/19
- **Infrastructure** - £4.4m in 2017/18 and a further £2.5m in 2018/19. These savings are based on spend to save schemes, likely impairments and increased commercial income as part of an efficiency review linked to the Carter recommendations and other benchmarked opportunities such as estate management and PFI efficiencies.
- **Workforce** – this is the biggest area of focus in provider plans and is centred heavily on reducing spend on temporary staffing. Plans currently aim for £9.2m in 2017/18 and a further £9.0m in 2018/19.
- **Clinical Practice** – a reduction of £2.5m in 2017/18 and £4.0m in 2018/19. These savings include productivity and efficiency improvements in areas such as length of stay, day case rates, outpatient follow up rates, reducing non attenders and readmissions as well as more efficient prescribing practise and improved theatre utilisation.
- **Other** - £3.1m in 2017/18 and a further £3.7m in 2018/19. These savings include improved income recovery through better productivity, improved CQUIN performance and better contract management.

Note that, combined, these savings equate to £21.2m and £21.7m respectively for the next two years. However, in order to achieve control totals, additional savings across the providers or almost £27m will need to be identified in 2017/18. The plans need to be updated to reflect new areas and values being agreed.

2017/18



2018/19



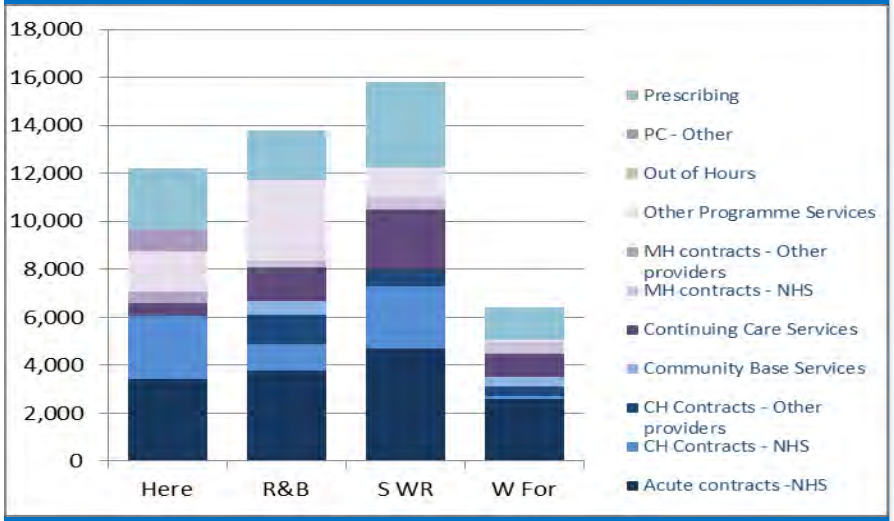
Identification of commissioner QIPP plans – 2017/18 and 2018/19

Commissioners are developing plans to deliver the 1% cost improvement requirements outlined on page 18. The QIPP detailed below is taken from the financial plans in March 2017. The plans cover the following areas:

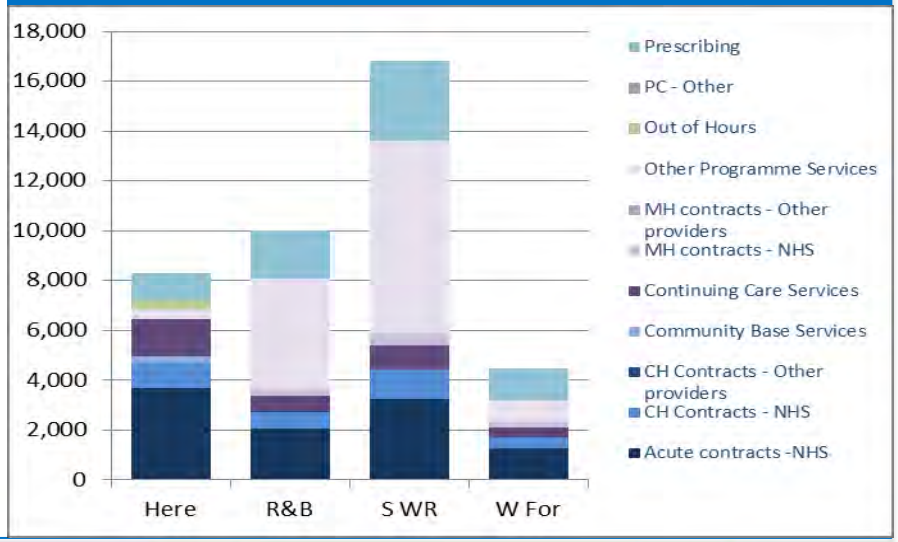
- **Prescribing** – £9.6m in 2017/18 with a further £7.4m in 2018/19. This will be delivered through a number so ways including reducing variation in drugs prescribed, repeat prescribing and review drugs available for prescription
- **Acute Contracts** – This is the largest area of focus with £14.4m in 2017/18 and £10.2m in 2018/19. As well as a 2% demand management requirement the other areas include follow up outpatient reductions, elective procedures being reviewed, procedures of limited clinical benefit and reductions in emergency admissions. All areas reviewed are subject to clinical agreement. This also includes the Right care opportunities as identified in the previous slide.
- **Continuing Care Services** - £5.4m in 2017/18 and a further £3.5m in 2018/19. This will focus on follow up reviews, 1:1 care packages, nursing care packages and ensuring full compliance with approved policies
- **Other Programme Services** - £6.4m in 201718 and £13.5m in 2018/19. For 2017/18 this covers a number of areas including a full forensic review of all CCG budgets. In 2018/19 this is mainly unallocated at this planning stage and will be allocated across programme areas once fully identified and agreed.
- **Other Health Contracts** - £8.8m in 2017/18 and £3.3m in 2018/19. This covers all community areas including Physiotherapy Therapy Service redesign, better care fund realignments and other technical savings

Note that, combined, these savings equate to £48m and £39m respectively for the next two years.

2017/18



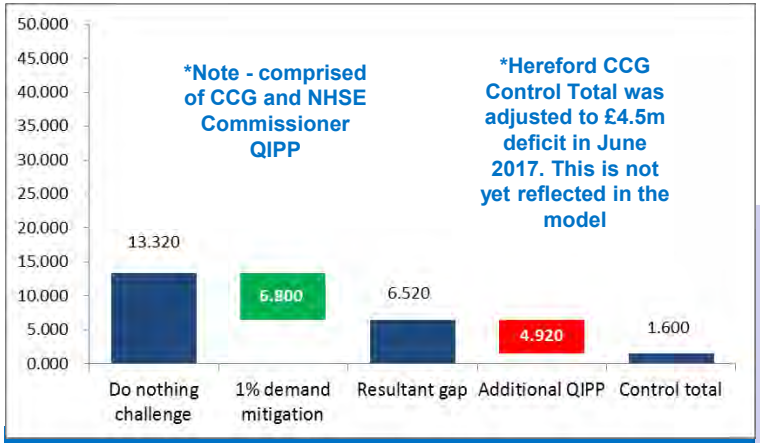
2018/19



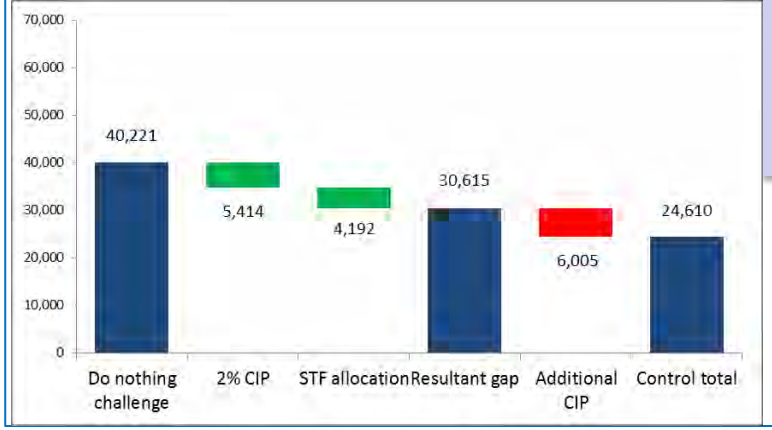
Our biggest challenges – finance and efficiency

Information has been updated to reflect the latest financial projections for CCGSs and Acute Providers, although work continues, the model continues to be updated to finalise our modelling assumptions and **refresh** the solutions. The current model is not a final position. Our financial modelling shows that we can bring the system into financial balance by 2020/21 by using **£26.7m** of our STF allocation to support sustainability. However, we have a significant challenge in achieving the system control totals for 2017/18 and 2018/19. In order to achieve the 2017/18 control totals, the Herefordshire system would need to achieve combined savings of £23.1m in year. For Worcestershire this figure is £58.6m. In reality because a significant proportion of the commissioner challenge would be in spend areas with the provider, the provider challenge would be further magnified. Significantly for the two acute providers these programmes equate to circa 12.2% and 10.2% of income respectively.

Herefordshire Commissioner Bridge 2017/18



Wye Valley Finance Bridge – 2017/18



Herefordshire Challenge

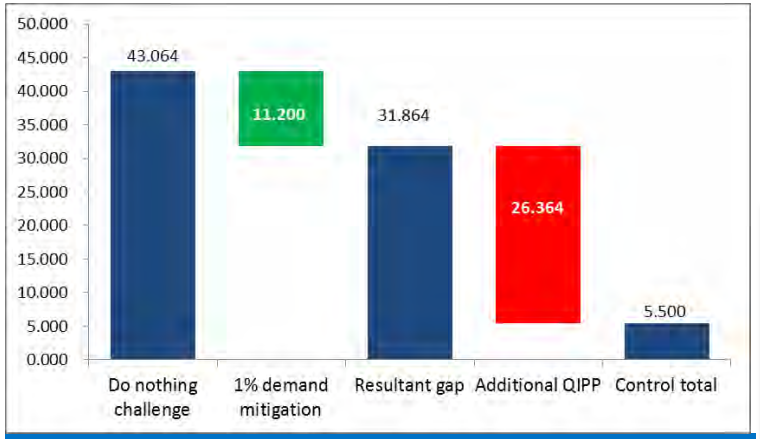
£6.8m
£4.9m
£11.7m

£23.1m

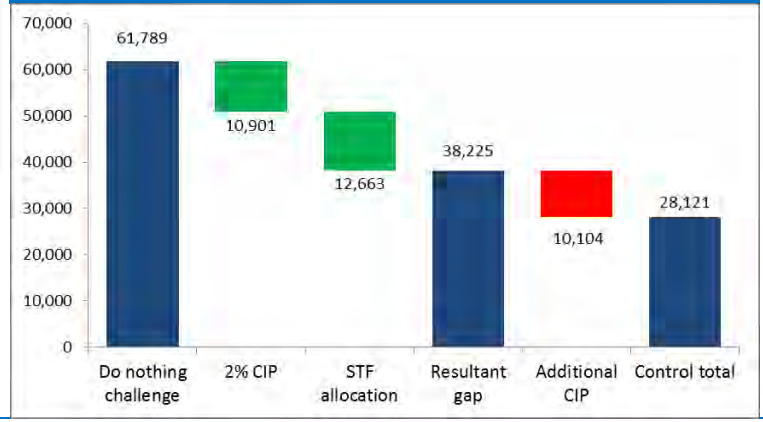
£5.4m
£6.0m
£11.4m

circa **12.2%** CIP (inc impact of commissioner QIPP)

Worcestershire Commissioner Bridge 2017/18



Worcs Acute Finance Bridge – 2017/18



Worcestershire Challenge

£11.2m
£26.4m
£37.6m

£58.6m

£10.9m
£10.1m
£21.0m

circa **10.2%** CIP (inc impact of commissioner QIPP)

Investing in change and transformation

An Allocative Approach to Budget Prioritisation

Partners on the programme board agreed to take a strategic approach to making investment and disinvestment decisions across the system budgets. A budget allocation exercise was facilitated by The Strategy Unit of the Midlands and Lancashire Commissioning Support Unit.

This process included partners reviewing national "asks", local performance and outcome information from the gap analysis and agreeing a strategic direction of travel for how we believed we could most efficiently optimise the use of resources to achieve the best outcomes for the population.

The core purpose was to enable rational allocation of any growth money that CCGs will receive in their allocations over the STP period and agree where the most significant efficiencies and service changes would need to be targeted in order to achieve this strategic intent. The intention is to use this process to support the strategic shift in resources over the lifetime of the STP.

However, it will be a significant challenge for the system to achieve this quickly using traditional methods of contracting. Any additional investment highlighted in the table is naturally reliant on the system's ability to disinvest equivalent amounts in the other areas. It is therefore a priority of the STP to move towards population based capitated allocations using more flexible contracts to enable commissioners and providers to ensure that resource is targeted to the right areas.

Through the joint operational planning process, CCGs and Providers are working together to develop joint schemes to support each other to deliver their respective financial positions.

Funding area	Indicative funding share	Real terms change*	Actual funding increase
Running costs	Reduce	-26%	-15%
Back office and infrastructure		-7%	
Urgent care and emergency admissions	Reduce	-6%	+7%
Maternity care	Increase	+1%	+15%
Mental health and learning disability services	Increase	+8%	+23%
Elective treatment – life threatening conditions (cancer, cardiac etc)	Increase	+7%	+22%
Elective treatment – non life threatening conditions	Reduce	-20%	-8%
Diagnostics and clinical support services	Reduce	-11%	+2%
Medicines optimisation	Reduce	-8%	+5%
Core primary care (GMS)	Apply national formula and GPFV requirements		
Extended primary and community services to support proactive out of hospital care	Increase	+17%	+33%
Total		**0.0%**	**+13.0%**

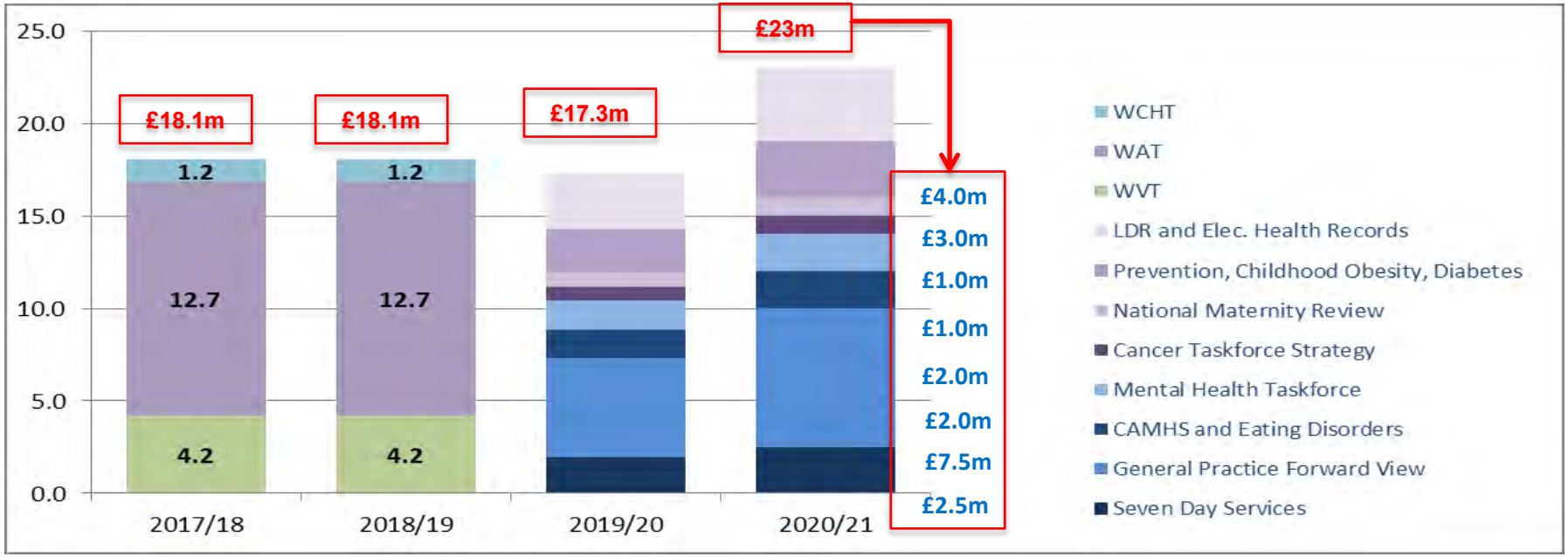
**Ambition for funding growth above inflationary increase*

Investing in change and transformation

Allocating the STF Money

The allocation exercise was also used to inform discussions and prioritisation for use of the transformation element of the STF. These investments will need to be made early in the planning cycle if they are to begin delivering the scale of transformation required to improve services and achieve financial balance. Any risk to our ability to make this investment will severely compromise our ability to deliver a balanced plan by the end of the period.

The chart below shows the initial proposed allocation of the STF transformation element. It shows the funding allocated to providers in 2017/18 and 2018/19 which is included within Provider Control Totals agreed with NHS Improvement. The model assumes £17.3m in 2019/20 to £23.0m in 2020/21 is invested in transformational solutions. It is important to note that this is the initial proposed allocation and may be subject to change as further work is conducted to develop the project delivery plans in each area.



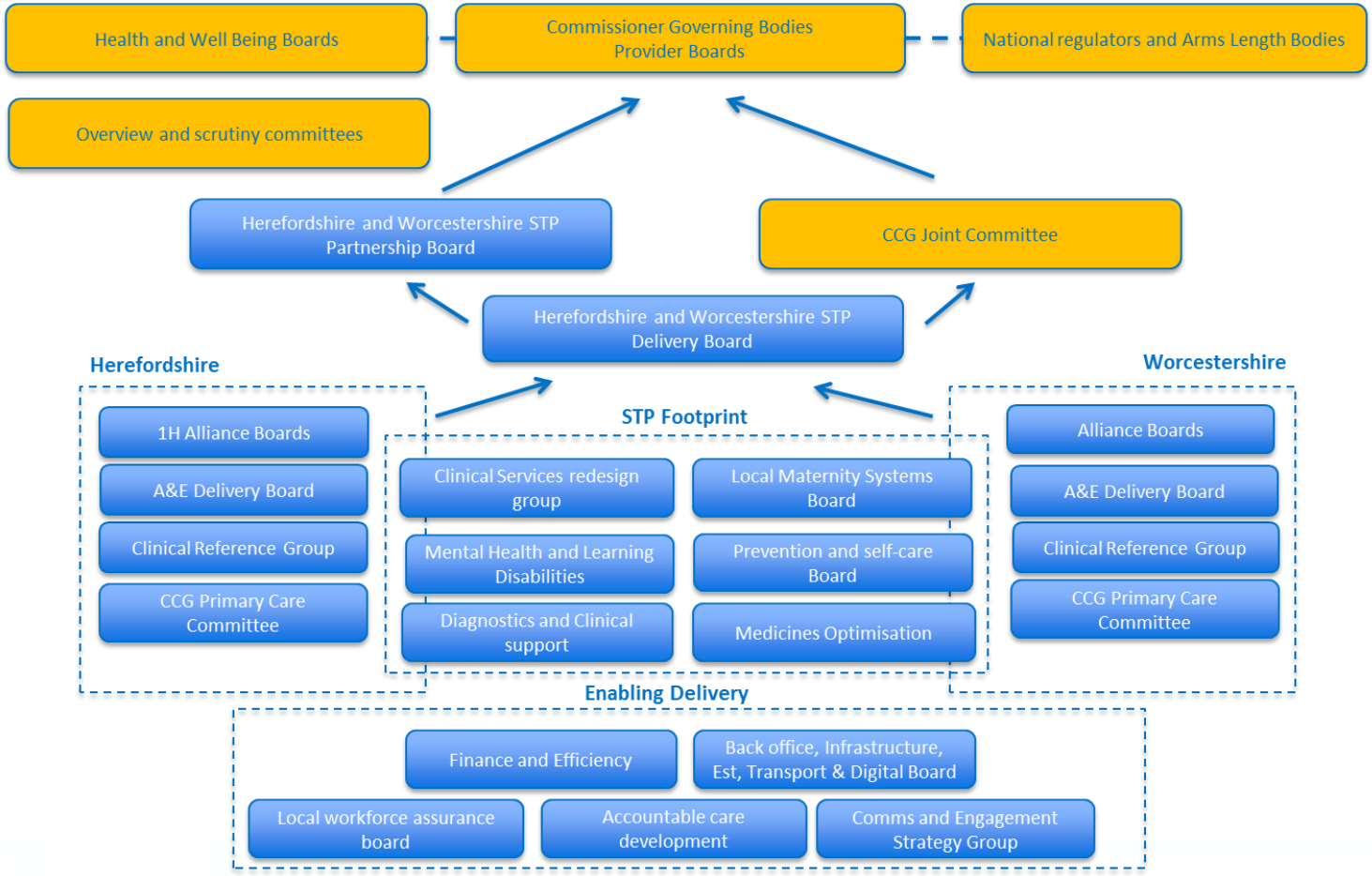
Within the use of this transformation resource there are specific primary care data sharing and governance issues that will need to be resolved.

Our priorities for transformation

Transformation Priorities	Delivery Programmes	Enablers
1 Maximise **efficiency and effectiveness** across clinical, service and support functions to improve experience and reduce cost, through minimising unnecessary avoidable contacts, reducing variation and improving outcomes.	• Maximising efficiency in infrastructure and back office services (annex 1a) • Transforming diagnostics and clinical support services (annex 1b) • Medicines optimisation and eradicating waste (annex 1c)	Develop **the right workforce and Organisational Development** within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face. Invest in **digital and new technologies** to support self care and independence and to enable our workforce to provide, and patients to access, care in the most efficient and effective way, delivering the best outcomes. Engage with the **voluntary and community sector** to build vibrant and sustainable partnerships that harness innovation, further strengthen community resilience and place based solutions. Develop a **clear communications and engagement plan** to set out our strong commitment to involving key stakeholders in the shaping of our plan and describe the process and potential timelines associated with this.
2 Reshape our **approach to prevention**, to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do.	• Embedding prevention in everything we do and investing in 4 key at scale prevention programmes (annex 2a) • Supporting resilient communities and promoting self care and independence (annex 2b)	
3 Develop an improved **out of hospital care** model, by investing in sustainable primary care which integrates with community based physical and mental health teams, working alongside social care to reduce reliance on hospital and social care beds through emphasising "own bed instead".	• Investing in primary care to develop the infrastructure, IG requirements and a new workforce model that has capacity and capability as well as resilience (annex 3a) • Redesigning and investing in community based physical and mental health services to support care closer to home (annex 3b) • Redefining the role for community hospitals (annex 3 c)	
4 Establish **sustainable services** through development of the right networks and collaborations across and beyond the two counties to improve urgent care, cancer care, elective care, maternity services, specialist mental health and learning disability services.	• Investing in mental health and learning disability services (annex 4a) • Improving urgent Care (annex 4b) • Delivering improved maternity care (annex 4c) • Improving elective care and reducing variation (annex 4d & 4e)	

Arrangements for delivering the plan

Governance and delivery arrangements - A robust and inclusive framework has been developed to support the work undertaken to date on developing the STP. There is an independent chair of the programme board, which is comprised of all key organisational leads and stakeholders. Working to the programme board there is a programme management office (PMO) in place that will be enhanced as we move into the delivery phase. There is an STP wide communications and engagement strategy group and there are clinical references groups supporting both counties that will come together to agree on pan STP clinical issues. We will develop an STP wide transformation team to bring together transformation resources across the two counties to work in a more coordinated way. Where it makes sense to do so, programmes will be developed across the STP area, where there are local or geographic imperatives that require local solutions, these are and will continue to be managed within each county's tailored transformation programme structure.



Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
1. STP	• Implement agreed STP milestones, so that you are on track for full achievement by 2020/21. • Achieve agreed trajectories against the STP core metrics set for 2017-19.	STP Priorities 1,2,3 & 4	We have a significant challenge in achieving the system and provider control totals for 2017/18 and 2018/19. In order to achieve the 2017/18 control totals, Herefordshire would need to deliver a combined QIPP/CIP programme of £23.1m and Worcestershire £58.6m Through delivering our programmes of work we will; • Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market". • Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions • Reduce variation in prescribing patterns and increase adherence to approved use of medicines, allowing allocation of additional resource available for new and proven treatments to support prevention and demand control • To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.
2. Finance	• Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector and CCG Sector needs to be in financial balance in each of 2017/18 and 2018/19. • Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. • Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes. • Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.		
3. Primary Care	• Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support and the 10 high impact changes. • Ensure local investment meets or exceeds minimum required levels. • Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors, pharmacists working in general practice by 2020,the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems. • By no later than March 2019, extend and improve access in line with requirements for new national funding. • Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.	STP Priority 3	**Programme 3a: Developing sustainable primary care** • Work with patients to develop improved access to routine and urgent primary care appointments across 7 days a week through roll out of Prime Minister's Access Fund initiatives. • Local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with patients, community pharmacy, third sector and public sector services as well as community and mental health services. • We will implement the "10 high impact areas for General Practice" within and across practices. • With increased capacity within primary care we will work with patient to adopt new ways of working: Moving to a proactive model of care, identifying and case managing through an MDT approach adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access.

Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
4. Urgent & Emergency Care	• Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan. • By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. • Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each county, including a clinical hub that supports NHS 111, 999 and out-of-hours calls. • Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department. • Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.	STP Priority 4	**Programme 4b: Improving Urgent Care** • Improve urgent care pathways to improve access, performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements • Deliver the four priority standards for seven-day hospital services for all urgent network specialist services **Programme 4a: Improving mental health and learning disability care** • Access will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision. • Implement the crisis concordat action plan
5. RTT and elective care	Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). • Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018. • Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups. • Implement the national maternity services review, Better Births, through local maternity systems.	STP Priority 3 & 4	**Programme 3c: The role of community hospitals** • More planned care will be available closer to home, e.g. outpatients and day case, reducing the need to travel for regular appointments **Programme 4c: Improving maternity care** • Citizens will have access to high quality, safe and sustainable, acute, women and neonatal and mental health services, localised where possible and centralised where necessary **Programme 4d: Elective Care** • Two aspects to improving elective care: 1. Effective commissioning policies and stricter treatment thresholds 2. Efficient organisation of services to meet demand, undertake more routine elective activity on a reduced number of "cold" sites
6. Cancer	• Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report. • Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards. • Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. • Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types. • Ensure all elements of the Recovery Package are commissioned	STP Priority 4:	**Programme 4d: Elective Care** • We aim to achieve deliver world class cancer outcomes for our population by delivering the national cancer strategy. This will mean fewer people getting preventable cancers, more people surviving for longer after a diagnosis, more people having a positive experience of care and support; and more people having a better long-term quality of life. • We aim to be better at prevention and deliver faster access to diagnosis and treatment. We aim to achieve consistent access of all cancer treatment standards . • There will be fewer diagnoses made through emergency admission or unplanned care provision and better patient experience of cancer care received.

Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
7. Mental Health	• Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages; additional psychological therapies, more high quality Children and Young people services, treatment within 2 weeks for first episode of psychosis, increased access to individual placement support, community eating disorder teams and a reduction in suicides. • Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals. • Increase baseline spend on mental health to deliver the Mental Health Investment Standard. • Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support. • Eliminate out of area placements for non-specialist acute care by 2020/21.	STP Priority 4	**Programme 4a:Improving mental health and learning disability care** • The requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision will be embedded across our two counties – including crisis care, Mental Health liaison, transforming perinatal care and access standards . • Access to mental health and learning disability services will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision. • Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4 • The services in place will be responding to the health and wellbeing gaps and health inequalities identified. • People who require more tertiary care/specialist support will have their care planned for via managed clinical networks.
8. Learning disabilities	• Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism. • Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population. • Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check. • Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.	STP Priority 4	**Programme 4a:Improving mental health and learning disability care** • Addressing Health Inequalities for people with LD – This is a priority for LD services its aim is to reduce barriers , promote inclusion and therefore increase access to health and social care services. • Transforming care - bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support. • Collaborating across Counties to provide Specialist services more efficiently/effectively.
9. Improving quality	• All organisations should implement plans to improve quality of care, particularly for organisations in special measures. • Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services. • Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.	Priorities 1,2,3 & 4	• There are currently two acute Trusts within STP area which are in special measures. A key component of our STP is to ensure care is delivered of a standard and quality which is acceptable for our population and to the CQC and is on a trajectory to GOOD and aspires to be OUTSTANDING. • An impact of achieving this will be delivering safe, sustainable and productive services through transformation in general practice, primary care, urgent, non-elective and elective care as described in the annexes of this plan.

Key risks and barriers to the delivery of our plan

	Key risk	Mitigation
Delivery	Insufficient redesign and transformation skills to transform the system and design care pathways across the health and care system	Learn from best practice elsewhere including successful individual organisational experience of transformation Core group identified and leading the STP Partnerships with external organisations (Provex, CSU to date , future plan being considered) Establish system transformation programme resource and central PMO
		Identify and maximise the transformation skills we have across the economy and ensure key people are focused on STP priorities
	Lack of sufficient capacity to focus on the change programme	Structure and commitment post 21st Oct submission being explored to transfer core STP work streams into operational plans, Programme Board are focused on capacity being identified
	Failure to maximise the potential for integration	Joint conversations and AO meetings to enable challenge to each other Significant relationship work has been undertaken to build trust
	Do not seize the opportunities presented by collaboration and continue to work in an isolated way	Joint conversations and AO meetings, Best Value challenge agreed at each point
	Programme does not deliver as insufficient focus and capacity agreed within the economy to deliver	Central PMO structure supported to 21st Oct submission but refresh of requirements moving forward currently underway
	Organisations do not commit to the changes and continue to look after self interests	Continued focus on local needs and the need to work differently as a system, national imperative OD plan moving forward to support more joined up working Develop a system risk share arrangement to incentivise system wide, not organisational thinking
	Planning process becomes overly health focused and as a consequence the role of social care, communities and the VCS sector is taken for granted and the associated costs not factored in	Engagement of wide range of partners on the STP Programme Board All SROs to consider this within workstream discussions Review of draft plans to strengthen this aspect Social care and the Voluntary and community sector are actively involved in programme board
	Inability to meet the requirements of the national strategies such as the mental health, maternity, and cancer strategies/taskforces within the resources that will be allocated	Establish clear agreement at STP board level over funding priorities Application of the strategic intent for resource allocation to operational plan development Develop alternative strategies where funding requirements cannot be fully met
Workforce	Insufficient staff are recruited or developed with the requisite skills to deliver the plan	Workstream focus on "World Class Worcestershire " – making system wide roles attractive. Ongoing recruitment processes Ongoing training programmes and collaboration with Universities to shape training for the future
	Retention of staff deteriorates during the changes	Monitoring systems in place to identify deterioration Effective communication and engagement with staff about proposed changes
	Fragility of the domiciliary and residential care market	Local Authorities to review the sustainability of the private domiciliary & residential care market
	Insufficient primary care staff to deliver at the scale required for the future, (42% of West Mids GP workforce expect to retire or reduce hours in the next 5 years)	Primary care workforce strategy Consideration of new roles and extended roles to support a potentially smaller GP workforce in the future

Key risks and barriers to the delivery of our plan

	Key risk	Mitigation
Engagement	Inability to resolve fundamental barriers for primary care relating to indemnity and property liability that will compromise their ability to engage with partners in new models of care or contracting arrangements	Recognition of the significance of the challenge at STP Board Level Continue work to explore resolutions that could be achieved to reduce the risk to individual GP partners On-going discussions taking place nationally to reduce structural barriers
	Insufficient clinical engagement to own and deliver the plan	Clinical engagement to date through reference groups, internal briefings and input into specific workstream discussions Clinical engagement strategy for post Oct being developed
	Insufficient public engagement in the early stages of the plan may undermine support moving forward	Public and community engagement strategy in place. Comprehensive engagement milestones and approaches which recognise co production H&WBB briefed regularly
	Failure to maintain continued involvement and support of staff	Regular briefings / updates on progress to staff Engagement strategy in place
	Wider clinical engagement does not yield support for the plan	Identify and respond as part of the Engagement strategy
Political & Regulatory	Limited or no political support for the decisions	Regular updates to key forums, specific briefings to MPs National recognition of case for change
	Disagreement between regulatory bodies around the key proposals	Regular communication with Regulators about emerging themes
	The limited capacity of leaders could impact on delivery of the transformation required. Compounded by regulatory processes already in place distracting focus	Identify specific leaders for the transformation process who are not absorbed in delivery of regulator actions day to day
Financial	Inability to release the resources from the existing urgent care system to create the ability to invest in scaling up primary and community service investment	Workstreams in place to identify top priorities. Financial support to model impact with CEO oversight
	Savings opportunities identified may deliver less than planned	Continued rolling refresh programme to revise assumptions Governance processes in place to provide oversight and assurance
	In year financial positions deteriorate further	Organisational recovery plans in place
	Insufficient resources allocated to fund the cost of change – Including availability of capital to enable reconfiguration of services	Programme Board oversight of resource requirement at STP level AOs to review internal capacity and how individuals roles and priorities can be aligned to the change and identify where and external expertise will be required and enabled
	Inability to access sufficient transformation funding to drive the changes required to release the longer term benefits, including the investment required to deliver the national must do's	Implement a clear process for developing and assessing robust business cases for proposed changes
	Decisions made in isolation by partners have unintended knock on consequences to other parts of the system and result in cost shunting	Risks to quality will be identified early stage through existing arrangements incorporating quality impact assessments. Key risks around decisions made under the STP will be fully considered at STP board level so they are identified and decisions are taken. Explore new ways of aligning financial incentives and risk share arrangements

Next steps

There are a number of immediate next steps we need to take to move the STP forward:

- Refine the planning and financial assumptions based on the new control totals and STF funding allocations, with a particular focus on years 1 and 2.
- Identify the steps required to address the financial gaps related to the additional CIP and QIPP requirements identified on page 18.
- Develop our plan for stakeholder and public engagement plan to help us co-produce solutions to address the challenges set out in this document.
- Take immediate action and further development of the four key “at scale” prevention programmes.
- Take immediate action on the primary care sustainability workstream to increase resilience in core general practice and prepare for delivery of Primary Care at Scale.
- Continue to develop the new out of hospital integrated care models in each county.
- Participate in the West Midlands clinical review of the implementation of transforming urgent and emergency care services in the West Midlands.
- Seek NHSE support to review specific services and test proposals to address them which have a potential solution beyond the providers within Herefordshire and Worcestershire – eg. Stroke, mental health and cancer.
- Establish the benefits and delivery plan for those benefits of being a rural pathfinder for new ways of commissioning specialised services.
- Explore how we can unlock the benefits of the STP through different contracting models to incentivise delivery and develop partner risk share arrangements.
- Agree the revised governance structure to enable us to complete the planning process and transition into operational planning and contracting
- Commission support to help shape the refinements of specific issues to include :
    - An understanding of the clinical dependencies needed to support an acute service in Herefordshire and the resulting costs, reflecting the challenges of rurality.
    - Undertake further analysis of the bed modelling work and assess the potential for change alongside our ambition to deliver more care at or close to home.
- Continue to develop and implement delivery plans for the five year forward view next steps priorities; Urgent Care, Primary Care, Mental Health, Cancer and integrated care alongside local priorities.
- Put a functional delivery mechanism in place to ensure that the work programmes within the STP are developed and implemented.

Detailed Plans

Name of footprint	Herefordshire and Worcestershire
Region	Midlands and East
Nominated Lead	Sarah Dugan, Chief Executive Worcestershire Health and Care NHS Trust
Contact Email	whcnhs.yourconversationhw@nhs.net

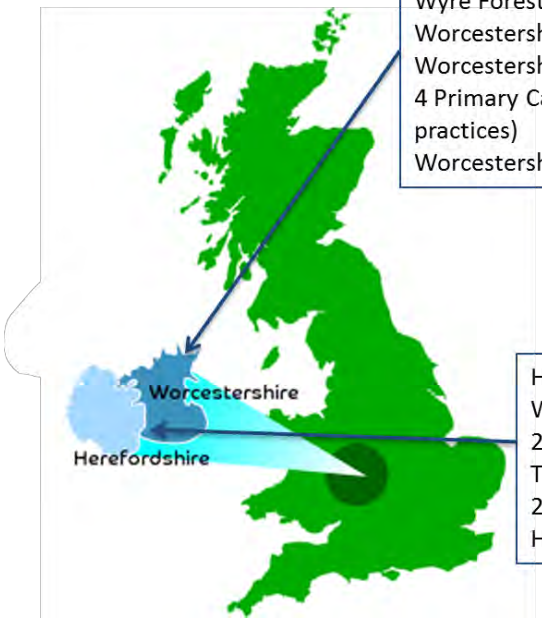
Partners involved	
GP Practices	90
CCGs	4
Acute Trusts	1
Combined Acute and Community Trusts	1
Combined Community and Mental Health Trusts	1
Mental Health Trusts	1
HealthWatch bodies	2
District and Borough Councils	6
Councils with Health & Well Being Boards	2

Key Statistics	
Population	780,000
Area	1,500sq miles
Annual NHS Allocation – 2016/17	£1.168bn
Annual NHS Allocation – 2020/21	£1.327bn
STF allocation in 2020/21	£50m
NHS "Do Nothing" financial gap to 2020/21	£288.1m
NHS Residual Gap after applying national planning assumptions	£61.3m

Herefordshire and Worcestershire

Sustainability and Transformation Plan

5th July 2017



Redditch and Bromsgrove CCG (R&BCCG)
South Worcestershire CCG (SWCCG)
Wyre Forest CCG (WFCCG)
Worcestershire Acute Hospitals NHS Trust (WAHT)
Worcestershire Health and Care NHS Trust (WHCT)
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council (WCC)

Herefordshire CCG (HCCG)
Wye Valley NHS Trust (WVT
2gether NHS Foundation Trust (2G)
Taurus GP Federation (representing 24 practices)
Herefordshire Council (HC)

Contents

Priority 1 – Maximise efficiency and effectiveness

Programme 1a	**INFASTRUCTURE AND BACK OFFICE**	**SRO**	Michelle McKay, CEO Worcestershire Acute Hospitals NHS Trust
Overall aim	Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market".		

What will be different between now and 2020/21

We intend to move to a place based model for commissioning support services, infrastructure and back office which results in the best value
The Back Office and Infrastructure Programme will both deliver improvements in service delivery and savings but will also enable the delivery of other STP work streams.

The key components are:

- **Single Procurement Strategy** - New contracting arrangements over longer time periods and single procurement framework for common services and products across all STP partners where beneficial.
- **Single Place Based Estates Strategy** – enabling co-location and service integration and the release of unwanted property and land. Careful consideration will be needed to see how the primary care estate can be included in this work given the different nature of ownership, financing and liability arrangements in place.
- **Single Transactional Services** – With end to end business processes and administration with joined up support services, commissioned and designed to meet the efficiency and STP programme agenda . – particularly in relation to consolidated approaches with an initial focus on:
    - Finance
    - Payroll
    - Procurement support services through making best use of NHS Shared Services or other competitive provider
- **"Virtual" Single Strategic Estates function** – making best use of collective resources, consistent with the "One Public Estate" ethos (and inclusive of wider partners eg. Police, Fire and DWP). To include considering the extension of Place Partnership Ltd in local NHS Property Management. Specific areas to be explored in wave 1:
    - Hospital Catering
    - EBME (Medical Device Management and servicing)
    - Courier & Taxi Services
    - Hard Maintenance
    - Help Desk
    - Waste Management
- **Joined up Digital Strategy** – with modern integrated technology ensuring 100% Digital Access, and paperless care by 2020 (ensuring all are digitally included and patients are empowered through technology) with a connected infrastructure and joined up access channels, including telephony. Overarching digital strategy which brings together the two Local Digital Roadmaps and future-proofs developments around five key areas: connected infrastructure, improving integration, empowering citizens, working collaboratively, enhancing our understanding.
- **Joined up Transport Strategy** – for patients and service users that ensures transport provision is optimised and a reduction in the number of vehicles on the road.

Priority 1 – Maximise efficiency and effectiveness

Programme 1a	INFASTRUCTURE AND BACK OFFICE	SRO	Michelle McKay, CEO Worcestershire Acute Hospitals NHS Trust
Overall aim	Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market".		

How will this be better for residents and patients in Herefordshire and Worcestershire

Before reviewing the provision of front line services within the STP we recognise the importance of maximising the value and impact, whilst reducing costs of our business support functions.

Through this programme, we aim to:

- **Reduce spend** across back office functions by more than 20% through more efficient infrastructure, organisation and reduced transaction costs. This will include fundamentally changing the way in which local NHS bodies contract with each other, by moving towards population based capitated budgets rather than having an internal market.
- **Co-locate and integrate services** with shared platforms and administration leading to the optimisation of resources across organisational boundaries and reducing unnecessary contacts and journeys.
- Achieve **intelligent estate planning** across the whole "one public estate" to reduce wasted space, enable the sale of surplus land and property and make better use of existing local facilities to support care delivery.
- **Standardise technology applications** to enable a one stop shop approach across all partners , including things like a single Help Desk.
- **Co-ordinate procurement**, bringing efficiency and standard approaches to maximise purchasing power and operational efficiency.
- **Integrate digital care records** to improve clinical management of patients and result in fewer handovers between services and organisations.
- **Coordinate existing transport** provision more effectively to Improve patient access and customer journeys and **Reduce vehicles** on the road and the associated environmental impact
- **Create a common digital infrastructure** with better digital links across organisations bringing enhanced understanding through new ways of data use, leading to earlier intervention and improved outcomes with enhanced and joined up access channels for customers.
- **Joined up channel and telephony** with integrated and effective channels for improved patient access and customer journey resulting in fewer handovers between services and organisations.

All of these programmes of work will provide the opportunity to explore joint working between a range of public sector partners including fire and police

Priority 1 – Maximise efficiency and effectiveness

Programme 1b	DIAGNOSTICS AND CLINICAL SUPPORT	SRO	Michelle McKay, CEO Worcestershire Acute Hospitals NHS Trust

Overall aim	Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions

What will be different between now and 2020/21

There are critical changes to be pursued within the STP. (1) **Amalgamation of pathology laboratory** services across the two counties and beyond and greater functional sharing and consolidation of infrastructure in other clinical support services such as radiology and pharmacy. (2) **Development of agreed system demand management strategies** and delivery mechanisms, with the aim of eliminating unnecessary requests and reducing overall requested activity.

Pathology:

- Early exploration of a consolidated service across both counties.
- Longer term plan to join forces with a larger regional provider or to explore the option of developing a private sector partnership model.

Radiology:

- Development of appropriate direct access initiatives to support ambulatory care outside of acute hospital settings.
- Shared arrangements for out of hours cover and diagnostic reporting.
- Centralisation of specialised services to align with emergency and elective centres.

Pharmacy:

- Development of a single stores, distribution and procurement function across the STP patch
- Options appraisal into medicines supply outsourcing at Worcestershire Acute.
- Other functional service consolidation such as medicines information.

How will this be better for residents and patients in Herefordshire and Worcestershire

- There will be fewer unnecessary requests for diagnostic imaging and laboratory testing, resulting in a reduction in unnecessary exposure to radiation and other harm.
- Workforce and processing of pathology samples will be centralised across a much wider area releasing costs, creating economies of scale and increasing purchasing power. These savings will offset pressures in other front line service areas.
- Patients will be able to access diagnostic services more local to them in their communities for less complex procedures and greater direct access will result in reduced need for unnecessary hospital stays.
- Some more specialised diagnostic services will be centralised in fewer emergency / major elective centres to ensure quality and sustainability of clinical skills.

Priority 1 – Maximise efficiency and effectiveness

Programme 1c	MEDICINES OPTIMISATION	SRO	Simon Trickett, Accountable Officer, RBCCG and WFCCG

Overall aim	To ensure medicines optimisation is integrated across all services to provide safe, cost effective medicines use, reducing variation in prescribing and patient outcomes to secure best value from finite NHS resources.

What will be different between now and 2020/21

- Standardised Care pathways to rationalise choice and place in therapy of medicines used.
- Redesign and recommission services to ensure appropriate prescribing/supply of medicines to address issues identified in the pharmaceutical needs assessment and to optimise outcomes and reduce waste.
- Greater use of IM&T to support appropriate use of medicines at every stage of care.
- Reduced variation in prescribing spend between practices.
- Virtual elimination of spend on low priority treatments.
- Enhancing pharmaceutical skill mix to optimise medicines use across all pathways.
- Improving patient reported outcomes that demonstrate effective medicine use.
- Investment into clinical capacity to implement change and deliver new service models, extending into community services.
- Robust and co-ordinated public engagement and communication strategy to support change messages.
- Significantly enhanced role for community pharmacies, including a review of dispensing practices in light of local population access and the most recent guidance and legislation.

How will this be better for residents and patients in Herefordshire and Worcestershire

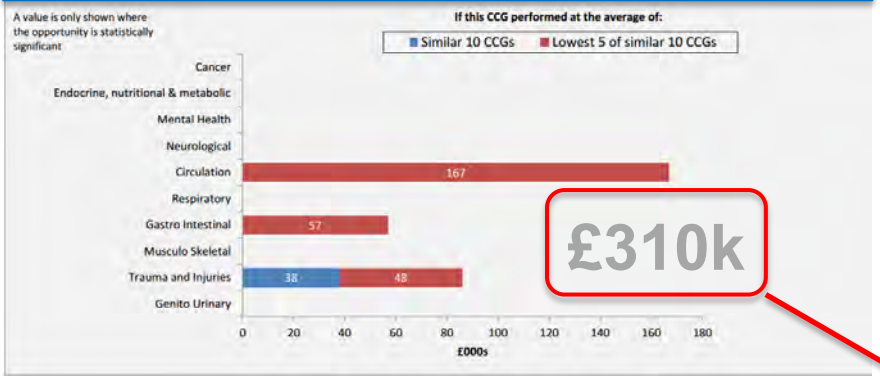
- Transformed access to medicines through service redesign, e.g. off- prescription supply models
- Greater integration and seamless care between all providers.
- Increased reporting of medication reviews across multiple care settings

Priority 1 – Maximise efficiency and effectiveness

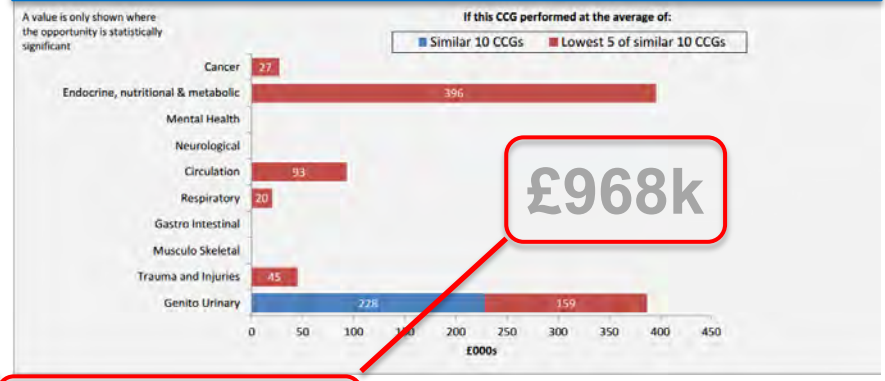
Programme 1c	MEDICINES OPTIMISATION	SRO	Simon Trickett, Accountable Officer, RBCCG and WFCCG

Overall aim	To ensure medicines optimisation is integrated across all services to provide safe, cost effective medicines use, reducing variation in prescribing and patient outcomes to secure best value from finite NHS resources.

Herefordshire



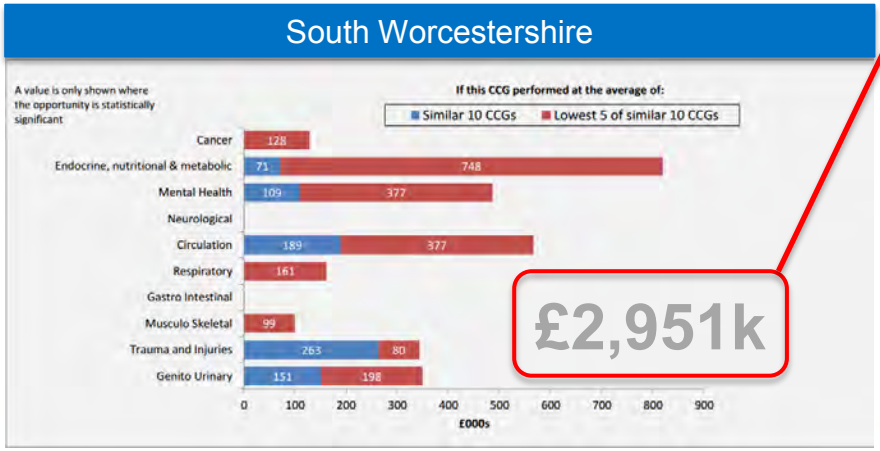
Redditch and Bromsgrove



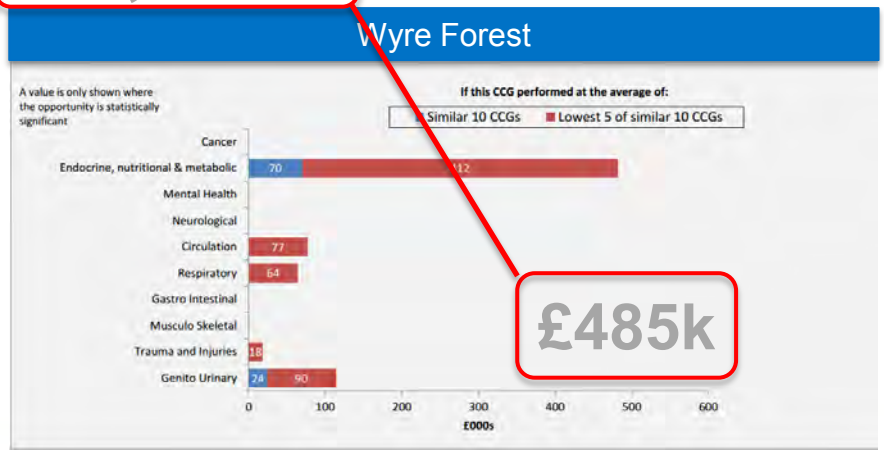
System total opportunity through achieving RightCare prescribing performance of comparable CCGs is a total **of £4.714m**

£4,714k

South Worcestershire

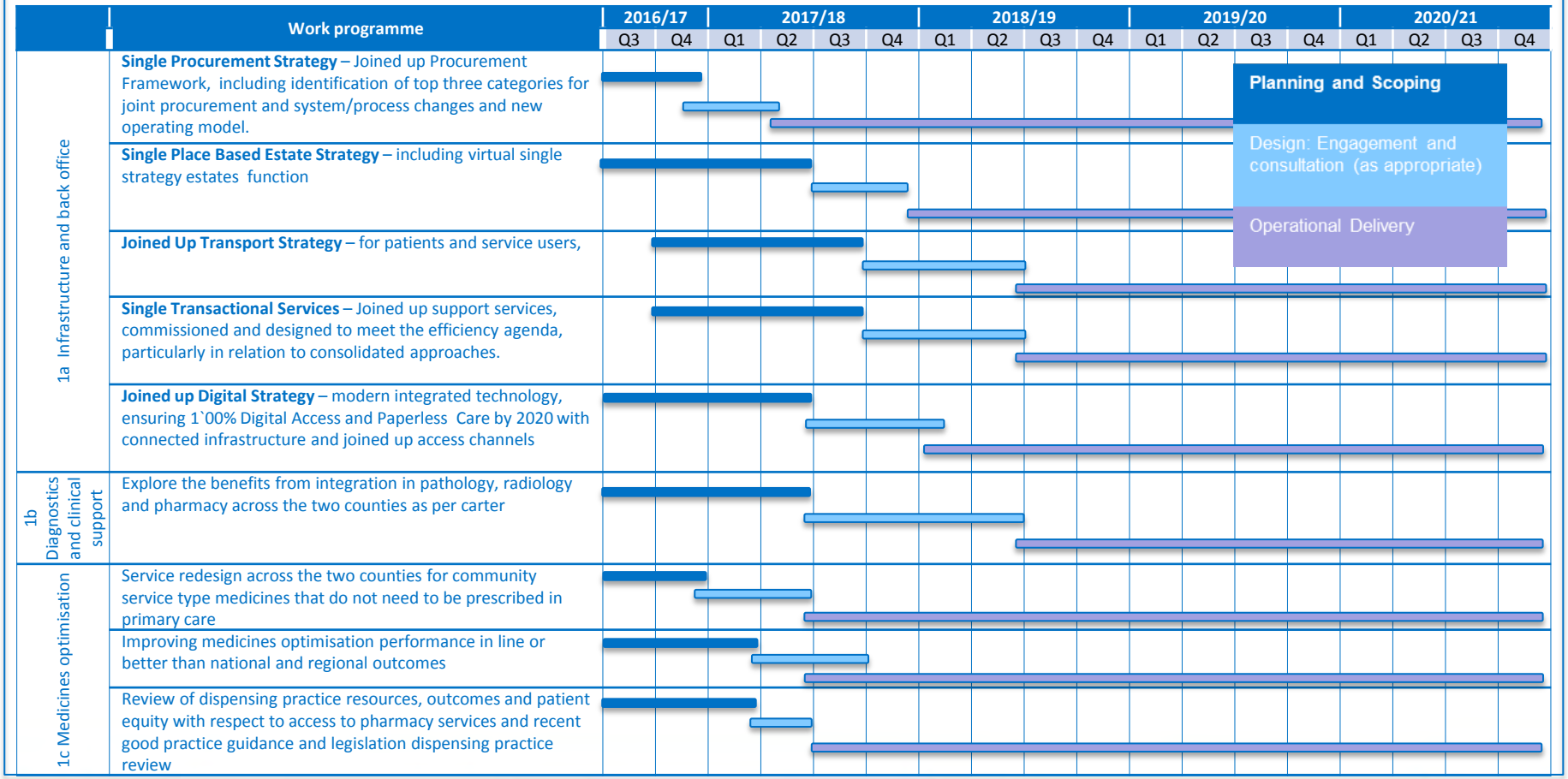


Wyre Forest



Delivery Plan – Priority 1: Maximise Efficiency and effectiveness

Infrastructure and Back Office SRO	**Michelle McKay -** CEO Worcestershire Acute Hospitals NHS Trust	**Programme Lead**	**Pauline Harris -** Programme Manager Worcestershire County Council
Diagnostics and Clinical Support SRO	**Michelle McKay -** CEO Worcestershire Acute Hospitals NHS Trust	**Programme Lead**	**Richard Cattell** – Director Medicines Optimisation & Pharmacy Worcestershire Acute Hospitals NHS Trust
Medicines and Prescribing SRO	**Simon Trickett** Accountable Officer – RBCCG and WFCCG	**Programme Lead**	**Jane Freeguard** Head of Medicines Commissioning WCCG's



Priority 2 – Our approach to prevention, self care and promoting independence

Programme 2a	PREVENTION	Owner	Simon Hairsnape, Accountable Officer, HCCG

Overall aim	To embed at scale delivery of evidence based prevention interventions across the health and social care system, achieving population behaviour change , and improving health outcomes

What will be different between now and 2020/21

Ensure evidence based prevention is delivered at scale across health and social care , working with partners to ensure that prevention is everybody's business.

- We will use the approach to prevention set out in our health and well-being strategies, working with partners to address the causes of ill-health as well as to deal with problems well as soon as they arise
- 4 prevention delivery platforms embedded across all health and social care services:
  - **Social prescribing** - Reducing escalation of conditions, supporting recovery and reducing dependence on services
  - **Making Every Contact Count (MECC) and 'a better conversation' health coaching approach** - Staff work in partnership with patients having a different type of conversation that guides and prompts individuals to be more active participants in their care and behaviour change to achieve goals and outcomes that are important to them
  - **Digital inclusion** - Preventing social isolation and supporting self care and recovery
  - **Lifestyle change programmes** - Focusing on obesity (diet and physical activity) smoking and alcohol harm reduction. National Diabetes Prevention programme rolled out across the two counties, as part of an integrated obesity strategy
- System wide approach to tackling key local issues - Uptake of flu vaccinations in vulnerable groups and carers as well as both systematic and opportunistic immunisation by staff across all service groups, Building resilience in parents and children – Redesigned health visiting, school nursing and family support services. Prevention of Cancer and related Screening - Reducing both the incidence/prevalence of cancer and earlier diagnosis. Prevention of serious injury from falls - contributing to ageing well. Extended healthy life expectancy, and narrowing the health inequalities gap - Elimination of variation between practices
- Developing 'asset rich communities' where local people thrive in a network of families, neighbours and communities, getting involved in activities and organisations for the benefit of all, and where front line staff across the systems are able to link clients to their local assets easily and constructively. Dementia friendly communities – integrating with dementia services to provide dementia friends training and support for Dementia Alliances

How will this be better for residents and patients in Herefordshire and Worcestershire

- Staff are confident in undertaking motivational conversations about lifestyle and able to deliver brief intervention and signposting
- Population behaviour change prevents ill-health - at population level and for individuals
- Reduced levels of preventable disease – in particular those caused by misuse of alcohol, smoking, inactivity and obesity, reducing demand for both elective and non elective services
- Improved self care by patients and their carers – reducing demand for non-elective services and improving patient experience
- Reduced levels of social isolation – reducing demand for services, improving mental well-being and prolonging independence
- Improved community support of individuals and their carers – reducing demand for services and improving well-being

Priority 2 – Our approach to prevention, self care and promoting independence

Programme 2a	PREVENTION	Owner	Simon Hairsnape, Accountable Officer, HCCG

Overall aim

Promoting better long term life outcomes for children, young people and their families' needs to be at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future. It is important to remember that 'Later interventions are considerably less effective if they have not had good foundations' (Marmot Review 2010)

What will be different between now and 2020/21

Best start in life - Focus on full implementation and adequate resourcing of the Healthy Child Programme (HCP) and broader early childhood services offer including;

- Effective early help - to improve the early identification and response to critical issues affecting children and young people's development as well as supporting parenting and socialisation
- 0 to 5 early years in Herefordshire – to improve the health, well-being, developmental and educational outcomes of children aged 0-5 years . Herefordshire is also currently developing and integrated 0-19 service model.
- Through the redesign of the Integrated Public Health Nursing 0-19 Service in Worcestershire, all children, young people and their families on their Starting Well journey will have access to the Healthy Child Programme delivered by skilled community Public Health teams at key development points
- Implement Connecting Families across Worcestershire taking a whole system response in overcoming challenges that prevent and/or delay positive outcomes for children, families and vulnerable individuals
- Vulnerable Groups - focus on vulnerable children and young people across the two counties who are more likely to experience difficulties in their lives and may need support to help overcome them. More can and should be done to address these health concerns through improving the quality of the workforce and range of interventions
- Mental Health - Focus on improving the emotional well being and mental health of children and young people
- Strengthening relationships with the education and skills sector as a key stakeholder in improving outcomes

How will this be better for residents and patients in Herefordshire and Worcestershire

In the short term:

- Improve information and support for children and families to enable self- management and independence
- Increase personalised care planning in partnership with children, young people and their families
- Strengthen information sharing across the system to enable a joined up approach and end to end care pathways
- Increase competency and confidence of staff across all sectors to manage children and young families needs in partnership with their parents
- Improve our 19-25 provision improving access to education for all (including recovery college)

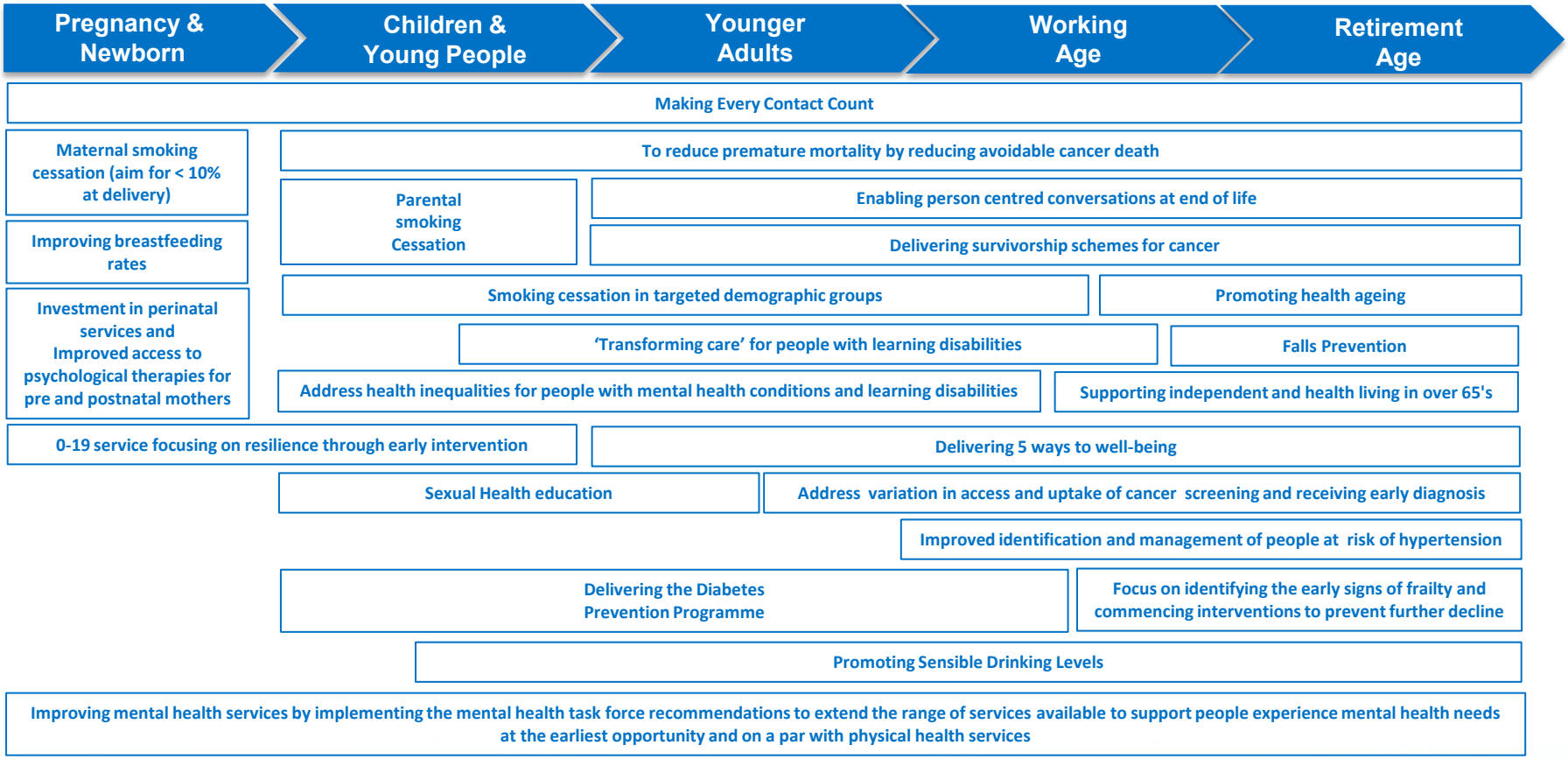
In the medium term:

- Increased choice and control through increased uptake of personal budgets
- Reduced referrals to specialist services
- Reduced out of county placements
- Reduced numbers of looked after children
- Improved educational achievement for vulnerable children and young people including those with SEND
- Reduced NEET and increased young people in education/training
- Improved wellbeing for children, young people and families

Priority 2 – Our approach to prevention, self care and promoting independence

Reshape our approach to prevention, to create an environment where people stay healthy and which supports resilient communities, where self care is the norm, digitally enabled where possible, and staff include prevention in all that they do.

Driving prevention through everything we do; The following diagram demonstrates how we are ensuring that a focus on prevention is inherent across our STP for all age groups and all work streams, delivering an improvement in health and well-being.



Priority 2 – Our approach to prevention, self care and promoting independence

Programme 2b	SELF CARE and PROMOTING INDEPENDENCE	Owner	Simon Hairsnape, Accountable Officer, HCCG

Overall aim	To support people to manage their own health and live independently, linking them with social support systems in their communities and identifying when a non-clinical intervention will produce the best experience and outcomes for patients. This approach should be led by communities with Health, Social Care and the Voluntary Sector working together to support.

What will be different between now and 2020/21

Building on the success of existing self care initiatives will continue to be regarded as a high priority area within the prevention agenda, helping people to stay well. Greater benefits will be realised for local people and staff as the following key interventions are expanded and further innovation applied:

- More individuals will utilise the range of solutions available to manage their condition including information, peer support, informal and formal education, digital approaches (e.g. Map My Diabetes, Patient Management Programme)
- Care planning and self-management will be hardwired into how care is delivered. Care plans will be digital and shared between care settings, owned by and useful for patients, their families and carers (e.g. iCompass)
- People already at high risk of ill health will be identified and offered behaviour change support (e.g. Pre Diabetes Project, Living Well service)
- Social prescribing schemes will be systematic, connecting individuals to non-medical and community support services (e.g. care navigators based in primary care to signpost and link people to social prescribing support).
- Extension of the roll out of national screening tools used to assess an individual's motivation to self care - thus tailoring the needs of the intervention (e.g. Patient Activation Measure)
- Early prevention will be embedded within each service that the person comes in contact with thus proactively supporting self care programmes, reducing social isolation and improving social integration [e.g. Health Checks, Falls Prevention, Strength and Balance classes, Reconnections] tailoring and focussing services on those who have the greatest need.
- We will be working more closely with front line services such as police, the Fire Service and housing agencies to deliver the prevention agenda.

How will this be better for residents and patients in Herefordshire and Worcestershire

Individuals will be increasingly independent, self-sufficient and resourceful to confidently manage their needs, thus reducing dependency on the health and social care system and improve their well-being and lifestyle. Ultimately individuals will:

- Increase their sense of control in their lives
- Feel confident to assess and address their health and well-being needs
- Better symptom management, including a reduction in pain, anxiety, depression and tiredness, reduced stress
- Experience improved health and quality of life
- Are able to live well with any health condition
- Are able to problem solve, make changes and manage their thinking, moods and behaviours positively
- Live as active participants in their communities
- Reduce their use of key services, with fewer primary care consultations, reduction in visits to out-patents and A&E, and decrease in use of hospital resources
- Increase their healthy life expectancy
- Live independently for longer

Every contact with a patient in primary, community and secondary care will be used as an opportunity to improve patient's knowledge of involvement in their care on an individual basis.

Delivery Plan – Priority 2: Our approach to prevention, self care and promoting independence

2 Prevention , Self care and promoting independence SRO	Simon Hairsnape Accountable Officer – Herefordshire CCG	Programme Leads	**Frances Howie** – Director of Public Health, Worcestershire **Rod Thomson** –Director of Public Health, Herefordshire **Menna Wyn-Wright** - Transformation Programme Lead - Worcs CCGs **Jacinta Meighan-Davies** - Clinical Programme Manager HCCG

2 Prevention, Self Care and Promoting Independence

Work programme	2016/17		2017/18				2018/19				2019/20				2020/21			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
SOCIAL PRESCRIBING SCHEMES will be systematic, connecting individuals to non-medical and community support services [e.g. care navigators based in primary care to signpost and link with social prescribing support] and will align to social work practice models which are developing a strengths and community based asset approach.																		
LIFESTYLE BEHAVIOUR CHANGE - More individuals will utilise the range of solutions available to manage their condition including information, peer support, informal and formal education, digital approaches. These will include a strong offer on behaviour change linked to the NHS health checks programme.																		
MAKING EVERY CONTACT COUNT - Front-line staff across the system will be trained with accredited materials to enable them to have motivational conversations with patients and public about lifestyle choice and healthy behaviours , guiding individuals to achieve goals and outcomes that are important to them. Whilst delivering brief interventions and signposting to further support.																		
DIGITAL INCLUSION/INFORMATION – A range of measures will be delivered to increase digital inclusion, so that everyone who wants to is enabled to get on-line and benefit from the digitalisation of services. Care plans will be digital and shared between care settings, owned by and useful for patients, their families and carers. Digital aids and tele-health will be utilised where appropriate.																		
EMBEDDING PREVENTION - Early prevention will be embedded within each service that the person comes in contact. STP clinical work streams will include a specific set of prevention actions thus prevention is core in all that we do. Whilst proactively supporting self care programmes, reducing social isolation and improving social integration, tailoring and focussing services on those who have the greatest need.																		
SYSTEM WORKING – All partners within the system will work together to contribute to identifying problems early and intervening early to stop them from getting worse. This will include partners in fire and rescue, voluntary organisations, and local government including housing providers.																		

Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

Priority 3 – Developing out of hospital care

Programme 3	INTEGRATED PRIMARY & COMMUNITY SERVICES	Owner	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

What will be different between now and 2020/21

Care will be developed and enhanced through the implementation of new models of care, which we will deliver through alliance working as we develop our Accountable Care Systems. We will use the "Primary Care Home" approach, recognising that no one model will work for the range of communities that we serve across Herefordshire and Worcestershire.

In line with the Primary Care Home approach the following has been agreed by primary and community care leaders;

Localities representing General Practice across the STP have come together and agreed to develop a new model of care based on the principles of the emerging vanguards. The local arrangements will be built around natural localities that either already exist or which are rapidly coming together. These localities will range in size from around 35k to potentially more than 150k population. There is widespread agreement about the scope and focus of these localities in bringing together primary, community, mental health and social care services as well as some aspects of acute services that could be more effectively delivered from a community base.

There is agreement that there will need to be some form of infrastructure organisation to enable these localities to operate at the required scale to enable integration with county wide partners, to manage risk as well as to provide economies of scale around back office functions. It is agreed that the localities will have a central role in setting local strategy and priorities, but there is widespread recognition that planning and service delivery will need to be layered – with some consistent county or STP wide pathways operating alongside some very local pathways built around smaller groups of practices.

Priority 3 – Developing out of hospital care

Programme 3a	DEVELOPING SUSTAINABLE PRIMARY CARE	Owner	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

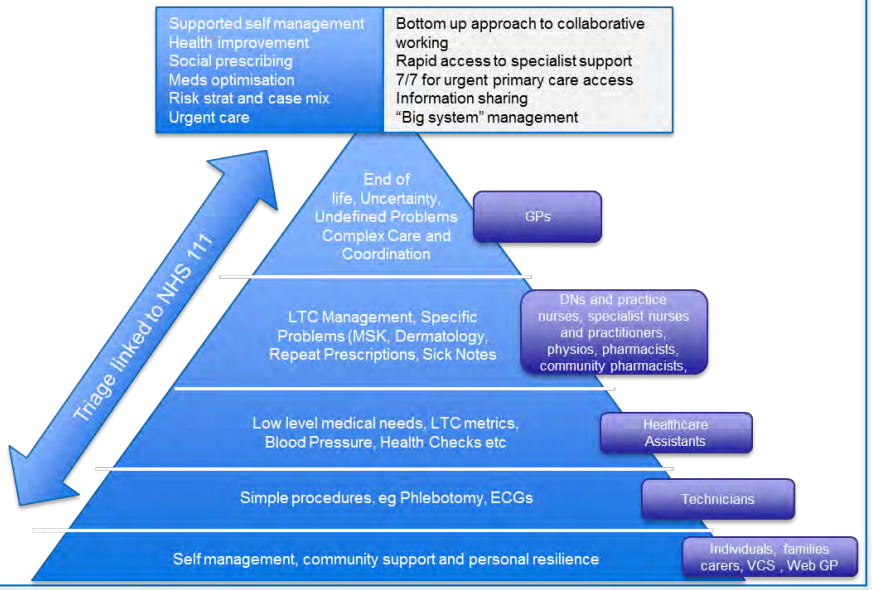
There are a number of fundamental challenges that need to be resolved to support primary care sustainability. Amongst the most significant of these are clinical indemnity, information governance and property liability. Successful delivery of the STP will be dependent on these issues being resolved in a way that enables full engagement of general practice in the new ways of working.

Implementing the GP forward view - Our system has long benefitted from strong primary care which has enabled us to adapt to change. We have a range of federations, including one of the most well developed federations in the country in Taurus. In Herefordshire and South Worcestershire there are already 7 day services delivered to the population. However the ability of primary care to continue to meet the changing needs of our population is at risk. Our approach will include investment from the transformation fund to ensure primary care remains sustainable and at the heart of delivery.

Our out of hospital care models will be based around the GP lists for local populations and this will support a shift of resource to enable out of hospital care to be a reality.

The models will recognise the differing needs across the "continuity of care spectrum" from those patients who absolutely need continuity of care to manage their conditions effectively and efficiently, to those with an episodic need where quick and convenient access is the priority. We will work with localities and practices to identify the "care functions" needed to provide holistic care across the spectrum.

The models will build on what is already working well and will embed social prescribing, health improvement and self-management, utilising digital solutions where possible to provide these at scale and support demand management in primary care. The model will seek to extend 7 day access to high quality primary and community care where needed. It will also deliver proactive anticipatory care, through risk stratification, case finding, case management and an MDT approach. The models are predicated on the sharing of resources and specialist primary care expertise across practices. We will work with localities and groups of practices to develop and implement these using a "bottom up" approach to identify what they will deliver (and be accountable for) at practice level, at locality level or at county level and beyond.



Priority 3 – Developing out of hospital care

Programme 3a	**DEVELOPING SUSTAINABLE PRIMARY CARE**	**Owner**	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

90% of all NHS contacts happen in primary care and it is widely accepted that if primary care fails then the whole health and social care system would be at risk. Therefore developing capacity and resilience in primary care, and particularly in general practice, is a priority for our STP. Resilient primary care with sufficient capacity and capability is also critical to our ability to improve health outcomes and to manage people closer to their own home/in community settings. It is a core building block to the development of our new model of care strategy

What will be different between now and 2020/21

- We will deliver this through local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with community pharmacy, third sector and public sector services as well as community and mental health services.
- Through our GP 5YFV work we will implement the "10 high impact areas for General Practice" within and across practices. This will include:
  - Embedding prevention and health improvement to "Make Every Contact Count"
  - Embedding social prescribing, to connect patients and their carers with community support
  - Training and educating our staff to be able to support self care by patients and carers
  - Utilising digital solutions to enable social prescribing and self-management, as well as new consultation types such as skype consultations and these at scale
- We will encourage all staff to recognise when the end of life is approaching and to have frank and honest conversations with patients and their loved ones and carers. This will lead to development of shared expectations and clear guidance with a view to helping patients take control.
- Through "big system management" we will use real time data collection and analysis to support continuous quality improvement and demand management
- Through primary care at scale we will redesign the primary care workforce to support comprehensive skills and capacity across primary care. Through our alliance working we will deliver this in partnership with acute and community providers through a delivery model that:
  - Enables seamless working across health/mental health community teams, social care and acute services to provide seamless out of hospital care
  - Enables sharing of resources (clinicians and managers) across organisational boundaries
  - Supports professional accountability, clinical governance, line management, education and development across organisational boundaries

Priority 3 – Developing out of hospital care

Programme 3a	**DEVELOPING SUSTAINABLE PRIMARY CARE**	**Owner**	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

What will be different between now and 2020/21

- With increased capacity within primary care we will adopt new ways of working:
  - Moving to a proactive model of care, identifying and case managing through an MDT approach those at risk of ill-health and/or emergency admission
  - Adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access).
- We will build upon the success of our "Prime Ministers Access Fund" pilots to provide 7 day primary care services, including 7 day access to Urgent Care.
- There will be a statute and regulatory compliant data-sharing model initially developed and delivered across Primary Care that will manage the risk of data breach. This will learn from existing service leading models and will need to be formally approved by the regulatory bodies and legal advisors. This will go on to form the foundation of the "Big Data" workstream ultimately sharing appropriate live data, throughout the Health and Social Care organisations in real time based on the point of individual need and express consent.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Improved access to primary care – for example in Herefordshire in 2016/17 an additional 24,106 appointments by the end of 2016/17 through the Prime Minsters Access Fund.
- Confidence that primary care can support their healthcare needs in a timely manner.
- Capacity and capability within primary care to meet their needs.
- Improved experience, and outcomes through support to prevent ill-health and self manage their own conditions.
- Continuity of care provided through consistent access to patient information.
- High quality care at every consultation, with reduced variation within and across practices.
- Resilient primary care, with the capacity to undertake proactive anticipatory care to prevent people becoming unwell.
- Continuity of care for those with complex needs
- Improved access to specialist opinion in primary care settings
- Patients consistently able to access the most appropriate help and support over 7 days, for both elective, urgent care needs and end of life care.

Priority 3 – Developing out of hospital care

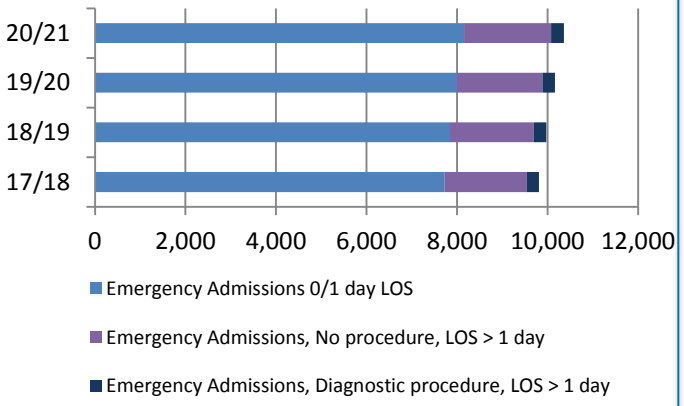
Programme 3b	INTEGRATED PRIMARY & COMMUNITY SERVICES	Owner	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

What will be different between now and 2020/21

- By April 2019 we will have used the Primary Care Home approach to deliver integrated primary and community services through our Accountable Care Systems.
- Our workforce will promote the wellbeing at every opportunity to reduce the impact of long term conditions. There will be a core focus on priorities such as immunisation programmes and falls prevention.
- Traditional organisational and professional boundaries will be removed, and a place-based model of care will be in place.
- The focus of the system will shift to an "own bed is best" model of care, using a proactive approach, optimising opportunities for independence and reducing reliance on bed based care.
- Care will be delivered by an integrated workforce, spanning primary, community, secondary and social care, organised around natural neighbourhoods.
- Local hubs will be developed from existing community sites as part of a coherent and effective local network of urgent care across 7 days, providing a comprehensive rapid response within communities and neighbourhoods – this includes a number of General Practices working collaboratively at scale, releasing GP capacity to care for patients with more complex needs.
- Specialist support will be available nearer to patients, reducing the time taken to access specialist input and reducing steps in the pathway.
- Robust information about patients, carers and their circumstances will be available digitally to all professionals involved in delivering care
- Personalisation of care will be prioritised , supporting self management and improvements in population health, working proactively with wider place based partners around the determinants of health (e.g. housing, leisure , education, employment, community engagement).
- An integrated frailty pathway will be in place which ensures people living with frailty are at the centre of services, enabling them to live well with their condition, age well and supporting them until the end of life. There will be a shift in focus on to what a person can do rather than what they can't do.
- Individual care and support plans will include carer support and encompass emotional as well as physical needs.

The chart below shows the activity that would be removed from the acute sector as a result **of full implementation of an integrated frailty pathway and other admission avoidance schemes** as , By 2020/21 there would be **10,359 fewer** hospital admissions within Worcestershire.

Admissions that will be avoided as a result of the new integrated frailty pathway and other admission avoidance schemes



The chart above shows that the most significant reduction in emergency admissions will be for those where the length of stay is one day or less.

Priority 3 – Developing out of hospital care

Programme 3b	INTEGRATED PRIMARY & COMMUNITY SERVICES	Owner	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

How will this be better for residents and patients in Herefordshire and Worcestershire

- Patients and their carers will be fully involved in the assessment of their needs, and integrated community teams will enable and support them to meet these needs whether they are health or social needs.
- Care plans will be person centred, and reflect specific needs and wishes. The plans should ensure that systems are in place to get help at an early stage to avoid a crisis.
- There will be continuity of care and support, patients will be able to build relationships with staff over time. Care will be delivered in an efficient and timely manner – things happen when they are supposed to and patients will know what to expect, and when.
- With patients permission, information from assessment and care planning is entered on to a digital record, and is shared with everyone involved including the patient. The professionals involved in care talk to each other and work as one team. Everyone has timely digital access to any updated assessments or changes to the care plans.
- Consistent information, is provided to patients and their carers at the right time, and in a format that is easily understood. Patients will have a consistent point of contact if they wish to discuss any concerns.
- Patients will be supported to be independent – our workforce are trained in coaching to enable patients to become more active in managing their own health, wellbeing and care. Staff have time to allow patients to continue to do what they can, make good choices and offer practical support where necessary rather than intervening because its is quicker. Clinicians work in partnership with patients to encourage lifestyle change, support self-management, increase medication compliance and aid complex decision making. This will be measured through Patient Activation Measures (PAMs)
- Patients are empowered to self manage their long term conditions using technology to achieve goals and outcomes that are important to them
- Patients at the end of life will be supported to have conversations about their choices, outcomes of the conversations will be shared and patients will be able to receive their care at home as long as it is safe to do so
- Patients will have one first point of contact in a crisis. It will be clear to the patients who to contact day and night and care will be seamless.
- Teams involved in care will have a comprehensive understanding of the range of formal and informal support available, so that they can offer alternative support where appropriate including from voluntary and 3rd sector agencies who will be part of the community teams.
- Carer's needs are considered – the needs and preferences of my family and other informal carers are taken into account, and they are able to access support to continue to care for as long as they wish.
- Where an admission to hospital is necessary, community teams familiar to the patient will in-reach and manage the discharge into the community and provide holistic support tailored to their needs.

Priority 3 – Developing out of hospital care

Programme 3c	THE ROLE OF COMMUNITY HOSPITALS	Owner	Simon Hairsnape, Accountable Officer, HCCG
Overall aim	To develop community hospitals as local delivery facilities for an increased range of activity including outpatients, day case and support services and also to develop the potential of some sites becoming specialist centres for frailty, stroke care etc		

What will be different between now and 2020/21

- We are engaging with patients, the public, local clinicians and other stakeholders to understand how we can make better use of our community bedded resources to support care closer to home in line with the principle "own bed is best", in line with what the public has told us. A range of activities could be provided from these facilities such as outpatient services and/or elective surgical procedures to support improved local access. Some sites might therefore become specialist centres or be points for new pathways of care (e.g. frailty assessment and specialist stroke rehabilitation).
- Some community hospitals may be able to operate as bedless, e.g. as a "locality hub" for domiciliary based community services integrated with primary care. This may include the co-location and integrated delivery of community teams with primary care based services and/or 24/7 primary care.
- Some community hospitals may be able to operate with a defined role in the system of care, as part of an integrated care pathway and some may need to reduce the number of beds as services are provided in new ways such as domiciliary based care.

How will this be better for residents and patients in Herefordshire and Worcestershire

Our ambition is that any of the benefits of a new role for community hospitals are consistent with those for community services. In addition, our ambition is that:

- The model of care will move from a reliance on bed based care to care in peoples own homes/their usual place of residence, reducing crisis admissions, onward deterioration and poor outcomes at the point of discharge.
- More planned care will be available closer to home (outpatients and day care for example) reducing the need to travel for regular appointments.
- People will experience more of a "one stop shop" in their Locality Hub as their locality teams (including community, primary and social care staff) will all be co-located.
- People who are frail will experience a wrap around response designed to treat and stabilise so people do not have to go into an acute hospital.

We are undertaking this on the principle of co-production with patients, the public and wider stakeholders to ensure we meet the needs of local populations. We will also work with local clinicians to ensure services are integrated and work seamlessly across 7 days.

Priority 3 – Developing out of hospital care

Improving integration between health and social care

In order to transform our services it is essential that we find more effective ways of organising services to respond to the increasingly complex and chronic health and social care needs of our population. This is to reduce duplication as well as to deliver improved outcomes for people and their carers. The evidence indicates that integration results in improved clinical outcomes and a better patient experience (Ref: Stepping up to the Place, NHS Confed and ADASS, 2016). This is supported by our engagement with local people who live with long term conditions and/or multiple needs, which highlights that people want more joined up care. In particular they tell us that the divide between health and social care often impacts on the effectiveness and the efficacy of the support they receive.

We are committed to continue developing services that work in a more integrated way; wrapping the necessary skills and competencies around people and their carers to enable them to live as independently at home for as long as possible. We believe that redesigning services around the needs of individuals in a locality / place presents the best opportunity to improve health and well-being and reduce health inequalities whilst also helping to bring about financial sustainability.

We will use our integrated care plans (Better Care Fund) to drive this integrated front line service delivery, developing and sharing skills and competencies across organisations at locality level, and at larger levels where it makes sense to do so. This includes working with organisations outside the NHS, including public sector partners and the VCS, to meet the totality of peoples needs.

To deliver this we will:

- Improve early and consistent provision of advice and information to individuals, their carers and families, to enable proactive decision making that supports and enables independence and self care
- Offer more choice and control for individuals and their carers, including the wider adoption of Direct Payments/Integrated Personalised Budgets as appropriate
- Embed personalised care planning, in partnership with individuals and their carers, as the central tenet to our ways of working. We will ask' "what matters to you", as well as "what's the matter with you."
- Ensure joined up working across disciplines through the MDT approach, supported by shared information
- Develop a multi skilled workforce that can work across organisational and professional boundaries, whilst identifying tasks which can be shared across professional domains to reduce duplication and improve efficiency
- Work with local communities and the voluntary/community sector, to understand where and how partnership working can support individuals and carers to manage their own health and care needs
- Successful delivery will require us to nurture leadership across our workforces, to drive change in both culture and ways of working across personal and professional boundaries.

Delivery Plan – Priority 3: Developing out of hospital care

Primary Care SRO	**Graeme Cleland** Managing Director - Taurus Healthcare	**Programme Lead**	**Lynda Dando –** Director of Primary Care , Worcestershire CCG's **Lesley Woakes -** Director of Primary Care, Herefordshire CCG
Integrated Care SRO	**Sarah Dugan** CEO Worcs Health and Care NHS Trust	**Programme Leads**	**Sue Harris –** Director of Strategy Worcs Health and Care Trust **Matt Stringer –** Strategic lead new models of care WHCT **Alison Talbot-Smith –** Director of Transformation for One H **Nisha Sankey –** Associate Director of Transformation WCCGs
Community Hospitals SRO	**Simon Hairsnape** Accountable Officer – Herefordshire CCG		

	Work programme	2017/18 Q1	Q2	Q3	Q4	2018/19 Q1	Q2	Q3	Q4	2019/20 Q1	Q2	Q3	Q4	2020/21 Q1	Q2	Q3	Q4
3a Developing sustainable primary care	Prioritise investment to ensure delivery of the General Practice Forward View – develop primary care at scale 'bottom up' and enhancing the role of wider primary care, including community pharmacy, ensuring stability in the longer term																
	Create an environment that enables sharing of resources, focused on 'Out of Hospital Care' (clinicians & managers) across organisational boundaries																
	Moving to a proactive model of care, identifying & case managing, potentially through an MDT approach, those at risk of ill health and/or emergency admission																
	We will, where required, create 'legally compliant' information across the Primary Care Community. This will include practices & other providers (where statutory compliance is achieved), to enable seamless care wherever patients enter the system																
	Through 'big system management' type activities, we will use real time data collection & analysis to support continuous quality improvement and demand management focusing on the future																
	Delivery of improved access to routine & urgent primary care appointments across 7 days a week through roll our of Prime Minister's Access Fund Initiatives																
	We will implement the '10 High Outcome Areas for General Practice' within and across practices																
	Adopting and deploying a contractual model (MCP/ACO) pan STP that will promote early clinical assessment within a robust framework directing patients to the most appropriate clinician underpinned by the 'Six Rights'																
3b Integrated primary & community services	Through the Worcs Alliance Boards, develop population based integrated teams																
	Through the One Herefordshire Alliance, develop population based integrated teams																
	Embed the integrated out of hospital care model into the development of our ACOs																
	Develop integrated frailty pathways in both counties																
3c Community Hospitals	Co-design options for change with patients, the public, local clinicians and other stakeholders to support care closer to home, based on the principle that "own bed is best".																
	Implement any resulting changes to inpatient beds, community based "hubs" and increased in planned care in community hospitals																

Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

Priority 4 – Establish clinically and financially sustainable services

Programme 4a	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

What will be different between now and 2020/21

We aspire to meet the requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision across the two counties. In order to achieve this aspiration, as partners across the system, we have agreed to prioritise investment in mental health services where financial circumstances permit.

We will work on the following priorities:

- A specific focus on Perinatal care as it delivers immediate benefits and evidence-based Mental ill-Health prevention.
- Increased access to psychological therapies for a range of common mental health disorders and the management of 'Medically unexplained symptoms' to reduce demand within acute and primary care.
- Strengthened management of people with dementia in acute urgent care systems and primary care at scale.
- Increased visibility, awareness and acceptability of mental health through a high profile Mental Health Cabinet focused on delivering integration rather than isolation.
- Collaboration to deliver a range of care more locally at an STP/STP Plus level i.e. Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4 CAMHS, Locked Rehabilitation, Complex Dementia services, eating disorder and personality disorder services.
- Moving mental health care from Good to Outstanding with immediate priorities for delivery focused on talking therapies (IAPT) and Early Intervention Services (EIS).
- We will conduct coordinated work on reducing stigma through campaigns and communications.

Through delivering these priorities:

- There will be better access to mental health and learning disability services at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision.
- Services will be responding to the health and wellbeing gaps and health inequalities identified within the Herefordshire and Worcestershire JSNA's and resultant Health and Wellbeing Strategies.
- Through *Transforming Care* - we will be bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support.
- People who require more tertiary care/specialist support will have their care planned for and provided across the STP and in partnership with neighbouring STPs via managed clinical networks.
- We will reduce expenditure in other programme areas, such as urgent care and complex care (ie CHC and social care packages) from the increased investment in mental health and learning disability services.

Priority 4 – Establish clinically and financially sustainable services

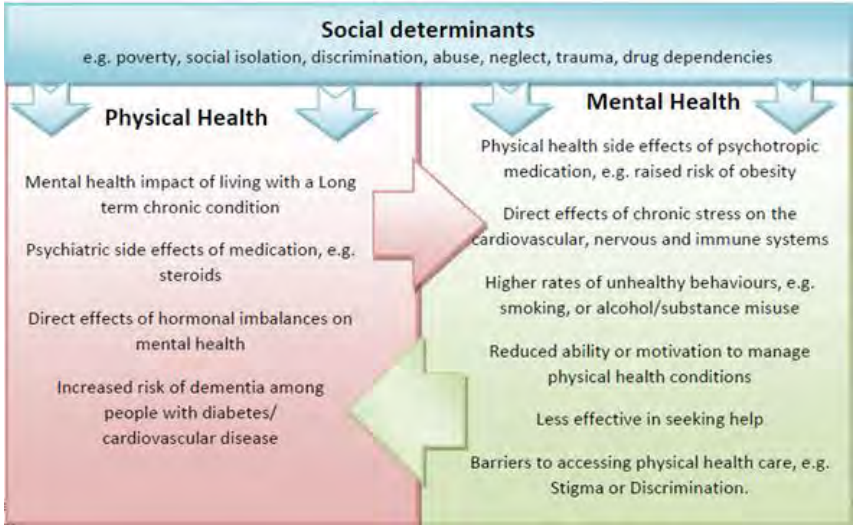
Programme 4a	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Citizens will have better access to information that promotes and supports positive mental wellbeing – social prescribing, MECC, digital inclusion and lifestyle change programmes – can all impact in the short to medium term. Longer term, tackling social deprivation through economic regeneration and the creation of healthy jobs has a significant role in improving population mental health and well being.
- The population's attitudes to individuals experiencing both common and more complex mental health difficulties will be better informed, more supportive and less stigmatised. This in turn will support earlier access to wellbeing services, diagnostics, treatment and better support and opportunities for recovery.
- Individuals who experience physical and mental health co-morbidities will experience well coordinated, education based packages of care that promote and enable self care and minimise the complications associated with comorbidities.
- Fewer people will need to access specialist services outside of the two counties.
- Improved rates of access to or sustained education, training and or employment consistent with local rates of whole population attainment.
- Improved access to and sustained stable accommodation consistent with local rates of whole population attainment.

Relationships between Social Determinants, Physical health and Mental health Adapted from "No health without mental health" by Prince et al in 2007



Priority 4 – Establish clinically and financially sustainable services

Programme 4a	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

Risks to delivery

There are a number of delivery risks to be addressed in order for us to deliver our shared ambition to make parity of esteem a living reality for the people of Herefordshire and Worcestershire. Predominantly we have to be able to address our immediate financial challenges and create the headroom to invest in improved services in line with the MHFYFV priorities. This will be challenging in the early years of the STP but we will continue to pursue the aspiration to prioritise investment in future planning cycles. To start this process off, we are commissioning a specialist review to examine existing expenditure patterns in order to explore opportunities to reprioritise current resources. This will include:

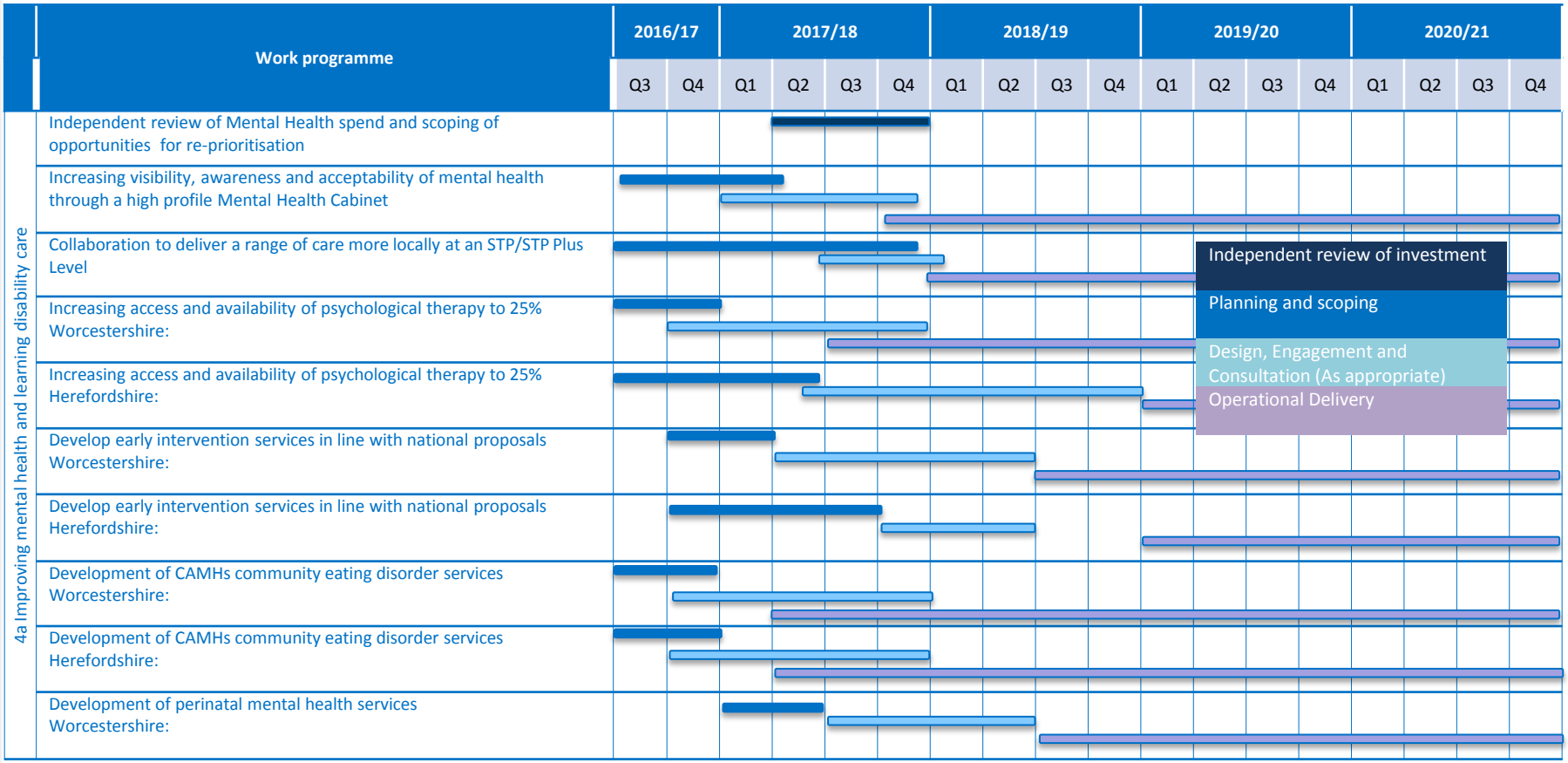
- Developing a plan that identified how to deliver core 24 standards in crisis care and MH liaison.
- Redesign early intervention services to extend age range and skills profile
- Review peri-natal pathways and opportunities to deliver STP wide service
- Develop a personality disorder service
- Develop more local CAMHS tier 3.5 and 4 service
- Develop a complex dementia service

Many of our services are rated highly by regulators and service users alike, and we are committed to maintaining and improving quality and supporting people to live healthy and fulfilling lives. As with other service areas, the ability to recruit and retain the right number and calibre of staff has a significant impact on the sustainability and development of services, and so our workforce development plans are therefore a key priority.

We are committed to adopting the early recommendations from the Kings Fund Evaluation of the New Models of Care, namely that mental health is a core component of all of our STP workstreams, especially in the design of Neighbourhood Teams and embedding of prevention initiatives. Therefore we will seek to involve patients, service users and carers early in the design process to develop mental health metrics that reflect outcomes, activity and quality of provision. Across our STP developments we will look to strengthen mental health capabilities in the primary and community health workforce by improving the confidence, competence and skills of GPs, integrated care teams and others and ensure that professionals involved in new models of care have protected time to provide an educational function to other members of staff, in order to share learning between health professionals working in physical and mental health.

Delivery Plan – Priority 4:Establish clinically and financially sustainable services

Mental Health & Learning Disabilities SRO	**Shaun Clee** - Chief Executive 2gether NHS Foundation Trust	**Programme Lead MH** **Programme Lead LD**	**Colin Merker** – Director of Service Delivery, 2gether NHS Foundation Trust **Liz Staples** – Deputy Director of Nursing ,Worcestershire Health and Care NHS Trust



Delivery Plan – Priority 4:Establish clinically and financially sustainable services

Mental Health & Learning Disabilities SRO	**Shaun Clee** - Chief Executive 2gether NHS Foundation Trust	**Programme Lead MH** **Programme Lead LD**	**Colin Merker** – Director of Service delivery 2gether NHS Foundation Trust **Liz Staples** – Deputy director of nursing Worcestershire Health and Care NHS Trust

4a Improving mental health and learning disability care

Work programme	2016/17		2017/18				2018/19				2019/20				2020/21			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Development of perinatal mental health services Herefordshire: *(To be agreed following independent review of investment)*																		
Development of crisis care and National Standards for Core 24/7 mental health urgent care services. (NB: small extended hours service currently in place) Worcestershire:																		
Development of crisis care and National Standards for Core 24/7 mental health urgent care services. (NB: small extended hours service currently in place)Herefordshire: *(To be agreed following independent review of investment)*																		
Development of CAMHS emergency, urgent and routine pathways																		
Development of dementia services – with a focus on early intervention, strengthened VCS links and interface with frailty pathway																		
Development of acute mental health care – reduce the need for admissions out of area and the number of re-admissions																		
Development of integrated mental health and physical health care pathways in line with alliance developments																		
Development of personality disorder services Worcestershire:																		
Development of personality disorder services Herefordshire:																		

Independent review of investment

Planning and scoping

Design, Engagement and Consultation (As appropriate)

Operational Delivery

Delivery Plan – Priority 4:Establish clinically and financially sustainable services

Mental Health & Learning Disabilities SRO	**Shaun Clee** - Chief Executive 2gether NHS Foundation Trust	**Programme Lead MH** **Programme Lead LD**	**Colin Merker** – Director of Service delivery 2gether NHS Foundation Trust **Liz Staples** – Deputy director of nursing Worcestershire Health and Care NHS Trust

4a Improving mental health and learning disability care

Work programme	2016/17		2017/18				2018/19				2019/20				2020/21			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q 4
Development of adult ADHD pathways subject to investment profile																		
Development of adult autistic spectrum disorder and neurodevelopment pathways subject to investment profile																		
With local authorities, develop joint outcomes and shared care for people with learning disabilities																		
"Transforming care" for people with learning disabilities – to reduce the number of people accessing services out of area																		
Improving rates of access to or sustained education, training and or employment - for people with learning disabilities - reducing health inequalities																		

Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access, performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Introduction

Delivery of high quality accessible urgent care services is a high priority for the populations in both Herefordshire and Worcestershire in terms of speedy access to the most appropriate services and of the experience of individuals entering the urgent care system. There are a number of key challenges that need to be tackled over the life of the STP, the most pressing challenge across both counties is to address the poor performance in terms of meeting the four hour emergency access standard. Acknowledging recent national guidance i.e. NHSE Urgent and Emergency Care delivery plan 2017, both Herefordshire and Worcestershire have reviewed and enhanced its local plan with actions to improve the emergency access standard. For the STP this reinforces the need to develop more effective streaming of patients to the most appropriate urgent care access point and to continue to improve lean patient flow through the system.

How will this be better for the residents and patients of Herefordshire and Worcestershire

- Communities will be able to access more convenient alternatives to hospital based urgent care services, such as community pharmacies which are closer to home
- People will have better access to primary care support and advice for their urgent care needs, 7 days a week (see priority 3A)
- Investment in public education to help communities navigate the new services, making it easier to get the right care, first time by the right person
- Patients who are at heightened risk of emergency admission will have their care more coordinated to reduce the likelihood of a crisis occurring
- Less patients will be admitted to acute hospitals, meaning they can receive care closer to home and remain in more familiar surroundings
- Patients who require emergency care from acute and/or mental health specialists will be quickly assessed and streamed into the most appropriate management, with fewer delays
- Patients receive supported discharge from hospital into an appropriate community environment, once the acute phase of their care is over
- Waiting time performance for access to key services – such as response to 999 calls and 4 hour waits in A&E will be significantly improved

There are many important aspects to our STP strategy for achieving this, namely:

- Integrated Urgent Care - Review of urgent care physical access points
- Development of seven day services
- Improving flow within hospitals
- West Midlands Urgent and Emergency Care network review
- Improving stroke services
- Designing an urgent care workforce fit for 2020/21

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

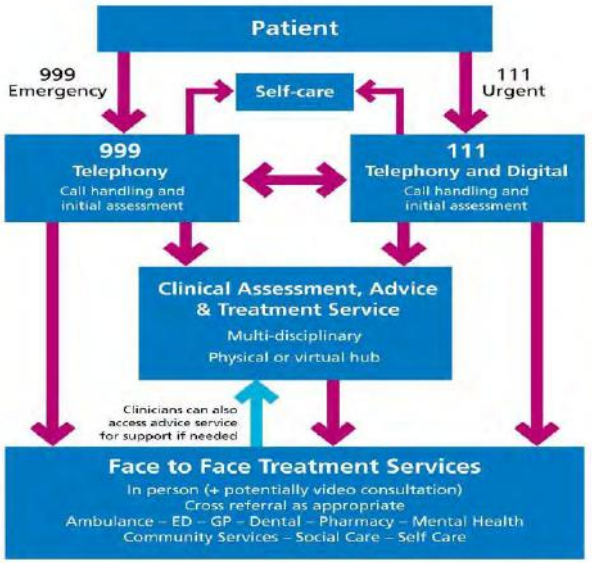
Introduction

Integrated Urgent Care - Urgent Care systems across both counties already provide 24/7 access for patients that need it. There are three 24/7 Accident and Emergency Departments, two 24/7 Minor Injury Units, 24/7 support and referral mechanisms through NHS111 and of course, accessible ambulance services through 999. In addition to this, although not operational 24/7, there are GPs working in one A&E in Worcestershire 8 hours a day on weekdays and 12 hours a day on weekends and GPs working with the ambulance service 12 hours a day on weekends and bank holidays. All of these services combine to provide a comprehensive urgent care offering. However, we recognise that we can do more to integrate services more effectively.

CCGs in both counties now have a newly commissioned Integrated Urgent Care Service, as part of the West Midlands service that went live on 8th November 2016. This new model provides a single point of access and clear onward referral arrangements to improve patient experience and to try and alleviate pressures across the health and social care systems. The model includes earlier clinical assessment and advice through the introduction of a clinical hub and supports closer working with the wider range of existing urgent care providers. The next phase of the development is looking at the expansion of the clinical hub; a number of pilots across the region including a Care Home HCP Support Line and the introduction of a Paramedic Support Desk by September 2017.

Within Worcestershire Care UK was selected to deliver both the NHS111 (for the WM Region) and the Out of Hours service (locally), ensuring that the opportunities for integration are maximised. Within Herefordshire, whilst different providers were selected for the two services, both are required to operate to a service specification that is built around effective integration between the two services under an Alliance Agreement.

The New Integrated Urgent Care Model
From November 2016 onwards



Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Review of urgent care physical access points - Alongside the new integrated urgent care model, we need to review physical access to urgent care services and the provision of specialist facilities – including the number of hospital beds required to support the demand. Changes to physical access is required because the system simply contains too many options, too much duplication; is too confusing for patients and the population and professionals to navigate effectively:

The complex array of ways to access urgent and emergency care across Herefordshire and Worcestershire

Current Provision	Herefordshire	Worcestershire
Telephone access	**NHS 111 and 999**	**NHS 111 and 999**
Main A&E departments	**Hereford**	**Worcester and Redditch**
Minor Injury Units	**Ledbury** (7 days / 24 hours a day) **Kington** (7 days - *8am to 8pm)* **Leominster and Ross on Wye** (5 days, 8:30 to 5:30)	**Kidderminster** (7 days / 24 hours a day) **Evesham, Malvern and Tenbury** (7 days, *9am to 9pm)* **Bromsgrove** (*Mon-Fri – 8am to 8pm, Weekends – 12pm to 8pm)*
Walk In Centres	**Hereford** (*7 days a week – 8am to 8pm)*	**None** (*Worcester's was closed in 2014)*
GP Out of hours hubs (dial NHS 111)	**Hereford, Leominster and Ross on Wye** *Weekdays - 6:30pm to 8:00am,* *Weekends – 24 hours a day*	**Evesham, Malvern, Kidderminster, Redditch, Worcester** *Weekdays - 6:30pm to 8:00am,* *Weekends – 24 hours a day*
Prime Minister's Access Fund/ single points of access for patient flow	**Primary Care Access Hubs in Across Hereford, Leominster and Ross on Wye** *Mon-Fri 6.30pm to 8pm, Weekends 8am to 8pm*	**Clinical Contact Centre in South Worcestershire (Telephone and face to face)** *Mon-Fri 8am to 8pm, Weekends 8am to 12 noon* **Patient Flow Centre to navigate professionals to the correct discharge to assess pathway**
GP Practices	**24 Practices** *Mon-Fri 8:00am to 18:30pm*	**67 Practices** *Mon-Fri 8:00am to 18:30pm*

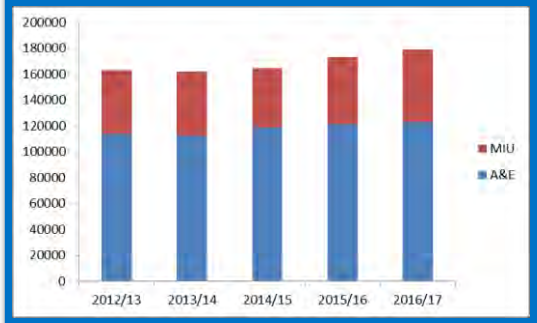
Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Review of urgent care physical access points– A&E and MIU Attendances during the last five years

A&E and MIU Attendance Trends - Worcestershire



Trend over 5 yrs

A&E = +7.8%

MIU = +14.1%

Amb conveyed patients to A&E +26.5%

A&E and MIU Attendance Trends - Herefordshire

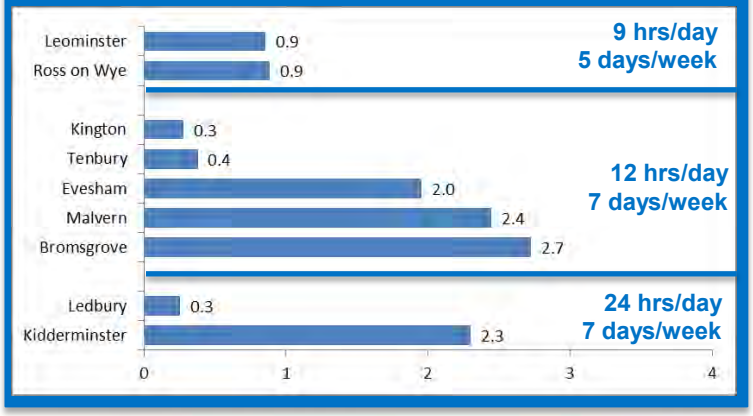
Trend over 5 yrs

A&E = +12.2%

MIU = +15%*

From 2013/14 otherwise opening hours not comparable

Average number of MIU attendances per hour open



- Activity in urgent care facilities has increased over the past five years across both counties. In Herefordshire the growth has been higher in the main A&E department than it has been in Worcestershire.
- Usage of MIUs varies significantly across the two counties, with not surprisingly, the busier units being based in larger population centres.
- There is a clear need to review the demand and capacity match and specification across all MIU sites to ensure that best use of resources is obtained from the facilities that are provided.
- Through implementation of the integrated urgent care model we expect to see this recent annual increase in demand mitigated initially before seeing actual reductions in later years of the STP as the service becomes embedded.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Review of urgent care physical access points – Emergency Admissions during the last five years

Emergency Admission Trend - Herefordshire

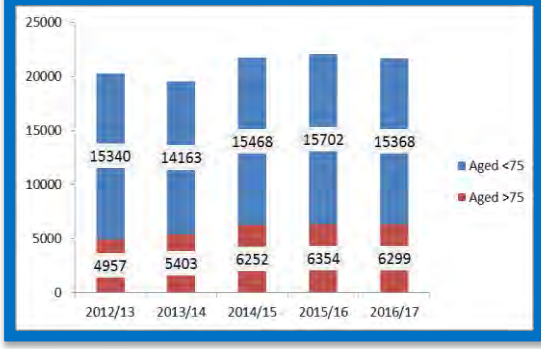
Trend over 5 yrs
Emergency admissions have increased by 6.7% over the last 5 yrs, but have steadied this year

Emergency Admission Trend - Worcestershire

Trend over 5 yrs
Emergency admission have been flat over the period, but there has been a 6.8% increase in >75 admissions this yr compared to last yr.

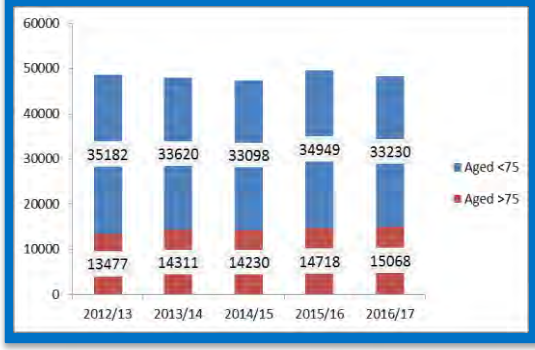
Successful delivery of our strategy to improve out of hospital care will relieve pressure on main A&E departments and the need for emergency admissions.

Emergency Admission Trend – Herefordshire Age Group



Trend over 5 yrs
>75 admissions have increased by 27% over the period and now represent 29% of all emergency admissions

Emergency Admission Trend – Worcestershire Age Group



Trend over 5 yrs
>75 admissions have increased by 12% over the period and now represent 31% of all emergency admissions

2016/17 extrapolated from first 6 months and previous annual profiles

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Implementing the seven day service standards

We intend to achieve roll out of the 4 priority clinical standards during 2017/18:

Standard	Our Baseline	Our Plan
2 - Time to consultant review Demonstrate evidence there is a clinical patient assessment by a suitable consultant and a first consultant review within 14hrs,7 days a week.	Target Compliance – 100% Current Compliance – 43.9% (Worcs), 40% weekdays and 70% weekends (Hfds)	All patients admitted through emergency portals will be reviewed by a consultant within 6 hours, supported by AEC and OPAL services.
5 - Access to diagnostics Access to diagnostic services 7 days a week for x-ray, ultrasound, CT and MRI, echocardiography, endoscopy, bronchoscopy and pathology.	Currently mainly 'day time' access to a number of these services x-ray available to Emergency Departments 24/7. Target Compliance – 100% Critical Care Current Compliance Within one hour – 100% Urgent Care Compliance Within 12 hours – <50%	95% of all patients requiring access to diagnostics will receive this within 12 hours Direct access to a range of diagnostics will be available for GPs to support admission avoidance
6 - Access to consultant-directed interventions Hospital inpatients have timely 24 hour access, 7 days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements.	Currently quite a traditional model of consultant availability prevails with ad-hoc GP to consultant telephone consultancy. Target Compliance – 100% Current Compliance – 33%	To utilise consultant telephone support for urgent care within agreed pathways to AEC, OPAL, hot clinics , direct diagnostics. 24/7 service for cardiac pacing across Herefordshire and Worcestershire to be developed.
8 - On-going review Patients on the AMU, SAU, ICU and other high dependency areas are seen and reviewed by a consultant twice daily. General ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours.	Target Compliance – 100% Twice daily ward rounds Current Compliance – 29% (Worcs.), 90% compliance (Hfds)	By March 2018 twice daily ward rounds will be undertaken on MAU, SCDU and ICU with 90% compliance 7 days a week.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

As part of the West Midland Urgent and Emergency Care Network we expect to participate in a fundamental re-organisation of our existing urgent care system. In line with national guidance we aim to secure, for all patients with urgent care needs, a highly responsive service that provides care as close to home as possible and for those patients with more serious or life threatening conditions we will ensure they are treated in centres with the right expertise, processes and facilities to maximise their chances of survival and a good recovery. Key aspects will be:

- Working collaboratively with all system partners to further develop our A&E delivery board plan, clearly defining 'what good looks like', with clear mapping & matching of demand and system capacity and clearly understood outcome measures. Refresh to be undertaken beginning of November
- As part of this strategy we will include the further development of seven day services, including a comprehensive workforce plan to support urgent and patient flow.
- Building on the digital infrastructure across Herefordshire and Worcestershire, we will ensure all urgent, emergency, physical and mental health partners are connected and that effective and prompt communication underpins and facilitates excellence in urgent care and end of life care.
- Reducing hospital admissions through the local adoption of well proven methodologies; e.g. reducing care home admissions, remote monitoring
- Improving flow in hospitals through streaming at the front door and more timely access to speciality medicine
- Influencing the regional ambulance commissioning strategy to ensure the provision of an 'urgent care' model of ambulance provision with ambulance clinicians increasing their use of hear and treat and see & treat, making better use of alternatives to ED and therefore reducing ED activity and emergency admissions
- Continuing to progress current improvement initiatives
  - Urgent Care Connect
  - Review of ED GP support/streaming at the front door of A&E
  - Implementation of frailty pathways that maximise independence
  - NHS 111 - Increased referral to clinical advisors and defined links to care homes to promote alternate pathways
  - Improving patient flow; further defining the capacity required for D2A pathways and Trusted assessor models
  - Reviewing and updating escalation and de-escalation plans, focusing on cross system escalation and rapid de-escalations actions.
  - Exploring benefits of further integration of access points into one single point of access for professionals within Worcestershire

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

Given our STP geography and system challenges, there are different but related review areas that we will need to explore locally to address our immediate pressures. These will need to be explored as part of the next phase of redesign and it is important, at this early stage, to identify their potential impact:

- **Review area 1** – Better use of telephone review (NHS 111 or local streaming through clinical contact centres), web based services and clinical navigation in providers to ensure people can either self- direct or are directed to the most appropriate facility. This action is core to our strategy and will be supported through the implementation of the new Integrated Urgent Care Pathway
- **Review area 2** – Review of existing access points and with the potential consolidation onto fewer individual sites. This would enable the scarce staffing to be co-located, resulting in a significantly reduced demand for expensive agency resources and simpler access routes . The sites that would need to be considered as part of this option in Herefordshire are the existing minor injury units, the out of hours GP hubs, and the Herefordshire Walk in Centre, in the context of the development of 7 day access to primary care . This option would have an impact on improving performance, better clinical outcomes through more specialisation and reducing cost through more effective use of existing resources. Within Worcestershire FOASHW plans to alter the provision of A&E services for certain conditions. The next stage will be to review the Worcestershire Urgent Care Strategy, taking into account national guidance, and the requirement for Urgent Treatment Centres (UTC's), determining the most appropriate location and capacity to meet the demand of the specification. We are planning for the provision of an 'urgent care' model of ambulance provision, in line with 'Clinical Models for Ambulance Services' with ambulance clinicians making better use of alternatives to ED, the new UTC's would strengthen this approach, further reducing conveyances to ED.
- **Review area 3** – This would explore the establishment of a single **Emergency Centre with Specialist Services** (ECSS) for Herefordshire and Worcestershire, alongside two **Emergency Centres (providing A&E functions)** (EC-A&E). This will be determined in conjunction with the regional network for urgent care. Based on current configurations, capability and geography, the ECSS) would need to be in Worcester, with EC-A&Es in Hereford and Redditch. This would enable more integrated working, mutual support and improved links to regional centres.

It is important to emphasise that any work to explore alternative options to the current model of provision would be subject to a full public consultation process.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements

What will be different between now and 2020/21

The number of hospital beds required to support the system

Whichever model is pursued, there will need to be access to the right number of hospital beds to support patient care needs. Detailed modelling has been undertaken by an independent organisation (Strategic Healthcare Planning) to help identify the bed requirements for Herefordshire and Worcestershire over the life of the STP. This has identified that if partners can achieve the transformational changes that are sought in out of hospital and social care provision, caring for more patients with integrated primary and community services provided 24/7 to support patients within their own homes, there could be a significantly lower number of hospital beds required than there are now. The modelling, which is based on the agreed system assumptions shows the following:

- **Herefordshire** - The need for a **+15%** increase the number of acute beds in Herefordshire, but the potential for a reduction of up to **-62%** in the number of community hospital beds.
- **Worcestershire** – There is potential for a small reduction in the number of acute beds and a **-30%** reduction in the number of community hospital and resource centre beds. In terms of acute beds, the main issue to address is location, with more beds required in Worcester but less required in Redditch. This is likely to result in a rebalance of some low level acute services across the acute area. There is also scope to reduce the number of NHS commissioned beds from the private care home sector from 86 in the base year to 9 in 2020/21.

	Herefordshire		Worcestershire	
	Base yr	2020/21	Base yr	2020/21
Acute Beds	226	260	743	740*
Community Beds	97	37	260* (Jun 17)	182
Total Beds	323	297	1,003	922
		- 26		-81

**FoASHW pre-consultation business case projection for 2018/19, all other numbers from the STP strategic model for 2020/21. # There have been planned bed reductions since the last STP submission*

In order to facilitate this scale of reduction in beds overall, the out of hospital care offering needs to be optimized. We are taking this forward through our alliance working and in Herefordshire our upcoming public engagement, to develop integrated primary and community services that can support people in their own homes 24/7. This will build upon previous engagement across the two counties for example evolving the coproduced outcomes for integrated care in Wyre Forest. Work is also underway to analyse what additional capacity and skill sets would be required in primary and community care services to enact any further reduction in community beds that will lead to more care being provided in home based settings, leading to better clinical outcomes and improved independence. It is acknowledged this aspirational transformation needs to be tested for deliverability, would be incremental and services would need to be in place before any changes are made.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

An urgent care workforce for the future

Key to the delivery of the local A&E delivery board plan to improve the emergency access standard and to delivery of the vision for the STP is an enhanced workforce in the most appropriate setting with a range of urgent care skills. Whilst there are national and local challenges with the recruitment of clinical workforce the urgent care systems working within Herefordshire and Worcestershire will design, agree and implement new roles to support these improvements.

These roles will be a mixture of qualified and non qualified practitioners that support reduced duplicate assessments and focus on early assessments and streaming to the most appropriate urgent care setting and will be aligned to the pathways for urgent care that will be developed.

Herefordshire and Worcestershire will learn from each other related to the innovation and design of the workforce and will use the STP workforce planning process to support this.

Routes to workforce change

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Stroke Services - The aim is to deliver high quality, sustainable stroke services across the two counties to ensure delivery of 7 day services and improved patient outcomes. A full options appraisal will be undertaken on the configuration of stroke services, specifically hyper acute and acute stroke services, to identify a sustainable solution that will deliver key clinical and performance standards in these areas (access to specialist consultant review, 24/7 thrombolysis and 4 hour admission to HASU) and which also delivers 7-day TIA services, high quality rehabilitation services including early supported discharge and a robust primary prevention strategy. Worcestershire is currently rated as Band D under the Sentinel Stroke National Audit Programme (SSNAP) and Herefordshire at Band B. The plans we are taking forward should achieve B (Good) across both counties once fully implemented.

What will be different between now and 2020/21

- High quality, timely and sustainable stroke services across Herefordshire and Worcestershire
- Telemedicine service across the two counties and networked with other Trusts to provide a service for Herefordshire, Worcestershire and mid-Powys.
- Collaboration across the two counties, to deliver a sustainable rota and seven-day TIA service.
- Highly skilled and competent workforce in place across Herefordshire and Worcestershire to ensure delivery of high quality stroke services and all key clinical and performance standards associated with delivery of stroke services;
- Robust clinical pathways to ensure optimum outcomes for patients throughout the stroke pathway

Specific short term goals for Worcestershire:

- Development of workforce plan that crosses organisational boundaries and optimises skills and expertise across the stroke pathway to build a robust and sustainable workforce going forward;
- Development of a 'Straight to Scanner' pathway;
- Development of nurse led TIA services;
- Establishment of an Early Supported Discharge service to facilitate timely discharge;

Specific short term goals for Herefordshire:

- Access to TIA clinics for those at risk of Stroke across seven days
- 24/7 thrombolysis treatment
- 24/7 access to specialist inpatient care advice
- Consistent access to therapists whilst an inpatient
- Consistent access to step-down community services

How will this be better for residents and patients in Herefordshire and Worcestershire

- Patients will receive best practice stoke services across the stroke pathway
- Improved outcomes for patients through access to timely and high quality stroke services
- Access to 7 day services
- Access to highly skilled stroke specialists as all stages of the pathway
- Improved primary prevention of stroke
- Increased levels of long term care at home
- Access to third sector services to support patients long term
- Care as close to home as possible

Priority 4 – Establish clinically and financially sustainable services

Programme 4c	IMPROVING MATERNITY CARE	Owner	Michelle McKay – CEO Worcestershire Acute Hospitals NHS Trust

Overall aim	Our vision is that our citizens have access to high quality, safe and sustainable, acute, women and newborn/neonatal and mental health services, localised where possible and centralised where necessary.

What will be different between now and 2020/21

Within Worcestershire maternity services are temporarily suspended on the Redditch site and re-provided on the Worcester site due to the Trust not being able to recruit sufficient staff to provide clinically sustainable services across two sites. The Future of Acute Services at Hospitals in Worcestershire (FOASHW) has completed public consultation on the permanent centralisation of these services on the Worcestershire Royal Site. This is a critical component of the clinical and financial sustainability of the Worcestershire service.

Beyond this **we plan to develop a Local Maternity System[LMS]to deliver Better Births , Saving Babies Lives and Maternal & Newborn Health safety Collaborative** locally across both counties. This will result in:

- The removal of traditional county boundaries with sharing of community and hospital based resources across a wider area. This is not expected to result in a change to the provision of obstetric services in Herefordshire.
- A joint maternity care offer with common clinical pathways that guide women to the most clinically appropriate place of birth.
- Review maternity specifications to reflect the requirements of a local maternity system.
- Integrated specialist/clinical teams (such as Antenatal Screening team, Governance team etc) to increase skills and ensure adequate access for women.
- Development of community hubs for maternity care.
- Integrated neonatal pathways between Hereford and Worcester.
- We will focus on the Secretary of States objectives of reducing still birth , perinatal mortality maternal death and brain injury by 20% by 2020 and 50% by 2030 based on 2010 data .
- We will focus on the implementation of Saving Babies lives bundle by reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movements , effective fetal monitoring during labour.
- Working with the national Safety Collaborative to develop clinical leadership in the delivery suit , human factors training and enhanced training in developing a safety culture
- We will implement the national system to systematically review still birth and perinatal death –SCOR [standardised computerised objective review]
- Shared approach for perinatal mental health offer for families.
- Shared end to end electronic maternity information system.
- IT links between the hospitals services .

Priority 4 – Establish clinically and financially sustainable services

Programme 4c	IMPROVING MATERNITY CARE	Owner	Michelle Mckay. Chief Executive, Worcestershire Acute Hospital NHS Trust

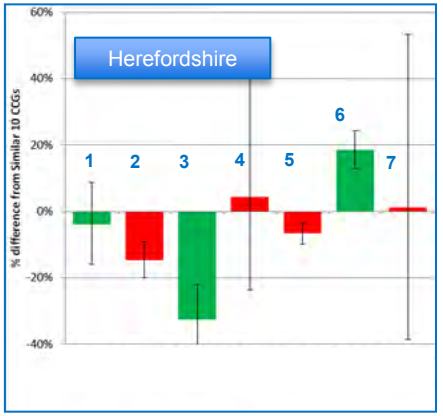
Overall aim	Our vision is that our citizens have access to high quality, safe and sustainable, acute, Women and newborn/neonatal and mental health services, localised where possible and centralised where necessary.

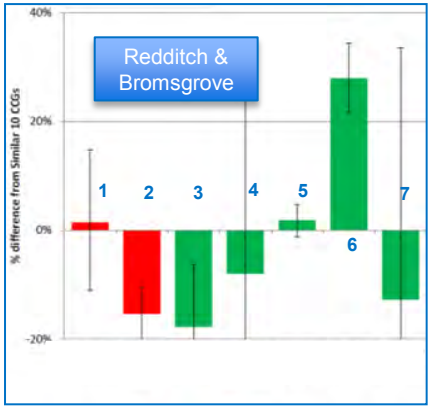
How will this be better for residents and patients in Herefordshire and Worcestershire

The overriding benefit to the local population will be a higher quality, more sustainable service that achieves improved health and well being outcomes for babies and young children. This will be achieved through:

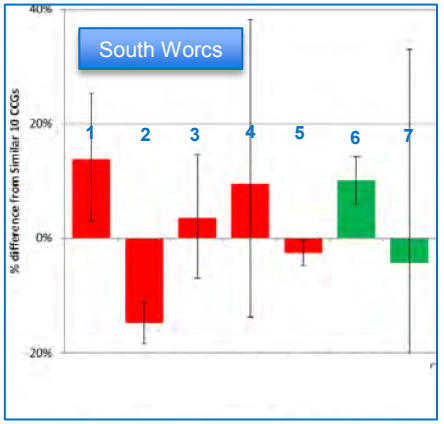
- Increased midwife led care and home birth numbers
- Improve women's access to birth in the most appropriate birth setting
- Reduce out of area neonatal transfers for sick and premature infants
- Increased specialist community based Perinatal Mental Health care
- Improved availability of access to specialist teams across both counties for women and babies
- Retaining local services for women and families within the counties
- Raised profile for maternity and newborn services across the West Midlands
- Reduction in Perinatal mortality rates
- Achieving national caesarean section rate
- Improved learning from strengthened governance will lead to a greater safety culture.
- Shared learning and development opportunities to increase and maintain knowledge and skills.

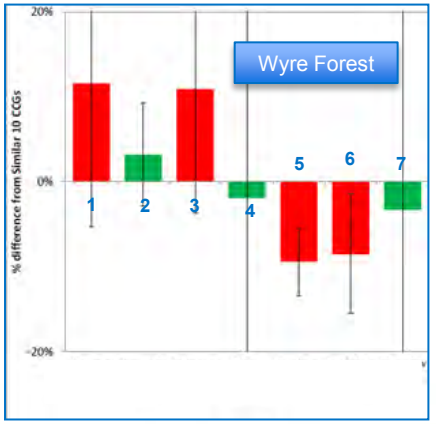
The charts of this page show where indicators are better (green) or worse (red) than comparable 10 areas nationally. Therefore the charts cannot be compared against each other.





1 < 18 Conception rates	2 Flu vaccine take-up by pregnant women	3 Smoking at time of delivery	4 % of low birthweight babies (<2500g)	5 Breast-feeding initiation (first 48 hrs)	6 Breastfeeding at age 6-8 weeks	7 Infant mortality rate





Priority 4 – Establish clinically and financially sustainable services

Programme 4d	ELECTIVE CARE	Owner	Carl Ellson, Accountable Officer, SWCCG

Overall aim

Non – life threatening conditions - Reduce clinical variation in referral and treatment, reduce the number of procedures performed where there is a limited clinical benefit or enhanced risk of harm and work with patients to improve their overall well being by seeking lifestyle improvement as part of the elective pathway.

What will be different between now and 2020/21

There are two key aspects to improving elective care – in terms of clinical effectiveness, achievement of performance standards and financial sustainability.

- **Effective commissioning policies** and stricter treatment thresholds
- **Efficient organisation of services** to meet demand.

During the allocative programme budgeting work, the STP partnership board recognised that significantly tightening commissioning policies and treatment thresholds for elective care would be required to support financial balance with the STP. In order to progress this, there were two distinct categories of elective care identified – treatment for life threatening conditions such as cancer, cardiac and renal services and treatment for non-life threatening conditions. The programme board agreed to prioritise investment in the former, in order to do this the following has been agreed:

- Develop a system wide (commissioner and provider across both counties) policy and treatment threshold on procedures that:
  - Are probably linked to an aesthetic benefit
  - Probably have a lower cost alternative
  - Have a relatively limited impact
  - Are perceived to have a close ratio of benefit to harm.
- Develop a policy to support lifestyle improvement by providing prevention interventions and alternatives such as social prescribing with regard to healthy weight (where possible), smoking and alcohol consumption to improve the likelihood of positive clinical outcomes following surgery.

Potential savings from achieving top decile rates

Elective procedures for non-life threatening conditions

CCG	Probably Aesthetic	Probably lower cost alternative	Limited Effect	Close Benefit to Harm Ratio
HCCG	£64k	£521k	£26k	£439k
RBCCG	£14k	£362k	£0k	£546k
SWCCG	£133k	£784k	£0k	£1,025k
WFCCG	£149k	£397k	£48k	£271k
Total	**£4,779k**			

Elective procedures that are likely to be wholly attributable to

CCG	Alcohol	Obesity	Smoking
HCCG	£0k	£28k	£72k
RBCCG	£124k	£57k	£153k
SWCCG	£599k	£59k	£478k
WFCCG	£279k	£50k	£199k
Total	**£2,098k**		

- Achieving top decile performance in these areas against comparator CCGs will release **£6.8m** worth of expenditure.

Priority 4 – Establish clinically and financially sustainable services

Programme 4d	**ELECTIVE CARE**	**Owner**	Carl Ellson, Accountable Officer, SWCCG
Programme 4e	**CANCER CARE**		
Overall aim	**Life threatening conditions (cancer and others)** -Increase funding to meet demographic pressures and increasing illness burden. Improve efficiency and reduce waste and waits across pathways and for all critical complex elective care, for clinical sustainability and quality outcomes, we will concentrate provision in centres of excellence		

What will be different between now and 2020/21

- Our Clinical Reference Group will focus initially on Breast Screening, Renal and Cardiology services a with a view to improving clinical outcomes, deliverability and sustainability of services in the best interest of patients.
- We will have implemented the key changes required from the national cancer strategy
- There will be much greater alignment between prevention strategies and treatment, but adopting a more integrated approach, where driving the prevention and healthy lifestyles message is the responsibility of all partners in the system.
- Far greater uptake of screening programmes across the population, where local performance is currently poor (see overleaf)
- We will ensure that we maximise the use of the diabetes prevention programme pilot currently being implemented across the STP and use the learning from this for other possibilities for using risk identification to target intensive lifestyle interventions.
- Revised pathways with increased pan-STP working, particularly with UHCW and Gloucestershire to enhance clinical sustainability and specialism to improve outcomes.
- Reviewing opportunities for repatriating activity and referring out of area to achieve the best use of resources and outcomes for patients.
- Joint staffing appointments to specialist roles across the STP or wider STP area (for example interventional radiology).
- Concentration of specialist complex surgery on fewer sites to secure clinical sustainability and improve outcomes.
- As part of the Specialised Services Rural Pathfinder we expect to redefine existing pathways to be locally commissioned, repatriate some current pathways including renal, some cancers and cardiac care, working closely with regional specialised providers.
- Implement alternative models for cancer survivorship through remote monitoring and supporting patients in out of hospital environments.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Local services will be better placed to deliver world class outcomes for cancer care.
- The system will achieve consistent access of all cancer treatment standards.
- Earlier recognition and faster diagnosis of cancers and other life threatening conditions.
- Faster treatments times and improved survival rates.
- Reduced diagnosis through emergency admission or unplanned care provision.
- Better patient experience of cancer care received (which is currently poor – see pages 77-79)

Delivery Plan – Priority 4: Establish clinically and financially sustainable Services

Urgent Care SRO	**A&E Delivery Board Chairs**	**Programme Leads**	**Stuart Ide –** Urgent Care Lead – Worcestershire CCGs **Hazel Braund –** Operations Director – Herefordshire CCG
Maternity Care SRO	**Michelle McKay** Chief Executive – Worcs Acute Hospitals Trust	**Programme Lead**	**Fay Baillie –** Deputy Director Nursing and Midwifery Worcs Acute Hospitals NHS Trust
Elective Care SRO	**Carl Ellson** Accountable Officer - SWCCG	**Programme Leads**	**Sarah Smith –** Worcestershire Acute Hospitals NHS Trust **Simon Gartland -** Deputy Director of commissioning WCCGs

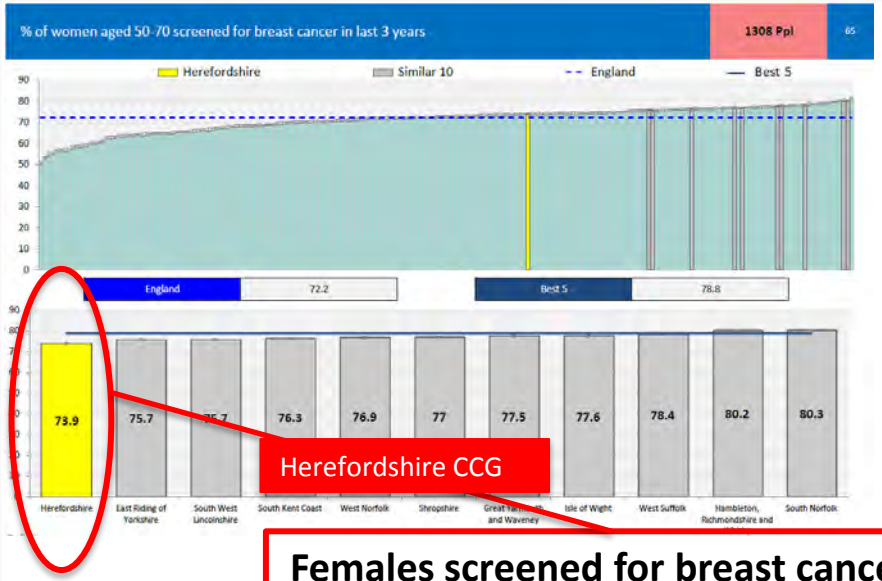
	Work Programmes	2016/17		2017/18				2018/19				2019/20				2020/21			
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
4b Improving urgent care	Complete review of emergency care provision, exploring reductions to the number of MIUs and the Walk in Centre in Herefordshire and standardised opening hours and enhanced specification for MIUs in Worcestershire.																		
	Shift to home based care – identify the requirements to increase home based care to deliver proposed bed reductions and test deliverability																		
	Design and agree a model for stroke services across two counties that meets the stroke standards and seven day working requirements																		
	Agree and implement a workforce plan for urgent care and patient flow across the health and social care within the two counties																		
4c Improving maternity care	Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme.																		
	Develop a Local Maternity System across Herefordshire and Worcestershire																		
	Establish a single service with specialist teams working under a common management structure, delivered locally.																		
	Deliver the FoASW objectives for gynaecology																		
4d Elective Care	Develop a system wide policy and treatment threshold on procedures of limited clinical value																		
	Develop a policy to support lifestyle prevention interventions and alternatives to improve health prior to surgery, thus improving outcomes																		
	Across Worcestershire undertake a greater proportion of routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes																		
	Revised pathways with increased pan STP working, reviewing opportunities for repatriating activity and referring out of area to achieve the best use of resources and outcomes for patients																		
4E Cancer	Expand pan STP working on cancer services and deliver the requirements of the national taskforce.																		

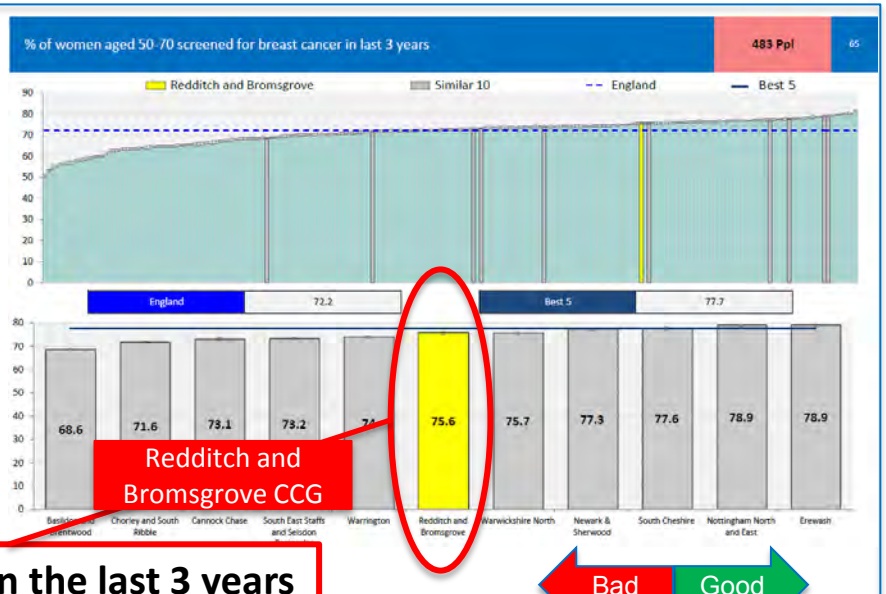
Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

Breast cancer screening



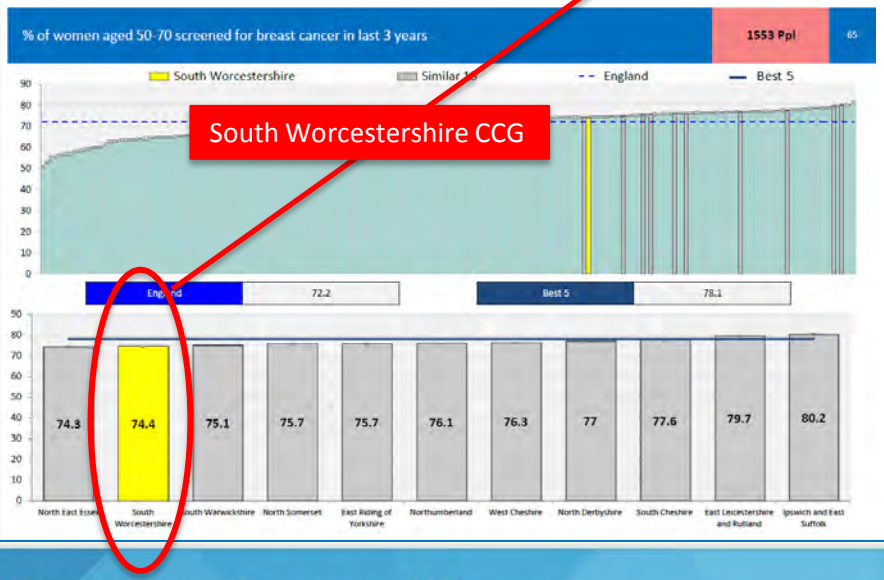


Redditch and Bromsgrove CCG

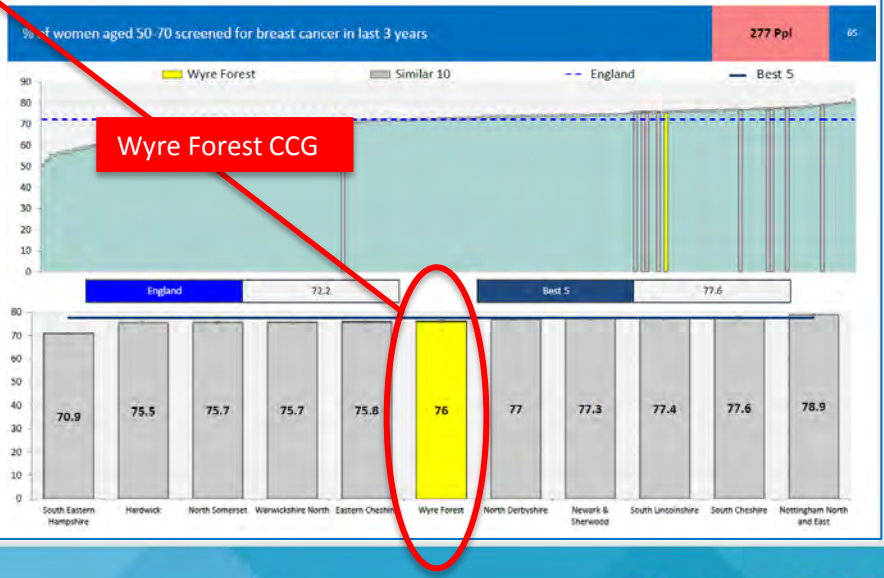
Herefordshire CCG

Females screened for breast cancer in the last 3 years

Bad — Good

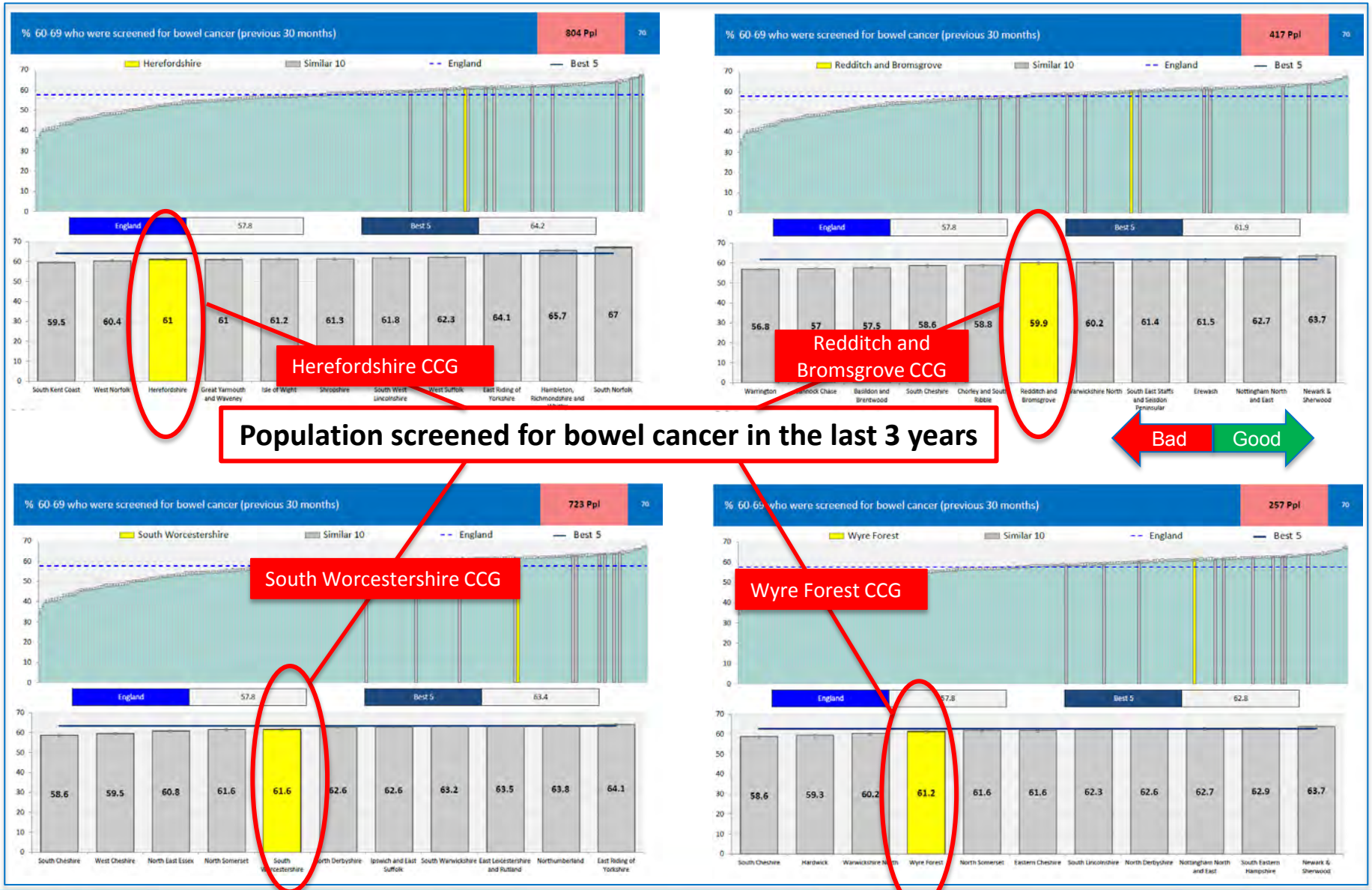


South Worcestershire CCG

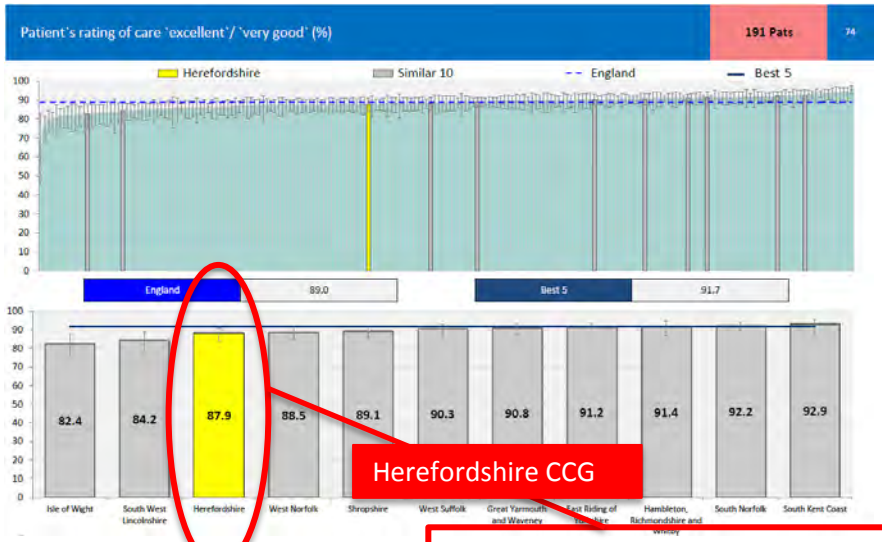


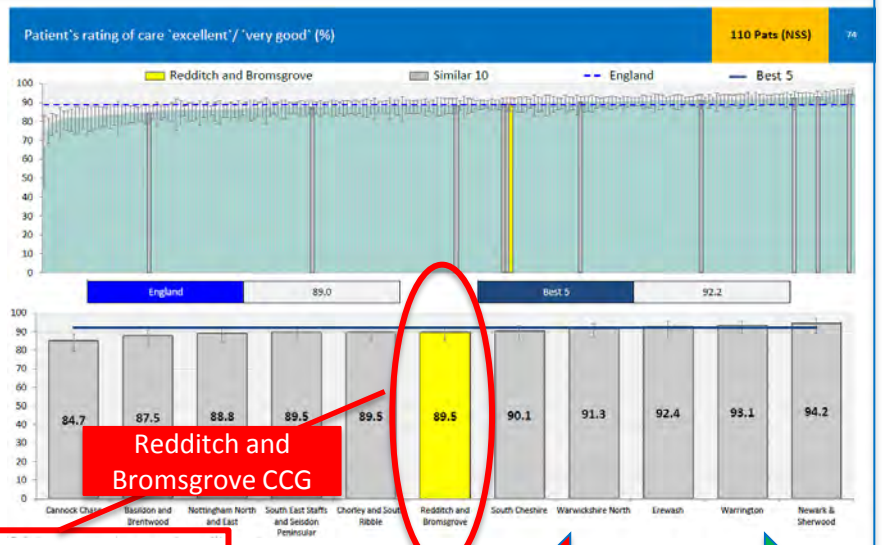
Wyre Forest CCG

Bowel cancer screening



Patient experience of cancer care



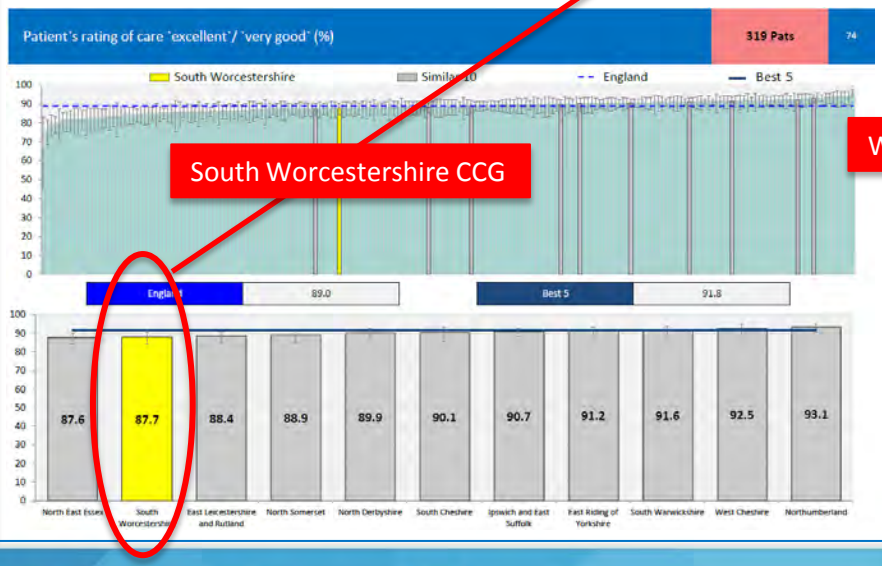


Herefordshire CCG

Redditch and Bromsgrove CCG

Patient's rating of quality of care given

Bad Good



South Worcestershire CCG

Wyre Forest CCG

Enabling change and transformation

Workforce and OD

Enabler 1	WORKFORCE AND ORGANISATION DEVELOPMENT	Owner	Shaun Clee, Chief Executive, 2gether NHS Foundation Trust

Overall aim

Develop the right workforce and Organisational Development within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face.

During 2016/17 the Workforce and Organisational Development strand has engaged with stakeholders across the STP to develop a People Strategy and Delivery Plan. The Strategy builds on the STP vision and priorities identified in the STP submission.

What will be different between now and 2020/21 - Update

- Erosion of traditional boundaries to **'teams without walls',** supported by a multi-disciplinary learning environment **Minimum standards for a multi-disciplinary system-wide Preceptorship programme have been drafted for consultation**
- Increased **investment** in the **mental health and learning disability** workforce
- **Less** reliance on **agency and temporary staffing HR Directors have agreed to lead on an STP-level piece of work during 2017**
- **Integrated multi-disciplinary teams** based around the person, supported by access to specialist advice and support
- Increased use of apprenticeship levy to ensure **appropriate training** for existing staff and 'new' roles, alongside work experience and **career pathways** to build the **future workforce University of Worcester has agreed to work with employers to develop an STP-level apprenticeship 'hub' during 2017**
- A **more diverse skill mix**, with 'new' roles embedded within teams offering greater flexibly and the potential to **work across traditional boundaries** and systems.
  Nursing Associates 'fast follower' training programme started across the STP in April 2017
- A shift to a workforce **culture focused on prevention , self-care and independence**, utilising, health coaching conversations across the workforce, improved signposting and better links to public health
- Flexible employment contracts, annualised hours, portfolio careers, and **incentives to retain and recruit staff** across the system
- **GPs** will have more time to focus on patient care **Primary Care workforce, workflow, capacity/demand work commenced as part of delivery of GPFV.**
- A more significant role for the voluntary and community sector, the public sector and the unpaid workforce (family, neighbours, carers, volunteers) **working together to deliver better outcomes for local people.**

How will this be better for residents and patients

- "**Tell my story once**" with fewer 'hand-offs' between clinicians and other practitioners
- **More care will be provided out of hospital**, with greater continuity of care and care wrapped around the person
- Health coaching conversations will **enable healthy behaviours and increased self- management of care**
- People will co-produce and **'own' individual care and support plans**
- People with on-going conditions will have more control over their lives and receive **more care provided closer to home**
- Improved access to **specialist care and expertise will be available when people need it**
- **Education and development for carers**

Digital and Technology

Enabler 2	DIGITAL	Owner	Michelle McKay, CEO Worcestershire Acute Trust
Overall aim	Invest in digital and new technologies to enable our workforce to provide, and patients to access care in the most efficient and effective way, delivering the best outcomes		

What will be different between now and 2020/21

- **We have two aligned Digital Road Maps within the two counties,** successful delivery of our digital roadmaps for Herefordshire & Worcestershire will be critical to improving access, increasing productivity and changing clinician /practitioner behaviour. One example is Worcestershire Health and Care NHS Trust being selected as a Global Digital Exemplar for Mental Health.
- **Creating a connected Infrastructure** e.g. modern and connected infrastructure enabling practitioners and linking services; e.g. better use of telemedicine and increasing use of e-consultations to improve access to specialist services
- **Improving integration** e.g. Integrated Digital Care Records for patient's and citizens across health and care - providing integrated records that have the ability to be interlinked care settings across the two counties; establishing a consent and information sharing model and robust data standards, security and quality.
- **Empowering residents and citizens through technology** e.g. creating a consistent user and patient experience – including common, digital front doors to our services, complementing traditional interactions. Enabling increased public and patient control and empowerment (i.e better use of apps, wearables and assistive technologies), moving away from a paternalistic culture of care; and supporting self-care and increasing levels of patient activation. A key enabler is consistent local access to broadband / digital options.
- **Enhancing our understanding**: New insights using health & care intelligence - Using data in new ways to lead to earlier intervention and enabling improved outcomes and wellbeing for people and the population
- **Working collaboratively** – ensuring we are reading as a system to work together and to deliver technological changes for the benefits of residents and patients, including using resources smartly and sharing good practice

How will this be better for residents and patients in Herefordshire and Worcestershire

- **Patient data access and information sharing**, care planning and transitions plans available across providers meaning patients will only have to tell their story once
- Patients access to own care records, giving a **better understanding of care received**
- Improved access to specialist services via telehealth and tele/video conferencing across acute and community, providing **faster access to specialist care**
- Use of tele/video conferencing in GP practices & nursing homes enabling **joined up care**
- Interoperability of systems across the two counties allowing **patient choice**
- Use of apps and wearables to support empowerment of patient and residents and **increase levels of patient activation**
- Better sharing of information
- Seamless care for patients
- Patients more engaged and self-sufficient
- Better use of pharmacies and review of medications

Engaging communities and the voluntary sector

Enabler 3	HEALTHY COMMUNITIES AND THE VCS	Owner	Martin Samuels, Herefordshire Council

- We recognise the importance of reengineering our system so that health and care services work alongside thriving communities to realise the value of individuals, their informal networks and wider communities. Being able to respond to the new landscape ahead requires the vision and commitment of all and embracing different partners into a new way of working. In particular this includes listening and responding to different solutions that are presented by the VCS, who often have effective methods, if not the means, to support those facing multiple disadvantage
- We will use the principles of co-production in our work with the VCS so that a common approach to the challenges we face is developed
- The adoption of 'a better conversation' approach across the wider system; including volunteers and community champions to develop a lay coaching model to focus on what is important to the individual in living with a health condition
- We recognise the depth of understanding that the sector can bring and the significant benefits of prevention. There are numerous asset based activities already implemented across our STP, creating social capital across our communities and we want to scale up this approach to promote and strengthen the factors that support good health and well-being, protect against poor health and foster positive communities and networks
- The VCS has a vital role in reducing demand on formal services such as unplanned hospital admissions for example through care navigation/bridging roles, peer support and group activities . The sector also helps to address health inequalities by contributing to wider social outcomes such as employment and school attendance
- Therefore, we need to find ways to tap into the energy, enthusiasm and innovation of the VCS in a coordinated manner, including a simplification of the commissioning process to enhance the contribution that the VCS can make, particularly those grassroots community organisations who struggle with complex commissioning arrangements. We will also strengthen how we support volunteering, recognising the assets and capacity of the workforce in our wider system planning

Healthwatch Perspectives

Engaging communities and the voluntary sector

The Chairs of Herefordshire Healthwatch and Worcestershire Healthwatch are members of the programme board and asked for the following content to be included in the STP submission:

healthwatch Herefordshire

Healthwatch Herefordshire (HWH) would wish to place on record its thanks to all involved in the production of the Herefordshire and Worcestershire Sustainability and Transformation Plan (2016 - 2021).

Healthwatch Herefordshire welcome the opportunity that STP presents in bringing all parties across health & social care together through the STP process to look at sustainability and importantly transformation of services. We hope that STP will lead to improved simplified patient pathways and increase access to services for the residents of Herefordshire and Worcestershire.

HWH wishes it to be noted that Herefordshire remains the most sparsely populated area of England. NHS England will need to address a number of key issues in relation to the needs of the population of Herefordshire and the future provision of the County's health and social care services. In HWH's view the sensitive issue of funding and the particular special case of rurality and rural sparsity is something which NHS England should take into account when it considers overall budget provisions.

HWH would like ensure that the plan recognises and addresses; issues which arise from the budget reductions to Herefordshire Council social care services and the projected increase in demand for services from the public in the future.

It is clear from proposed future models of service delivery in health and care across the STP footprint that greater involvement and assistance will be put on the voluntary and community sector to assist in maintaining peoples wellbeing . The STP needs to make sure that this is resourced and supported adequately, involving the public, communities and voluntary sector organisations in the plans and implementation.

As STP moves into the implementation phase HWH will continue to be actively involved and will ensure that the voice of the public is fully taken into account. The public need to see transparency and honesty throughout the STP process and a genuine opportunity for involvement

HWH has assisted in engagement and involvement of putting the public's views into this planning process from Autumn 2016- spring 2017 and we will be monitoring that the inclusion of those views are at the heart of the process and that the STP continues to inform the public abut the process going forward.

HWH would like to see that the focus of the STP is directed at how H&SC professionals and VCS organisations work across organisational, and where of benefit geographical, boundaries for shared outcomes for people's wellbeing, rather than being diverted into being concerned about structures. HWH makes a special a plea to NHS England to minimise the levels of bureaucracy in relation to the overall plan.

Engaging communities and the voluntary sector

healthwatch Worcestershire

Healthwatch Worcestershire [HWW] has been engaged in the process to develop the Sustainability and Transformation Plan for the Herefordshire and Worcestershire footprint since January 2016. HWW's contribution has included membership of the former Programme Board since the Board was set up and more recently the Partnership Board. It has been represented on both Boards by its Chair, who has significant experience of working at a strategic leadership level in health and care matters across both Worcestershire and Herefordshire. HWW was also an attendee at the communications and engagement group in which HWW has provided advice, guidance and support to the NHS and Local Government stakeholders.

HWW recognises the inclusive approach the STP leadership team has taken to engaging with Local Healthwatch as the voice of patients and the public in developing STP proposals, given the constraints we understand were initially placed on engagement by NHS England, and the extensive programme of public/patient involvement that has taken place since the publication of the STP plan in November 2016. HWW welcomes the positive response the STP team have made to HWW's comments during the process and to the public's feedback during the engagement programme.

HWW therefore welcomes the opportunity to make the following comments on the July 2016 version of the plan :

- HWW recognises the need for change and has a track record of arguing for safe, sustainable and integrated health and care service provision in Worcestershire which, for example has enabled HWW to support the recommendations for the future delivery of acute hospital services in Worcestershire and the developments in primary care such as 'care at home' and new models of care. HWW therefore welcomes the incorporation of these and associated initiatives into the STP, building on Worcestershire's 'Well Connected Programme' as a pioneer and the review of future Acute Hospital Services in Worcestershire, with a view to delivering the necessary improvements in health care.

- HWW is principally concerned with championing the interests of those who use health and care services in Worcestershire. In that context, from the outset HWW has been concerned about the potential implication for Worcestershire's patients and public of 'pooling' the funding allocations to the Worcestershire CCGs with the allocation to the Herefordshire CCG.

In response to HWW concerns the 2020 financial position as between Herefordshire and Worcestershire has been detailed in the STP submissions, which reflects that Herefordshire's potential gap will be £468 per head as opposed to Worcestershire's gap of £279 per head.

Engaging communities and the voluntary sector

healthwatch Worcestershire

HWW welcomes the recognition from STP stakeholders that achieving financial balance across the STP footprint would result in significant subsidy to Herefordshire from Worcestershire, with a consequent impact on service provision for patients and the public in Worcestershire.

- HWW believes the patients and public in Worcestershire expect the NHS to make efficiency savings in the 'back office' and in the delivery of support services as a pre requisite to making savings in patient services. This should include consideration as to the number of commissioners and providers operating in Worcestershire, as well as the STP footprint.

- HWW recognises the STP proposals include significant reductions in 'elective care' and expects the CCGs to properly involve patients and the public in these proposals as they are developed.

- HWW is concerned that NHS plans to deliver care at home could place additional burdens on social care services and have raised an issue about domiciliary care based on its knowledge of the review of the existing care market in Worcestershire.

- HWW endorses the concerns that were widely expressed during the public engagement programme including the potential requirement that will be placed on patients to travel to access services, the implications of the planned reduction of beds across the community hospitals and the impact of the proposals on carers. In particular HWW is concerned about how the proposals will affect the vulnerable and those who live with health inequalities. HWW will expect work-streams in the STP to specifically address this issue.

- HWW recognises that the proposals relating to Self-Care and Prevention require significant behavioural change by the population at large and within the NHS, and considers that this is unlikely to be achieved without a national communications/engagement exercise because of the resources that will be required.

Worcestershire Health and Well-being Board summary comment on Herefordshire and Worcestershire draft STP submissions.

The Worcestershire Health and Well-being Board welcomes the opportunity for comment at this stage on the STP.

The Board has received regular reports and presentations on the developing STP plans since the STP process was first announced in December 15. Sarah Dugan, as the lead Accountable Officer for the STP, and members of the STP project team have attended these discussions and have taken every opportunity to answer Board members' questions.

The Worcestershire Health and Well-being Board has also met with the Herefordshire Health and Well-being Board in a private joint development session in June 2017 to further discuss the STP.

Throughout these discussions, a number of points have been raised consistently by Board members as being areas which need focus or strengthening within the plans:

- Worcestershire Health and Well-being Strategy priorities. The Board has sought reassurance that the Strategy priorities are strongly reflected in the STP. These priorities are: prevention; reducing heath inequalities; reducing the harm from alcohol; increasing physical activity; and improving mental health and well-being.

- Prevention. The Board has asked for a robust prevention narrative to be evident throughout the STP. It asked for prevention to be embedded within each programme area, as well as delivered through specific delivery platforms such as social prescribing.

- Engagement. The Board has sought assurance that engagement will continue beyond the 2016 phase of engagement on high level plans. It expects strong engagement and formal public consultation on specific programme areas as more detailed plans develop.

- Housing. The Board has stressed the importance of appropriate and safe housing to individual health outcomes and has asked for plans to include reference to closer working on housing across the whole system.

- Transport. Board members have consistently expressed concern about changes in service location. They have stressed the challenges of rurality and importance of maintaining good access to services.

- Digital health offer. Although the Board has recognised the potential benefits of digitalising the heath offer, for example by on-line appointment booking; Skype consutations; or access to digital advice, it has also sought reassurance that those who cannot access on-line services should not be disadvantaged.

- Impact on Adult Social Care. Board members have consistently asked about the potential impact of the STP on other services, in particular on Adult Social Care. They have expressed concern that the STP may increase demand for Adult Social Care and that this has potential has not yet been modelled.

- Impact of partners across the system. Board members have emphasised the need to involve partners across the system, including District Councils, Police, Fire and Rescue, in considering the challenges and opportunities of the STP.

- Details of plans. Board members have regularly asked for the detail of the plans. They have been broadly in agreement with the high level aims, but have wanted to see more detail about specific impact on local residents.

The STP has been amended during the period of time that the Board has held its meetings. The Board will next discuss the STP in public session at its meeting on 11th July.

June 27th 2017

Date of meeting: 5 July 2017 **Enc G1**

Report to Trust Board

Title	**Care in the Corridor Survey report – Healthwatch Worcestershire**
Sponsoring Director	**Vicky Morris, Chief Nurse**
Author	**Dilly Wilkinson – Interim Deputy Chief Nurse** **Clare Bush – ED Matron** **Marc Tarrant – ED Matron**
Action Required	QGC are asked to receive the Healthwatch Worcestershire report and approve the action plan to meet the recommendations.
Previously considered by	

Priorities (√)

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

Related Board Assurance Framework Entries	*The full BAF risk needs to be entered, not just the number*
Legal Implications or Regulatory requirements	**Health and Social Care Act (Regulated activities) Regulation 2014** Regulation 9 – Patient centred care Regulation 10 – Privacy & Dignity Regulation 11 – Need for consent Regulation 12 – Safe care and treatment Regulation 13 – Safeguarding users from abuse and improper treatment Regulation 14 – Meeting nutrition & hydration needs Regulation 15 – premises and equipment Regulation 16 – Receiving and acting on complaints Regulation 18 - staffing
Glossary	HWW – Healthwatch Worcestershire ED – Emergency department MAU – Medical Assessment Unit

Key Messages

- The Trust has received a report of a survey undertaken by Healthwatch Worcestershire (HWW) which describes the experience of patients who are being cared for in the corridor in the Emergency Department at the Worcester Acute and Alexandra Hospitals.

- HWW undertook 31 unannounced visits in February and March 2017.

- There were no occasions where patients were found to be being cared for in the ED corridor at the Alexandra.
- Patients in the corridor reported a number of issues when surveyed and these have been developed into 38 recommendations.
- The Matron's for ED for both hospitals have developed an action plan to address those recommendations.
- 19 actions are either already in place or have been completed since the survey was undertaken. These are reflected in the action plan.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 5 JULY 2017

1. Situation

In May 2017 Healthwatch Worcestershire (HWW) undertook a survey of patients on trolleys in the corridors of the emergency departments (ED) at both the Worcester Acute and the Alexandra Hospitals. The survey was precipitated by concerns received from patients who had been cared for in the corridors at the trust and performance data that shows that the Trust had the highest 12 hours trolley wait breaches in the country in January 2017.

2. Background

The report was received by the Trust in June 2017 and this paper will describe the actions taken to address the findings and recommendations within the report. The report can be seen as appendix 1.

The Trust agrees that caring for patients on trolleys in the corridor of ED is not desired practice and as such should not be normalised, therefore any actions taken are by their nature to be temporary.

3. Assessment

HWW developed the survey to address all areas of concern regarding care, privacy and dignity. They surveyed 119 patients being cared for in the corridors of ED and the Medical Assessment unit (MAU) over the course of 31 unannounced visits undertaken between 13th February and 26th March 2017 on the Worcester site. No patients were found to be being cared for in the corridor at the Alexandra Hospital during their 13 unannounced visits.

Findings

The full report is attached in appendix 1 and this includes the full findings. The key findings are as follows:

- 43% did not know the name of the person who was looking after them.
- Most patients knew how to get the attention of the nurse looking after them although they had not had to use it
- Of those who had requested assistance (27%) 46% reported waiting over 5 minutes.
- 88% had had a drink and 62% had had food whilst they were in the department.
- 1 patient who had waited 8-12 hours and 3 who had waited over 12 hours reported not being offered food.
- 60% felt that staff were doing all they could to manage their pain. 21% reported that they did not feel staff were doing all they could to manage their pain.
- 65% felt there was sufficient staff whereas 19% felt there was not enough staff:
- Only 30% felt they had enough privacy to discuss their personal details.
- 85% had not been told how long they might be waiting in the corridor.
- 74% felt they were well cared for by the Trust staff; 18% felt this was true sometimes and 9% felt this was not the case.

4 Recommendation

The report has made 38 recommendations of which 2 have already been completed, some will not be possible to implement such as closing the doors in the middle of the corridor and turning off the lights at night and the remainder have been developed into an action plan which is to be discussed at the next Emergency Department Board and are attached to this paper as appendix 2.

The action plan will be actively managed by the matron for ED at WAHT through the Medical Division Governance meeting. The action plan was developed with the Interim Deputy Chief Nurse and the matrons for ED for both sites to ensure that all improvements are made on both sites.

Vicky Morris
Chief Nursing Officer

Appendix 1

Care in the Corridor at the Worcestershire Royal Hospital

Survey Report

May 2017

Healthwatch Worcestershire,
Civic Centre, Queen Elizabeth Drive,
Pershore,
Worcestershire,
WR10 1PT
Tel. 01386 550 264
Email: info@healthwatchworcestershire.co.uk

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Acknowledgments

HWW acknowledge the co-operation of the Trust's leadership, the matrons of the A&E Departments and A&E staff throughout the visit programme.

EXECUTIVE SUMMARY

Introduction

1. Healthwatch Worcestershire (HWW) provides an independent voice for people who use publicly funded health and social care services. Our role is to ensure that people's views are listened to and fed back to service providers and commissioners in order to improve services.
2. Patients have reported to Healthwatch Worcestershire their experience of long waits at the Accident & Emergency Department (A&E) at Worcestershire Royal Hospital, some of which took place on trolleys in corridor areas at the hospital.
3. Health and Care organisations in Worcestershire have stated that nursing patients on trolleys is not an acceptable practice[1]. Figures published by NHS England[2] in March 2017 however identified Worcestershire Acute Hospitals Trust as the worst in the country for "trolley waits" of over 12 hours during January 2017.
4. Healthwatch Worcestershire agrees that patients being cared for in corridors is unacceptable and does not endorse this in any way. Nevertheless this situation is being experienced by patients.
5. We undertook the Care in the Corridor Survey to directly gather patient's experience of being cared for in corridors at A&E and the Medical Assessment Unit. From 13th February 2017 – 26th March 2017 HWW completed 31 unannounced visits to Worcestershire Royal Hospital and 13 unannounced visits to Alexandra Hospital using our powers to Enter & View[3] premises. The WAHT has been fully cooperative with our Visit programme.
6. *Awaiting contextual information from CCGs re attendance figures and performance during the time period of our visits.*

What we did

7. Our survey asked patients about information provided to them about being in the corridor area; their care; the environment; privacy and dignity; waiting times; and their overall experience of being in the corridor area of the hospital. We have already reported urgent issues that emerged from our visits to the WAHT.
8. There were no patients in the corridor at the Alexandra Hospital during any of our visits.
9. We spoke with 119 patients at the WRH, 96 in the corridor areas at A&E and 23 in the corridor of the Medical Assessment Unit, of whom 51% were female and 49% male.

What we found out

10. In the Report we have provided further information & commentary about our findings. The main headlines are set out below.
11. We found that the majority of respondents had not been given any information about being in the corridor area and 43% did not know the name of the person looking after them.

[1] Risk Summit meeting 18th January 2017

[2] Monthly A&E Timeseries January 17, NHS England, published March 2017

[3] Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

12. Most patients knew how to call for attention from staff but had not needed to do so. Of those (27%) that had called for attention 46% reported that they had waited over 5 minutes for help or had not received the help that they needed. We also observed patients who appeared confused or distressed, had communication difficulties or sensory impairments in the corridor areas. We question whether a corridor is ever the right environment for these patients.
13. The majority of patients had been provided with a drink (88%) or food (62%) since being in the corridor area. When cross referencing patients who had been offered food by the time patients had waited we found 1 patient who had waited 8 – 12 hours and 3 patients who had waited over 12 hours who reported they had not been offered any food since being in the corridor area. We noticed that food and drink was sometimes placed at a distance to patients. A refreshment trolley was available in the MAU, but needed to be clearly signed with instructions available for patients and visitors.
14. Half of the patients that we spoke to had been in pain since being in the corridor area, 60% of these patients felt that staff were doing what they could to control their pain, whilst 19% thought this was true to some extent and 21% did not. A patient reported that they had not been given their prescribed medication during nearly 24 hrs in A&E.
15. We asked patients whether, in their opinion, there were enough staff on duty in the corridor area of the hospital to care for them. 65% said that yes there were enough staff, 19% said that there were not enough staff and 16% did not know.
16. Patients reported that it was difficult to sleep and rest in the corridor areas. We received negative comments about people & equipment moving around, noise, doors opening and closing and bright lighting. We observed staff leaning across patients on trolleys to use the electronic fob to open doors to another part of the hospital. We also observed staff coming through these doors into A&E.
17. 75% of patients reported that there was nowhere to safely keep their personal belongings in the corridor area of the hospital, or they did not know where this was (18%).
18. Whilst 30% of patients reported that they had definitely been given enough privacy when discussing their personal information; condition or treatment in the corridor area, 19% of patients agreed to some extent, however 28% disagreed. Despite moving away from patients to complete our observations we overheard patient's personal information, treatment and condition being discussed on 21 of our visits to the A&E corridor areas. We twice heard test results and diagnosis being given to patients by doctors in the corridor.
19. When asked whether patients had been given enough privacy when being examined or treated 31% reported that this was definitely the case, 19% agree to some extent and 12% disagreed. On three occasions we observed a mobile screen in use in the corridor when a patient was being examined. The screen was insufficient to completely shield the patient from view of other patients and passers-by.
20. Most patients (85%) had not been told how long they might be waiting in the corridor area for, and 16% did not know the reason that they were waiting.

Most patients told us they were waiting to be admitted to a ward or MAU (48%), or were awaiting scans, tests or a decision about next steps (34%).

21. We asked patients how long they had ACTUALLY been waiting in the corridor area of the hospital. 47% (55) of respondents had been waiting for less than four hours. 19% (23) had been waiting 4 – 8 hours, 16% (19) had been waiting eight – twelve hours, 15% (18) had been waiting over 12 hours and 3% (3) didn't know or could not remember
22. Patients reported that overall they had been well looked after by hospital staff, with 74% saying that this was always the case, 18% sometimes the case and 9% disagreeing. The answers varied by age, with people over 50 more often saying that they had been well looked after than those under 50.
23. We asked patients "Overall do you feel that you have been treated with respect and dignity while you have been in this area of the hospital?" 76% reported this was always the case, 15% sometimes the case and 9% disagreed. Again people over 50 more often reported that they had been treated with respect and dignity than those under 50.
24. We asked patients to rate their overall experience of being nursed in the corridor by giving it a number between 1 – 10, where 0 was very poor and 10 was very good. 8% of patients rated their experience between 0 – 3; 46% rated their experience between 4 – 7 and 46% rated their experience between 8 –10. Most (79%) of patients who rated their experience 8 – 10 were over 50, and many had given negative response to other questions in the Survey.
25. From our observations and the comments we received patients appear to be making a distinction between the staff in the A&E Department and the situation that they find themselves in of being cared for in the corridor area. Patients appear to empathise with the pressure on staff in the Department, whilst being unhappy about some aspects of the experience of being cared for in the corridor.
26. We observed that facilities for visitors can be very limited. On 16 occasions there was nowhere for at least one visitor to sit down. Visitors are not routinely offered drinks even after waiting with patients for some hours.
27. On three occasions patients reported to us inaccuracies in their records, and on four occasions we noted equipment partially obstructing fire exits.
28. We have made 38 recommendations based on the findings which can be found at 1. below.
29. Implementation of the Recommendations set out in this Report should ensure that patients experience and views are given proper consideration in the improvement process and assist with improving the patient experience in what are acknowledged as being extremely difficult circumstances.

1. RECOMMENDATIONS

(Numbers in brackets refer to the section of the Report where the recommendations originate)

Information (5.1)

1. All patients being cared for in the corridor of the A&E Department to be given the letter prepared by WRH explaining about being in the corridor.
2. The WRH letter should be amended to briefly explain HWW role. The text for this can be supplied by HWW.
3. All patients should be given a HWW leaflet so they are aware they can report their experiences to us independently of the hospital.
4. The designated corridor nurse to be identified by wearing a specific coloured badge (similar to the Nurse in Charge badge) to clearly identify them to patients.
5. All staff to introduce themselves to patients by name, in line with the #hellomynameis campaign.
6. Photos of A&E/MAU staff making this pledge could be shared in the A&E areas, subject to Health & Safety considerations.

Patient Care (5.2)

7. WAHT to ensure it is explained to all patients how to call for attention in corridor areas of the hospital, including the MAU where there are no call bells available.
8. WAHT to consider whether patients who appear to be confused or living with dementia, or who have specific communication difficulties or sensory impairments should be nursed in corridor areas of the hospital.
9. WAHT to provide reassurance that best practice on nutrition and hydration of patients on wards is being followed in corridor areas when patients are waiting for lengthy periods.
10. Staff to check patients are able to reach food and drink placed at the end of the trolley and whether any assistance with this is required.
11. Consideration to be given to reinstating a refreshment trolley in the A&E corridor area similar to that in the MAU for patients and visitors.
12. Refreshment trolleys to be easily identifiable to patients and visitors with clear instructions about their use.
13. WAHT to consider how signage could be improved to make this more visible to patients.
14. Patients to be routinely offered pillows and blankets when waiting on trolleys in the corridor areas.
15. Patients to be asked as part of “Care & Comfort” rounds if there is anything that can be done to make their wait more comfortable.
16. Patients to be told the location of the toilets and how to ask for assistance if they require it.
17. WAHT to provide reassurance that procedures are in place to control patient’s pain whilst they are being nursed in corridor areas of the hospital.

18. WAHT to provide reassurance that procedures are in place to provide patients with their prescription medication when they are subject to extended waits in the A&E Department.
19. WAHT to provide information about how A&E and MAU staff will be clearly identified so that patients know who they can ask for assistance.
20. WAHT to consider, in light of the findings and recommendations from this Survey, whether there are sufficient staff to care for patients in the corridor areas in A&E and the MAU throughout the 24hr period.

The Environment (5.3)

21. Consider whether doors to the A&E Assessment corridor need to remain open throughout the day, accepting that this may be the least disruptive option for patients.
22. Consider whether doors to the staff toilets can be modified to prevent them from banging.
23. Relocate the electronic fob in the side corridor to the opposite wall to ensure patients are not disturbed by staff operating the doors into the hospital.
24. Monitor staff movement from the hospital side of the doors into A&E to reinforce the message that this should not be used as a short cut.
25. Dim the lights in the corridor areas earlier at night to allow patients to rest and sleep.
26. WAHT to provide information about how noise will be controlled in corridor areas, particularly at night.
27. Provide secure storage space for patient valuables and belongings when they are being nursed for extended periods in the corridor area of the hospital.

Privacy & Dignity (5.4)

28. Consistently use private areas when providing patients with diagnosis or test results.
29. Consistently use the reserved curtained cubicles within the A&E Department when examining or treating patients.
30. When it is unavoidable to discuss patient's personal information in the corridor areas ensure patients are screened and voices are kept as low as practicable.
31. When it is unavoidable to examine or treat patients in the corridor areas ensure patients are screened sufficiently to protect their privacy and dignity.

Waiting Times (5.5)

32. Provide patients with an indication of how long they might be waiting in the corridor area and provide reassurance to patients whilst they are being nursed in the corridor.
33. Provide patients with a clear reason why they are waiting in the corridor area.
34. WAHT to provide information and reassurance to the public about the specific actions that are planned to ensure that WAHT is able to meet national standards for trolley waits, and the timetable for implementation.

Other Recommendations (6)

35. Provide basic facilities for relatives and visitors, including a seat and access to drinks.
36. Visitors who are staying overnight should be informed of where hospital facilities can be found and offered blankets.
37. WAHT to provide reassurance that processes are in place to ensure patient records are accurate.
38. Ensure that health and safety requirements in respect of the corridors are always complied with.

2. ABOUT HEALTHWATCH WORCESTERSHIRE

Healthwatch Worcestershire (HWW) provides an independent voice for people who use publicly funded health and social care services. Our role is to ensure that people's views are listened to and fed back to service providers and commissioners in order to improve services.

3. WHY DID WE UNDERTAKE THE "CARE IN THE CORRIDOR" SURVEY?

Worcestershire Acute Hospitals NHS Trust (WAHT) is responsible for the provision of acute hospital services in the County. The Trust run two Accident & Emergency (A&E) Departments.

One is located at the Worcestershire Royal Hospital (WRH) in Worcester. The Department is responsible for all emergency care for children in the County. It also sees patients who have had a suspected Stroke. The WRH has a Medical Assessment Unit (MAU). Patients are admitted to the MAU for observation or for further tests to see whether admission to a ward is required.

The other A&E Department is located at the Alexandra Hospital (the Alex) in Redditch. This is for adults requiring emergency care. During 13 visits to the Alex we did not observe any patients being cared for in the corridor area. This Report is therefore focused on the Worcestershire Royal Hospital.

Patients have reported to Healthwatch Worcestershire their experience of long waits at A&E at Worcestershire Royal Hospital, some of which took place on trolleys in corridor areas at the hospital. Figures published by NHS England in March 2017 identified Worcestershire Acute Hospitals Trust as the worst in the country for "trolley waits" of over 12 hours during January 2017. In the same period 65% of patients were seen within 4 hours of arriving at A&E, the national average was 77% and the government target is 95%[4].

The WAHT has identified pressure on the A&E Department at WRH is due to:

- high demand – number of patients coming to A&E in person or by ambulance
- overcrowding – not enough cubicles/ beds available in the department for the number of patients attending
- lack of available beds in the main hospital to transfer patients into, often due to delays in patients leaving hospital when they are medically fit to do so

[4] Monthly A&E Timeseries January 2017, NHS England, Type 1 A&E, published March 2017

As a result patients at Worcestershire Royal Hospital are being cared for on trolleys in the corridor areas of the A&E Department or on chairs, trolleys or beds in the corridor area of the Medical Assessment Unit (MAU), as all other spaces in the Departments are occupied. The situation occurs regularly, to the extent that 6 "call bells" have been installed in the A&E corridor areas where the trolleys are placed at the request of the WAHT Patients Public Forum in an attempt to improve patient experience.

WAHT has been in special measures since December 2015 after being rated inadequate by Care Quality Commission (CQC) Inspectors. In December 2016 the Trust was re-inspected. At a Risk Summit held on 18th January 2017 health and care organisations in Worcestershire, including the WAHT, stated that nursing patients on trolleys is not an acceptable practice. There is a lot of work going on both within WAHT and from other health and social care agencies in Worcestershire with the aim of improving performance across the Trust.

Healthwatch Worcestershire agrees that patients being cared for in corridors is unacceptable and does not endorse this in any way. Nevertheless this situation is being experienced by patients. It is recognised that this is unsatisfactory for both patients and hospital staff.

Healthwatch Worcestershire has been involved in both Quality Monitoring and Risk Summit meetings relating to the Trust and has regularly highlighted the implications for patients of the difficulties being experienced, including through local and national media.

HWW undertook the Care in the Corridor Survey to directly gather patient's experience of being cared for in these areas. One of the roles of Healthwatch is to make recommendations about how local health & care services could or ought to be improved.

Implementation of the Recommendations set out in this Report should ensure that patients' experience and views are given proper consideration in the improvement process and assist with improving the patient experience in what are acknowledged as being extremely difficult circumstances.

4. HOW DID WE UNDERTAKE THE SURVEY?

4.1 Unannounced Enter and View Visits

HWW wrote to WAHT and informed them of our intention to carry out a series of unannounced Enter and View visits to the A&E Departments during the period 13th February 2017 – 26th March 2017.

Healthwatch has the power to "Enter and View" [5] premises where health or social care services are being provided, speak with patients and to observe for ourselves how care is being delivered.

Over the 6 week period Healthwatch Worcestershire completed 44 visits. Of these 31 were to Worcestershire Royal Hospital and 13 to the Alexandra Hospital. We decided to visit the WRH more frequently than the Alexandra Hospital as statistical data and information from the Care Quality Commission (who are responsible for regulating and inspecting hospitals), indicated that corridor waits were more frequent at the WRH.

Visits were carried out at different times in the day and in the evening on weekdays and weekends. The hospital staff did not know when we would be visiting. For further details of the visit programme see Appendix One.

4.2 The Corridor Areas

Worcestershire Royal Hospital

a. Accident & Emergency

The corridor areas that we visited are in two parts. Both are relatively narrow, brightly lit spaces. When there are patients waiting on trolleys in the corridors areas it is difficult for beds, trollies or other equipment to get through the corridor.

Main Corridor

This is located just outside the main A&E area and separated from the assessment area corridor where patients arrive by ambulance by double doors. On one side of the corridor there is space for three trolleys. There are call bells fitted to the wall on this side. Further along there is another set of doors into the main A&E area and a door to a staff only area. On the other side of the corridor there is a unisex patient toilet, double doors to a lab area and 3 staff only doors to sluice, drugs and storage areas. Further along there is a door to an office. The corridor is a busy thoroughfare, with people (staff, patients and visitors) and equipment coming and going through the corridor.

Side Corridor

The second is a shorter corridor leading off from the main corridor area. On one side of the corridor there is space for three trolleys. There are call bells fitted to the wall on this side. There is also a door to a staff changing area which is located between the second and third trolley area. On the other side of the corridor are separate female and male staff toilets and 2 further doors labelled as staff changing rooms.

At the end of this corridor there are double doors into another part the hospital. On the A&E side of the door there is an electronic pad which staff swipe with cards to open the doors. This is located on the wall behind one of the trolley bays. Although this corridor is generally quieter than the main corridor areas it can be particularly busy at staff handover times.

[5] Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

b. Medical Assessment Unit (MAU)

There is a short corridor area through double doors at the entrance to the main MAU. We observed that chairs, trolleys and on 2 occasions beds are placed on the left hand side of the corridor for patients who are waiting either to be admitted to the MAU or for test results. We also observed a refreshment trolley here on occasions. On the other side of the corridor are 3 doors labelled as offices. There are boards displaying useful information for patients and visitors on both sides of the corridor and photographs of staff receiving awards and thank you cards on display. The unisex toilet, waste room and staff room are located just outside of this area, further along the corridor.

Alexandra Hospital

The corridor area is in the main body of the A&E Department, along from the area where patients arrive by ambulance. We did not observe any patients being nursed in this area. Staff drew to our attention that the area is cold and heating inadequate. We have passed on these observations to WAHT.

4.3 Survey and Observations

We developed a survey focusing on different aspects of patient care. Some of the questions were based on the CQC National Inpatient Questionnaire. We piloted the Survey with patients at WRH and made some revisions based on the pilot.

The Survey asked patients about their care; the environment; privacy and dignity and the information that had been provided to them. We also asked patients to rate their overall experience. The Survey can be found at Appendix Two.

Where we have received comments from patients these have been coded as neutral, positive and negative and then themed. Themes identified are presented in order of frequency. Anonymised quotes from patients are also used to highlight issues within the Report.

We also carried out observations and recorded what we saw during our visits using prompt sheets. Findings drawn from observations are reported where relevant in the Commentary sections below.

4.4 Total Respondents

A total of 119 surveys were completed face to face by HWW at Worcestershire Royal Hospital.

- 96 took place in the corridors in the A&E Department
- 23 took place in the corridors in the Medical Assessment Unit

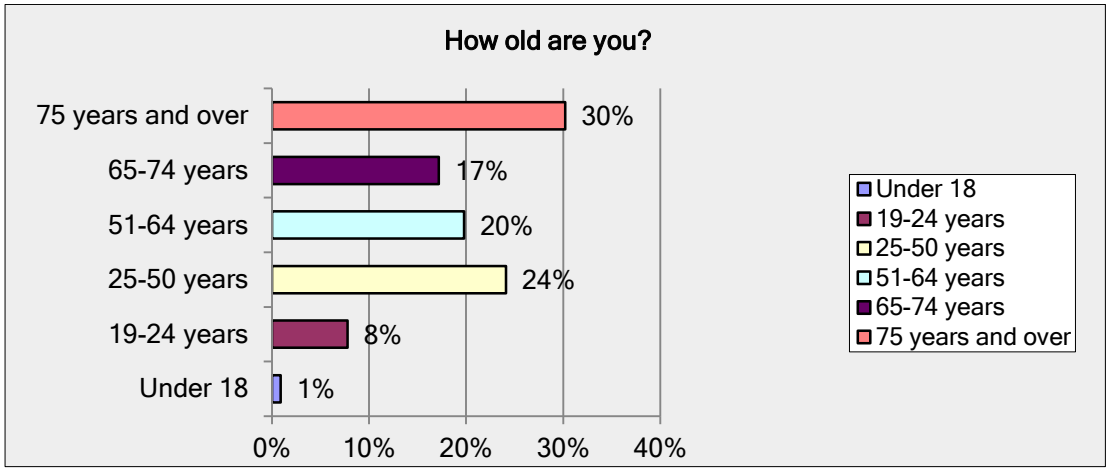
92% (108) of the surveys were completed with the patient, 6% (7) were completed with the patient and a friend or relative and 3% (3) were completed with a friend or relative of the patient.

4.4.1 Respondents by gender

- 51% (61) of respondents are female
- 49% (58) of respondents are male

4.4.2 Respondents by Age

The chart below shows that of the people who answered this question 30% are aged 75+, 24% are aged 25 –50, 20% are aged 51 – 64, 17% are aged 65 – 74, 8% are aged 19 – 24 and 1% are aged Under 18.



4.4.3 Respondents by Ethnicity

97% of the people who answered this question identified themselves as White British. The 3% of respondents who gave a different response identified themselves as Any Other Background (White European)

NOTE

Not all questions were answered by all respondents. When non-response is present, percentages are reported based on the numbers answering the question. The number of respondents to each question can be found at Appendix Two.

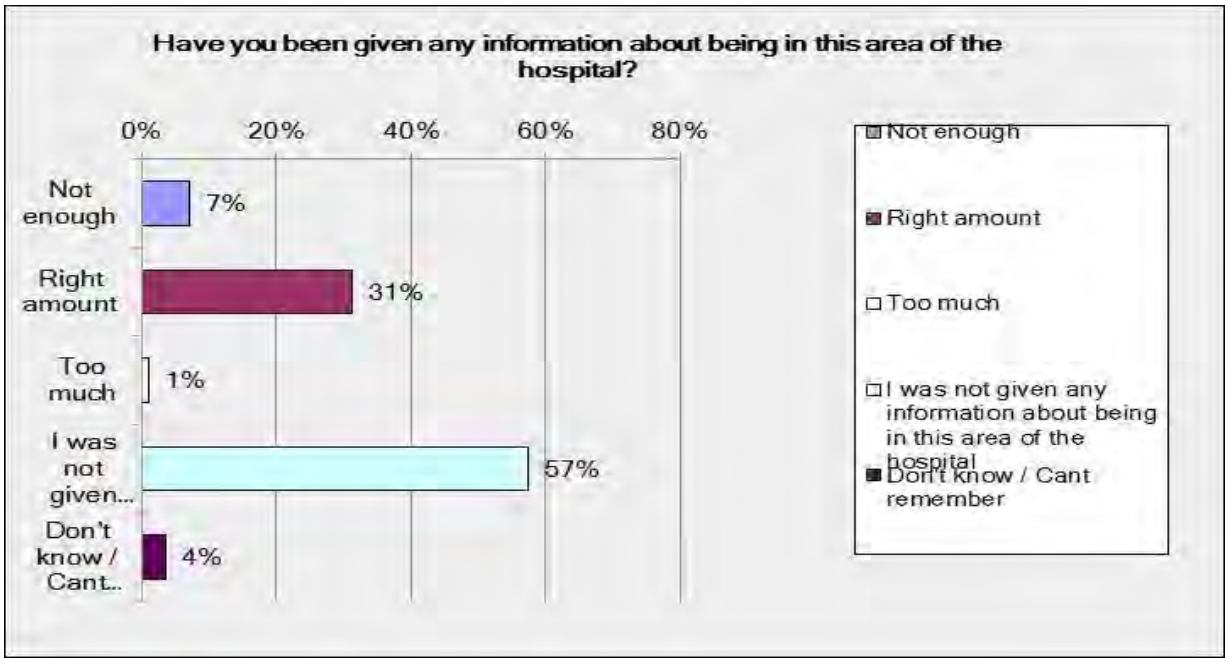
Results have been rounded to the nearest whole number, therefore will not always sum to 100%.

5. SURVEY RESULTS

5.1 INFORMATION

5.1. a. Have you been given any information about being in this area of the hospital?

The chart below shows that the majority of respondents (57%) reported that they had not been given any information about being in the corridor area of the hospital. 31% felt they had received the right amount of information, 7% had not had enough information and 1% too much and 4% did not know or could not remember.



Commentary

HWW observed that some patients have been given an explanatory letter prepared by the Emergency Department "Worcestershire Royal Hospital Emergency Department Patient Information Being in the Corridor". The letter does not seem to be provided consistently to every patient.

Recommendations

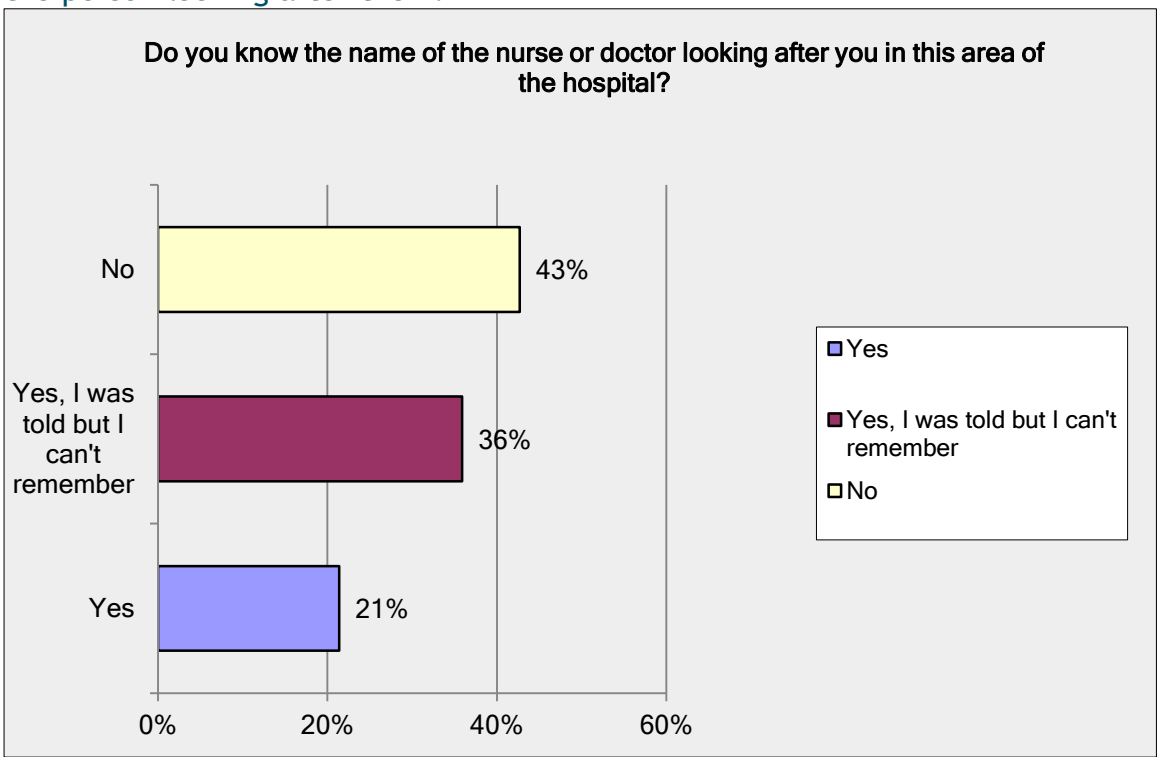
i. All patients in the corridor of the A&E Department to be given the letter prepared by WRH explaining about being in the corridor.
ii. The WRH letter should be amended to briefly explain HWW role. The text for this can be supplied by HWW.
iii. All patients should be given a HWW leaflet so they are aware they can report their experiences to us independently of the hospital.

5.1. b. Do you know the name of the nurse or doctor looking after you in this area of the hospital?

WAHT is a supporter of the #hellomynameis campaign, which aims to encourage staff to introduce themselves to patients, ensuring patients feel respected and welcomed and to improve their quality of care.

57% of the respondents to this question had been told the name of the nurse or doctor looking after them, however of these 36% were unable to remember the

person's name. 43% of respondents reported that they did not know the name of the person looking after them.



Patients Said ….

"I would have liked someone to come and introduce themselves I feel a bit cut off here" (A&E)

Recommendations

i. The designated corridor nurse to be identified by wearing a specific coloured badge (similar to the Nurse in Charge badge) to clearly identify them to patients

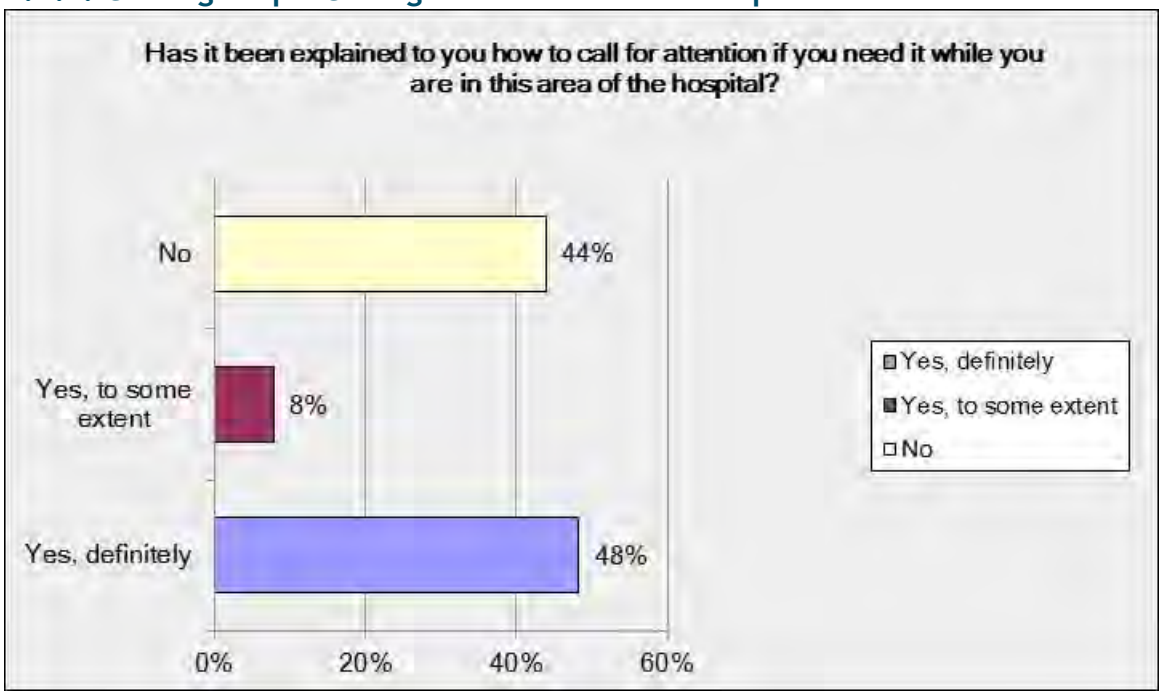
ii. All staff to introduce themselves to patients by name, in line with the #hellomynameis campaign.

iii. Photos of A&E /MAU staff making this pledge could be shared in the A&E areas, subject to Health & Safety considerations.

5.2 PATIENT CARE

We asked a series of questions about the care received by patients in the corridor area of the hospital.

5.2.a. Getting Help – Calling for Attention and Response Times

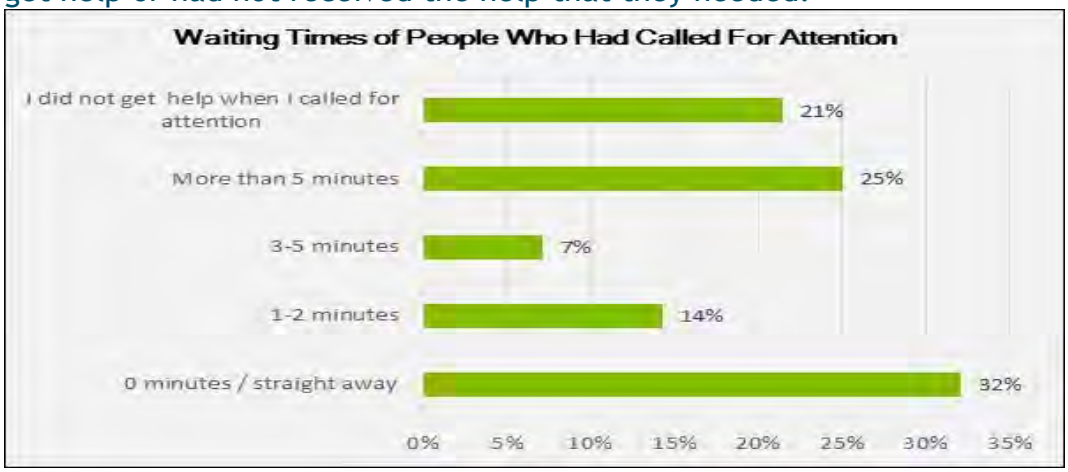


The chart shows that 48% of patients reported that it had definitely been explained to them how to call for attention if they needed it in the corridor area of the hospital, whilst 8% felt this had been explained to some extent. 44% had not had this explained to them.

We asked patients how many minutes it took after they had called for attention before they got the help they needed.

27% of patients had called for attention, whilst 74% had not.

The chart below shows the time that patients who had called for attention reported they waited to get help. 46% of patients waited more than 5 minutes to get help or had not received the help that they needed.



Patients Said ….

We received 7 comments from patients about getting help. These have all been coded as Negative Comments

Negative Comments

- Have not got a bell – 2
- Have a bell but cannot access it – 2

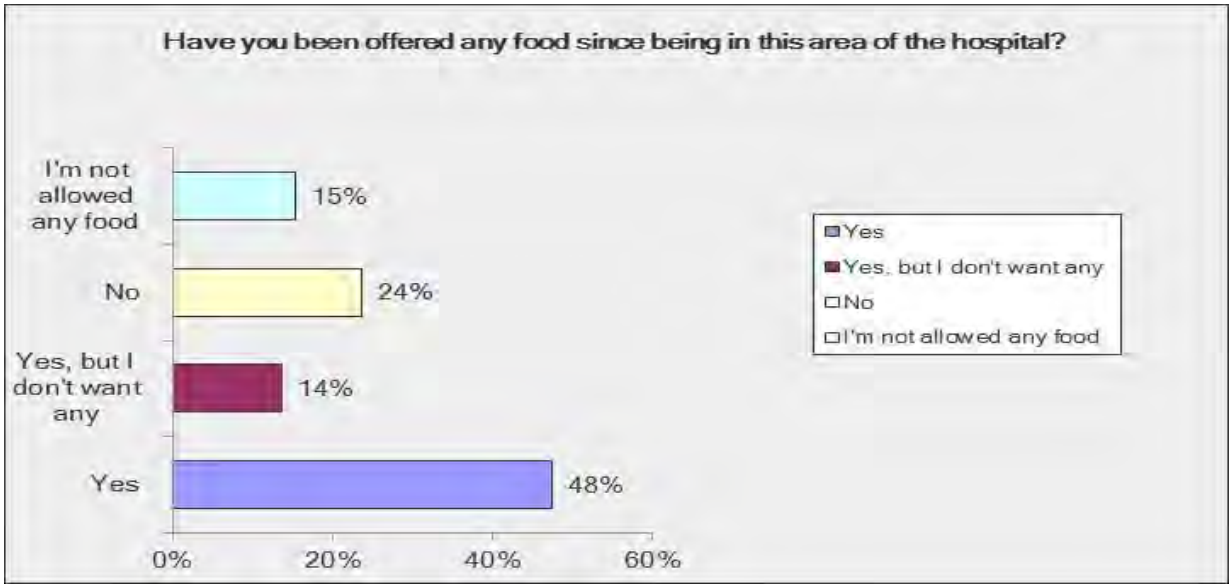
- Delays in answering the bells – 2
- Broken call bell – 1

"There are staff but you can never find them when you need them. I was in pain & I was crying. Staff walked past me when I was crying. It took 20 minutes for someone to come" (A&E)	*"It's a matter of getting hold of staff when I need them. I don't want to run them down, they are lovely" (A&E)*
"I've seen the buzzer, but I've not been shown how to use it" (A&E)	*"Have not got a bell, nurse said to shout for help" (MAU)*

Commentary
On 5 of our visits to WRH we observed older patients, who appeared to be confused or distressed, waiting on trolleys in the corridor areas.
We also observed one patient who was unable to communicate and a patient who was blind in the corridor (both were accompanied by a visitor).
We question whether a corridor is ever the right environment for these patients.
It is also concerning that, although the actual numbers are low, of the patients who had called for attention 21% (6) reported that they did not get the help they needed and 25% (7) waited for more than 5 minutes before they got help.
Recommendations

i. WAHT to ensure it is explained to all patients how to call for attention in corridor areas of the hospital, including the MAU where there are no call bells available
ii. WAHT to consider whether patients who appear to be confused or living with dementia, or who have specific communication difficulties or sensory impairments should be nursed in corridor areas of the hospital.

5.2.b. Food and Drink
We asked if patients had been able to get a **drink** since being in the corridor areas of the hospital. 88% of respondents had been able to get a drink, 7% had not been able to get a drink and 5% were not allowed a drink.
Of the patients who had been able to get a drink 88% had been provided with a drink by staff, 7% by a friend or relative and 5% had got a drink themselves.
Most of our respondents (75%) did not need help from staff to have their drink, 16% reported that they definitely got enough help from staff to have their drink, 3% reported that they had help from staff to some extent and 6% reported that they did not get the help that they needed from staff to have their drink.
We asked if patients had been offered any **food** since being in the corridor area.



62% of patients had been offered food, 15% were not allowed any food and 24% of patients had not been offered any food.

Of the patients who had been offered food 62% had been offered a sandwich or savoury snack; 15% had a cold meal (usually breakfast); 5% had a biscuit, cake or sweet snack; 2% a hot meal and 16% reported they had another food option (usually the patient had a sandwich and a cold meal e.g. breakfast).

We asked if patients had enough help from staff to eat their food. 86% (51) reported that they did not need any help, 7% (4) had definitely had the help they needed, 3% (2) had help form staff to eat their food to some extent whilst 3% (2) reported that they did not get the help they needed.

Patients Said ….

We received 14 comments from patients about food and drink. Of these 2 were positive and 12 were negative. Themes identified in order of frequency are:

Positive Comments

- Food was nice/meals of good quality (2)

Negative Comments

- Can't reach/No table (3)
- Waiting for staff to respond to request for a drink (3)
- Not offered food or drink (3)
- Not enough food or drink provided (1)
- Support not provided to eat or drink (1)
- Easier Access to drinks (1)

"I asked for a cup of coffee at least 4 times. No drink for 7 hours" (A&E)	*"Food was nice" (A&E)*
"Only two cups of tea within 16 hours" (A&E)	*"Meals of good quality" (A&E)*
"Unsure if supposed to drink, nurse said she would return and tell me. No one returned after 20 minutes, so I drank it as I had not had one all day" (A&E)	

"It's a bit far away, I can't reach it" (A&E)	
"Cold, burnt toast for breakfast" (A&E)	

Commentary

Whilst the numbers of patients who reported they did not get the help that they needed with food and drink are small hydration & nutrition are obviously important areas.

When cross referencing patients who had been offered food by the time patients had waited we found 1 patient who had waited 8 – 12 hours and 3 patients who had waited over 12 hours who reported they had not been offered any food since being in the corridor area.

We observed on our visits that patients had been provided with small bottles of water. We are not clear of the frequency at which these are provided to patients.

We also observed the trays on which drink and food are placed are fixed to the end of the trolleys. This means that for some patient's food and drink is placed at a distance from them.

On our preliminary visit to the A&E Department prior to the start of the E&V programme we observed that there was a drinks trolley available in the corridor, although this did appear to be causing an obstruction when beds / trolleys were passing through. We did not observe this trolley on any subsequent E&V visits.

In the Medical Assessment Unit we observed that there was sometimes a trolley in the waiting area that contained magazines, water and biscuits. We welcome the initiative to provide these for patients and visitors, however the trolley is not clearly identified as a refreshment trolley. We did not observe anyone helping themselves from the trolley. On one occasion on the top of the trolley we observed two laminated A4 notices. One said "Help yourself to food and drink". The other said "Please ask a member of staff if you can eat or drink".

In the A&E corridors we observed, following some initial feedback to the WAHT from our E&V visits, laminated A4 notices have been placed above the trolley bays and on the wall in the corridor area. These say "Meal rounds begin at 08:00; 12:30; 18:00 and 22:00 – if you require refreshments outside of these times please ask a member of staff to assist you". On a number of occasions we pointed out these notices to patients who did not appear to have noticed them.

Recommendations

i. WAHT to provide reassurance that best practice on nutrition and hydration of patients on wards is being followed in corridor areas when patients are waiting for lengthy periods
ii. Staff to check patients are able to reach food and drink placed at the end of the trolley and whether any assistance with this is required
iii. Consideration to be given to reinstating a refreshment trolley in the A&E corridor area similar to MAU for patients and visitors
iv. Refreshment trolleys to be easily identifiable to patients and visitors with clear instructions about their use
v. WAHT to consider how signage could be improved to make this more visible to patients

5.2.c. Patient comfort

We asked patients if anything more could be done (excluding pain relief) to make them more **comfortable on the trolley**.
65% answered No, 16% would have liked more pillows and 14% more blankets. 4% did not know.
It should be noted that the majority of patients that we saw in the MAU were seated on chairs rather than on trolleys or beds.
We asked patients did they get enough help from staff to **use the toilet**. 65% of respondents reported that they did not need any help from staff to do this; 29% reported that they had definitely got the help that they needed; 1% reported that they had been helped to some extent, and 5% reported that they did not get the help they needed from staff to use the toilet.
Patients Said …
We received 46 comments about patient comfort (going to the toilet and being comfortable on the trolley). 5 were positive and 41 were negative.
Positive Comments

- Help received from staff to go to the toilet (3)
- Have been provided with pillows (2)

Negative Comments

- Discomfort – Needed more pillows/blankets (13)
- Discomfort – trolley (12)
- Couldn't access the toilet/found the toilet myself (7)
- Sides up on the trolley (5)
- A friend/relative helped me to the toilet (3)
- Length of time for staff to take to toilet (1)

"A longer trolley, my feet are jammed against the end of the trolley. If I did not have a friend I would not be able to get out because the bars were up. When had to go to the toilet a friend lowered the bars." (A&E)	*"Staff moved the trolley to right in front of the toilet door and then waited outside for me" (A&E)*
"It would be nice if the trolley was softer" (A&E)	*"Staff pushed me to the toilet in a chair" (A&E)*
"Pillows are very hard" (A&E)	*"Nurse walked with me to the toilet" (A&E)*
"The chair is uncomfortable. I could have done with a cushion" (MAU)	
"I had to wait 15 minutes for them to put the side down so I could go to the toilet" (A&E)	

Commentary
7 patients reported they did not know where the toilets were or had found them by themselves.
5 patients reported they could not get off their trolley because the rails on the trolley had been put in the raised position. We raised this issue with WAHT following which laminated notices were put up on the walls in the A&E area which

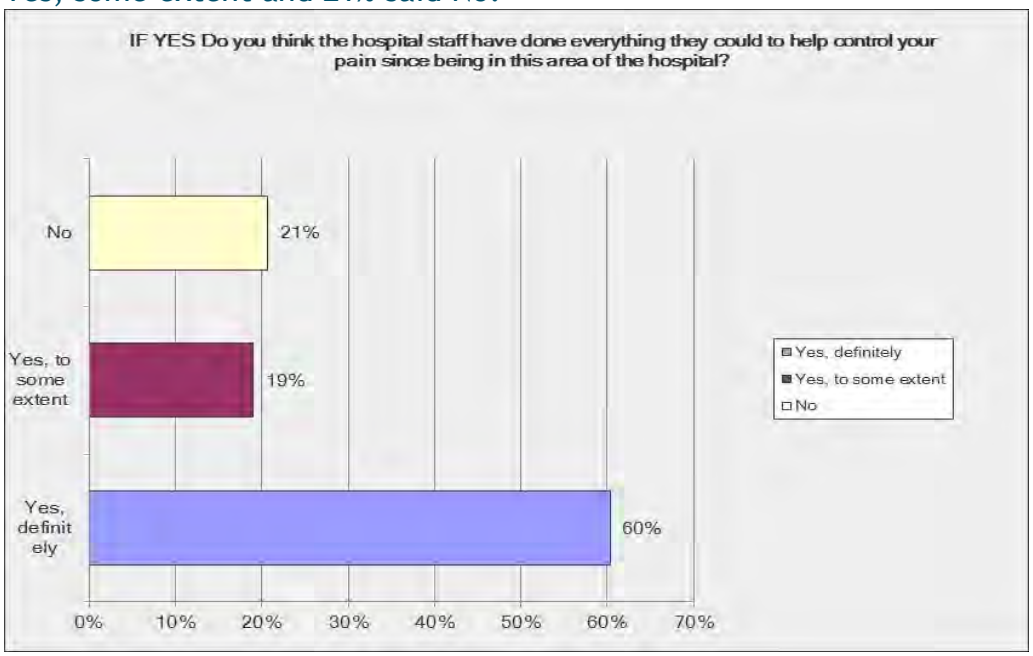
state: “Trolley sides are for your safety. If you wish to have them down please ask a member of staff to assist you”.
In the MAU one patient reported that it was difficult to manoeuvre a wheelchair into the toilet. Another reported that another patient had got stuck in the toilet cubicle and they had called staff for help. The patient who got stuck was told by a member of staff to ask for help next time as it causes problems.

Recommendations

i. Patients to be routinely offered pillows and blankets when waiting on trolleys in the corridor areas
ii. Patients to be asked as part of “Care & Comfort” round if there is anything that can be done to make their wait more comfortable
iii. Patients to be told the location of the toilets and how to ask for assistance if they require it

5.2.d. Managing Pain

We asked patients if they had been in pain since being in the corridor area of the hospital. 50% of patient’s reported that they had been in pain and 50% reported they had not.
We asked those patients **who had been in pain** if they thought that hospital staff had done everything they could to help control their pain since being in the corridor area.
The chart below shows that 60% answered Yes definitely to this question, 19% said Yes, some extent and 21% said No.



Patients Said ….

We received 11 comments about managing pain. 3 of these were positive and 8 were negative.

Positive Comments

- Received pain relief (2)
- Staff were supportive (1)

Negative Comments

- Time patients spent waiting for pain relief (4)
- Not being offered pain relief (3)
- Pain relief ineffective (1)

"Had to wait quite a long time for pain relief. Also have not had my prescribed meds" (A&E)	*"Been very supportive" (A&E)*
"Been waiting 1 hour for pain medication, not received" (A&E)	*"Given paracetamol" (A&E)*

Commentary

A patient reported that he/she had not been given prescribed medicines during the nearly 24 hours they had been in A&E, including 8 hours whilst being nursed on a trolley in the corridor and that no explanation for this had been provided. We have made the WAHT aware of this issue.

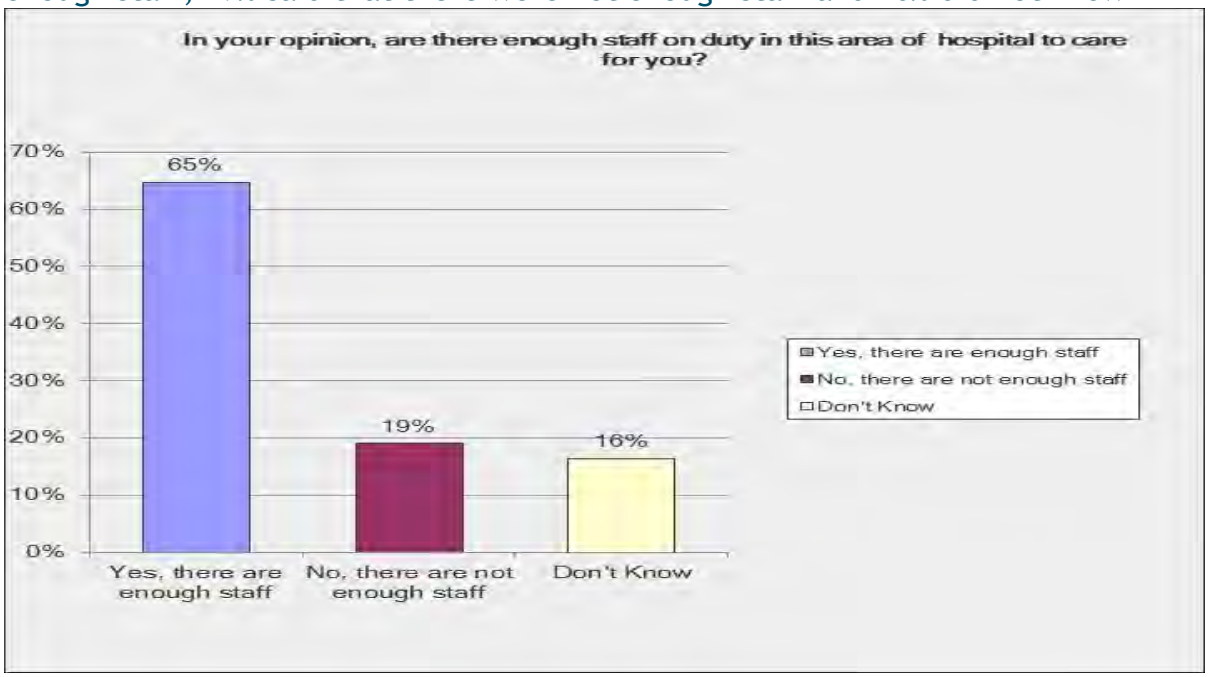
Recommendations

i. WAHT to provide reassurance that procedures are in place to control patients pain whilst they are being nursed in corridor areas of the hospital

ii. WAHT to provide reassurance that procedures are in place to provide patients with their prescription medication when they are subject to extended waits in the A&E Department

5.2.e. Staffing levels

We asked patients whether, in their opinion, there were enough staff on duty in the corridor area of the hospital to care for them. 65% said that yes there were enough staff, 19% said that there were not enough staff and 16% did not know



Patients Said ….

We received 21 comments in total about staffing levels. 2 were neutral, 2 of the comments were positive and 17 were negative.

Positive comments

- Staff walking about (1)
- Last night 1 nurse between 3 (1)

Negative comments

- Lots of staff but they are all busy (9)
- Not enough staff (5)
- Don't see nurses / feel out of the way (3)

"There are lots of staff constantly passing me but I have not had a lot of attention" (A&E)	*"Last night there was 1 nurse between 3 patients" (A&E)*
"Barely, staff are very busy" (A&E)	*"Staff appear to have too many people to look after, so I am alright but were they?" (A&E)*
"They are stretched" (MAU)	*"There seems to be staff but how they are allocated I don't know" (A&E)*
"They appear run off their feet" (MAU)	

Commentary

A number of patients commented that there are lots of staff coming and going along the corridors, but they are not always sure which staff are part of the A&E or MAU and can therefore be asked to help them.

Recommendations

i. WAHT to provide information about how A&E and MAU staff will be clearly identified to patients so that patients know who they can ask for assistance

ii. WAHT to consider, in light of the findings and recommendations from this Survey, whether there are sufficient staff to care for patients in the corridor areas in A&E and the MAU throughout the 24hr period

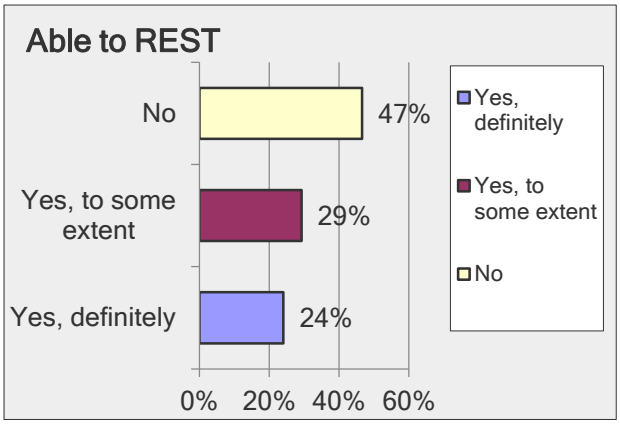
5.3 THE ENVIRONMENT

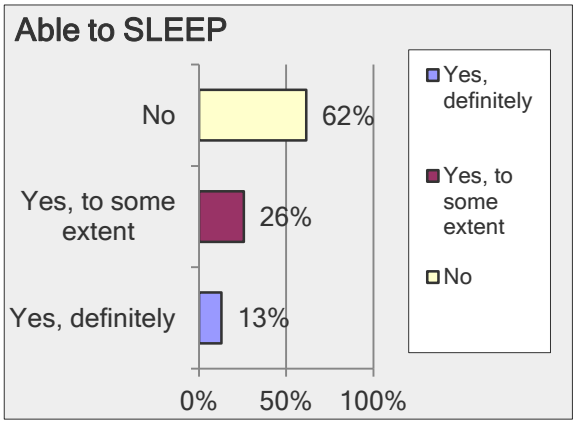
5.3.a. Noise, Rest and Sleep

We asked patients whether they had been bothered by **noise** since being in the corridor area of the hospital. 42% reported that they had been bothered by noise whilst 58% had not.

We asked patients if they were able to **rest** in corridor areas of the hospital. 47% of patients did not feel able to rest in the corridor area, 29% could rest to some extent and 24% were definitely able to rest.

We also asked if patients were able to **sleep** in corridor areas of the hospital. Fewer patients felt able to sleep than to rest. 62% reported that they would not be able to sleep, 26% said they could sleep to some extent and 13% said they could definitely sleep in the corridor area.





Patients Said ….

We received 89 comments relating to noise, rest and sleep. 9 comments were neutral; 5 were positive and 75 were negative.

Positive Comments

- Staff turned lights off (2)
- Moved to a warmer part of corridor (1)
- Better than a cubicle (1)
- Not noisy (1)

Negative Comments

- People/equipment moving (23)
- Noise (22)
- Doors opening/closing/key pads (9)
- Too bright (9)
- Buzzers/beeping/printer (6)
- Discomfort (3)
- Strange environment (2)
- Unhygienic (1)

"Noisy, trolleys moving. Bleeps going off all the time" (A&E)	*"Noise does not bother me. I know they are busy. They are all working hard" (A&E)*
"It's like the M5, everything and everybody coming past you" (MAU)	*"Quite noisy but I did manage to get some rest" (A&E)*
"I am right by the doors with the fob scanner above my right shoulder. The corridor is busy, including with waste bins. I would rather be here than by the toilet though" (A&E)	*" I find it better out here than in a cubicle with the curtain closed, at least there is stuff going on" (A&E)*

"Bright lights - didn't go off until early hours of the morning" (A&E)	*"They turned the lights off at one point which really helped me [sleep] (A&E)*
"It's difficult to sleep at night because of all the banging going on. Particularly difficult because staff are using the loos during the night and the doors bang" (A&E)	
"It is noisy. The floor moves when people walk up and down" (MAU)	

Commentary

On 20 of our 31 visits we observed the main corridor area in the A&E Department was especially busy, with lots of people (staff, patients and visitors) and equipment coming and going through the corridor.

On 16 occasions we described the A&E corridor areas as noisy.

We observed that the double doors to the corridor area where patients who have arrived by ambulance are sometimes assessed were often open during our visits.

The side corridor in the A&E Department was generally quieter but could be particularly busy at staff handover times when the changing rooms are in use. Patients also reported being disturbed through the night by staff using the toilets located in this corridor.

On 2 occasions we observed Trust staff leaning over patients on trolleys to use the electronic fob to open the doors into the hospital. Patients (5) also reported to us that Trust staff leaned over them to access the fob. We also observed staff from the hospital coming through these doors into the A&E corridor area. We observed a sign on the hospital side of the door instructing that the corridors should not be used as a "short cut" as patients are being nursed on the other side of the doors. We have already passed on these observations to WAHT.

Patients reported noise at night time. Two examples were a printer being used at 03:00 a.m. and staff holding non work related conversations at night in the corridor areas by patients on trolleys.

We observed that the lighting in the corridor areas is bright, with lights located above the trolley areas. Patients told us the lighting was sometimes not dimmed until the early hours of the morning.

Patients in MAU observed the floor shudders when people walk through the corridor area.

Recommendations

i. Consider whether doors to the A&E Assessment corridor need to remain open throughout the day, accepting that this may be the least disruptive option for patients

ii. Consider whether doors to the staff toilets can be modified to prevent them from banging

iii. Relocate the electronic fob in the side corridor to the opposite wall to ensure patients are not disturbed by staff operating the doors into the hospital

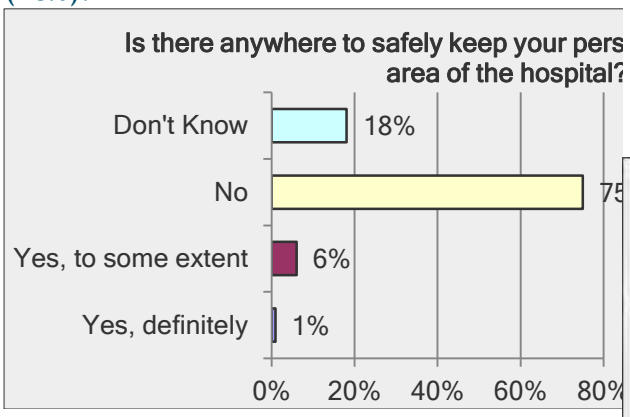
iv. Monitor staff movement from the hospital side of the doors into A&E to reinforce the message that this should not be used as a short cut
v. Dim the lights in the corridor areas earlier at night to allow patients to rest and sleep
vi. WAHT to provide information about how noise will be controlled in corridor areas, particularly at night

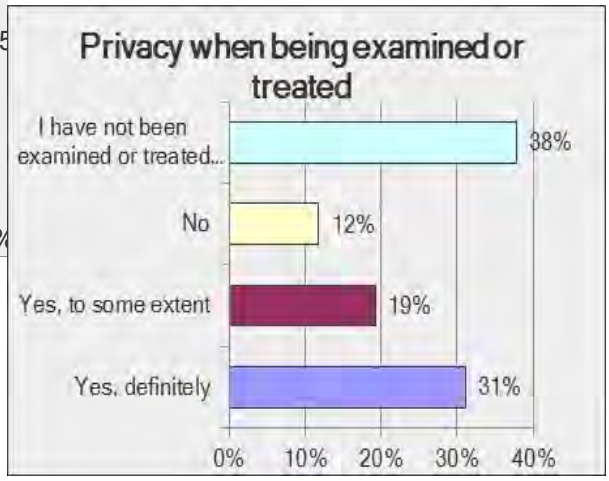
5.3. b. Temperature

Most patients (66%) found the temperature in the corridor area of the hospital about right. 15% reported that it was hot (7%) or too hot (8%) or, whilst 20% found it cold (17%) or too cold (3%)

5.3. c. Personal belongings

75% of patients reported that there was nowhere to safely keep their personal belongings in the corridor area of the hospital or they did not know where this was (18%).





Patients Said ….

We received 6 comments about personal belongings. All were negative.

- Fear of losing belongings (3)
- Don't know where belongings are (2)
- Nowhere safe for belongings (1)

"I took my shoes off when I was admitted but no one knows where they are" (A&E)	*"I had my arm on my bag all night just in case" (A&E)*	*"I was panicking because I couldn't find my bag" (A&E)*

Recommendations

i. Provide secure storage space for patient valuables and belongings when they are being nursed for extended periods in the corridor area of the hospital.

5.4 PRIVACY AND DIGNITY

We asked patients whether they had been given enough privacy when discussing **personal information, your condition or your treatment** since being in the corridor area of the hospital. The chart shows that 30% of respondents reported this was definitely the case, 19% agreed to some extent, 28% did not agree that they had been given enough privacy and 22% had not discussed these subjects since being in the corridor area.

We asked patients whether they had been given enough privacy when being **examined or treated** since being in the corridor area of the hospital. The chart shows that 31% of respondents reported this was definitely the case, 19% agreed to some extent, 12% did not agree they had been given enough privacy and 38% had not been examined or treated since being in the corridor area.

Patients Said ….

We received 30 comments relating to privacy and dignity. 2 comments were neutral; 7 were positive and 21 were negative.

Positive Comments

- Taken to a cubicle or private area for discussion or treatment (4)
- Screen used to provide privacy (3).

Negative Comments

- Lack of privacy during examination/consultation (5)
- No privacy/the situation is not right for privacy (5)
- Can overhear/be overheard (4)
- Feel watched/people walking past (4)
- No screens (1)
- Curtains needed for privacy (1)
- Could be treated with more dignity (1)

"None whatsoever [privacy] when discussing personal information and completely opposite to privacy when being examined" (A&E)	*"They put a screen around me" (A&E)*
"The location doesn't make being treated with dignity and respect easy - especially if you are worried about being overheard" (A&E)	*"Wheeled screen, staff tried, to the best of their ability" (A&E)*
"I feel a bit watched. There is no privacy. I can overhear everything the doctors are saying" (A&E)	*"I was pushed into a cubicle when they needed to look at my leg" (A&E)*
"I overheard all the details of a consultation with a lady who was on the trolley next to me, also had to avoid looking through the screen that	*"When in the corridor the doctor examined me but he was quickly put right by a nurse who suggested he should move me into a cubicle which*

was around her" (A&E)	*he did" (A&E)*
"I was examined in hallway where everyone can see including personal areas, I am not happy about that" (A&E)	
"A lady was examined by the doctor in the corridor and I could see her stomach and breasts, she laughed but I felt it was not right" (A&E)	

Commentary

Despite moving away from patients to complete our observations we overheard patient's personal information, treatment and condition being discussed on 21 of our visits to the A&E corridor areas.

We twice overheard test results and diagnosis being given to patients by doctors in the corridor. Other patients in the corridor at the time would also have heard this information. On one other occasion we observed a screen was being used and efforts were being made to speak softly and maintain patient privacy.

On three occasions we observed a mobile screen in use in the corridor when a patient was being examined. The screen was insufficient to completely shield the patient. Other patients and people walking past could see the patient being examined.

We also observed patient's blood being taken; a cannula fitted and bandages being removed. More routine checks such as blood pressure were also undertaken in the corridor area.

Recommendations

i. Consistently use private areas when providing patients with diagnosis or test results

ii. Consistently use the reserved curtained cubicles within the A&E Department when examining or treating patients

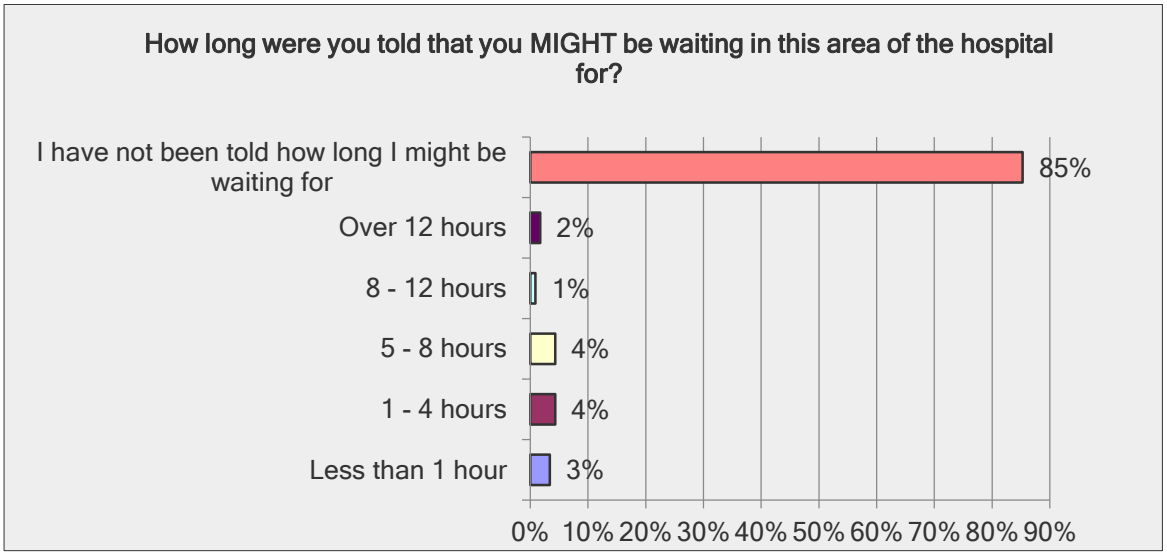
iii. When it is unavoidable to discuss patient's personal information in the corridor areas ensure patients are screened and voices are kept as low as practicable

iv. When it is unavoidable to examine or treat patients in the corridor areas ensure patients are screened sufficiently to protect their privacy and dignity

5.5 WAITING TIMES

5.5.a. Informing patients about how long they MIGHT be waiting

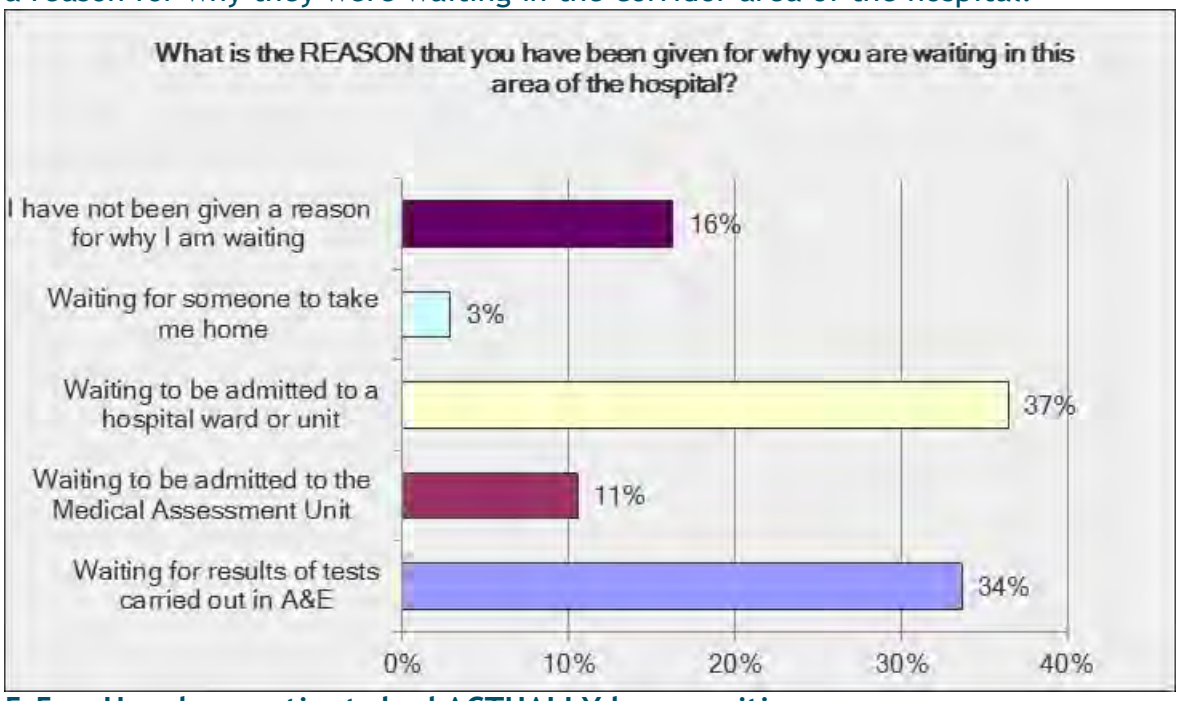
We asked patients if they had been told **how long they MIGHT be waiting** in the corridor area. 85% of respondents had not been told how long they might be waiting, the chart below gives the distribution of remaining answers. Patients who had been told they would be waiting more than 12 hours had usually been informed they would be in hospital overnight.



5.5.b Informing patients about the reason they are waiting

We asked patients what was the **reason** they had been given for why they were waiting in the corridor area of the hospital.

The chart shows that 37% of patients were waiting to be admitted to a hospital ward or unit, and a further 11% were waiting to be admitted to the Medical Assessment Unit. 34% of patients were waiting for results of tests carried out in A&E. It should be noted that patients who told us they were waiting to go for scans or tests, or who were waiting to speak with doctors or consultants so a decision could be made about next steps have been included in this category. 3% of patients were waiting for someone to take them home. 16% of patients had not been given a reason for why they were waiting in the corridor area of the hospital.

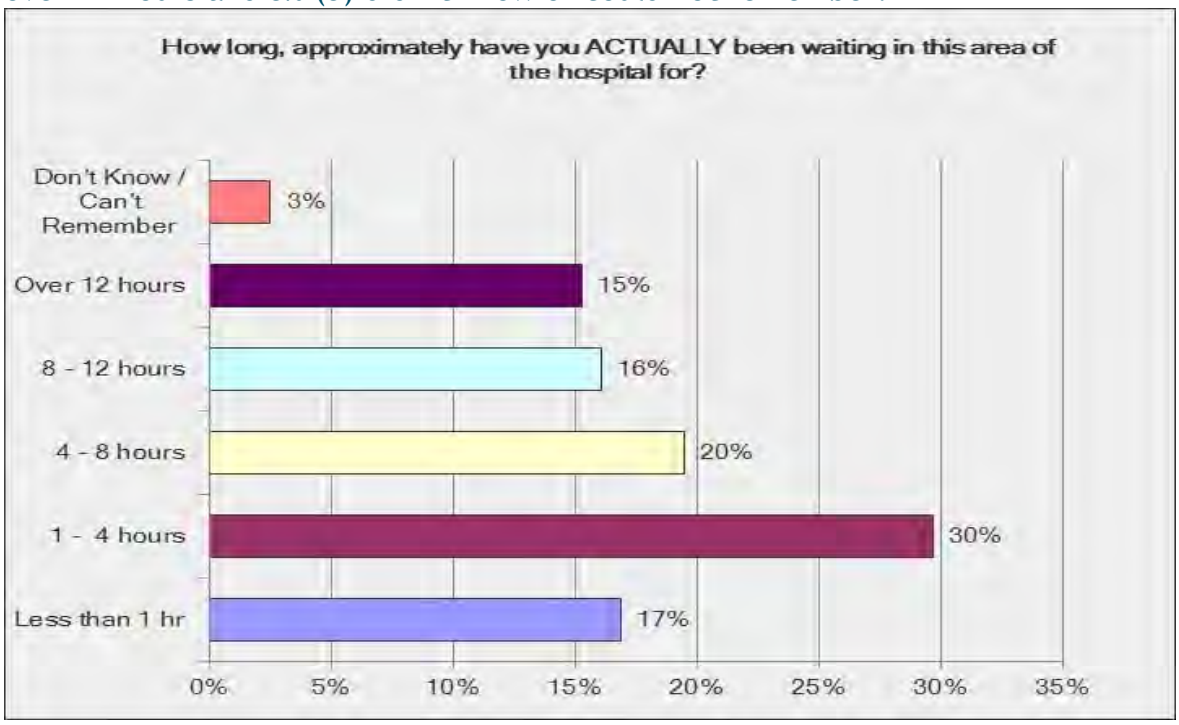


5.5.c. How long patients had ACTUALLY been waiting

We asked patients how long approximately have you ACTUALLY been waiting in the corridor area of the hospital. We were clear with patients that we were not asking about when they had first arrived in the Emergency Department, we were asking about time spent waiting in the corridor.

17% (20) of respondents reported they had been waiting for less than an hour, 30% (35) had been waiting between one – four hours; 19% (23) had been waiting 4 – 8

hours, 16% (19) had been waiting eight – twelve hours, 15% (18) had been waiting over 12 hours and 3% (3) didn't know or could not remember.



The table below shows waiting time by age.

Age	Waiting time				
	Under 1 hour	1-4 hours	4 – 8 hours	8 – 12 hours	Over 12 hours
Under 18	0%	0%	0%	5%	0%
19 - 24	0%	12%	9%	16%	0%
25 - 50	30%	15%	36%	26%	22%
51 - 64	20%	21%	18%	21%	11%
65 - 74	20%	15%	14%	11%	28%
75 +	30%	36%	23%	21%	39%

The table shows that the highest percentage of patients waiting over 12 hours are aged 65+, this could be due to patients who are older having multiple medical conditions.

Patients Said ….

We received 7 comments relating to waiting times all of these were negative and referred to length of wait.

"At first I was told I was waiting for a bed. I was offered a trolley about 8pm. I thought there will be a bed soon so I refused. I finally got a bed at midnight. I am in bed but I am still in the corridor" (MAU)	*"Staff have been brilliant, but could keep you better informed about how long you have to wait" (A&E)*
"I wish treatment would happen quicker" (A&E)	*"Had to wait 7 hours to see a doctor" (A&E)*

Commentary

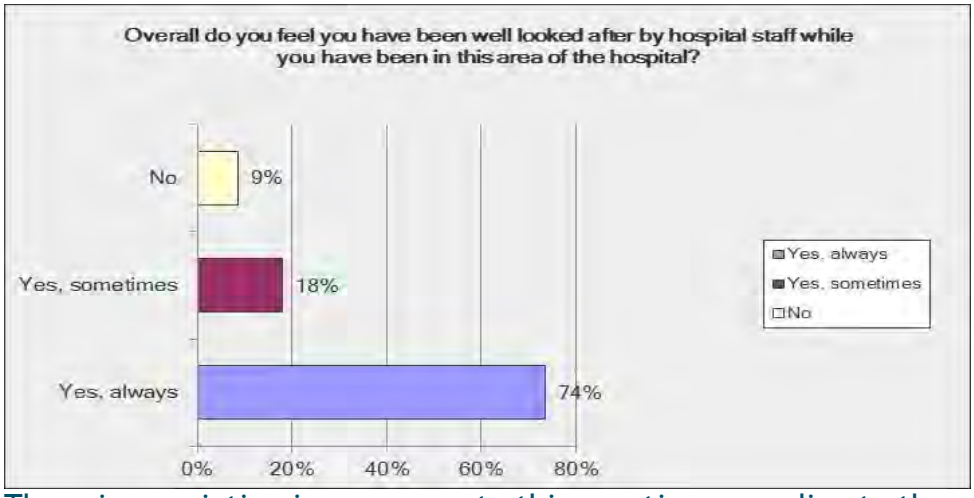
There are a number of national targets relating to A&E. These include:

- Attendances – patients being seen in under 4 hours from arrival at A&E to admission, transfer or discharge
- Number of patients spending over 4 hours from decision to admit to admission,
- Number of patients spending over 12 hours from decision to admit to admission.

The latter 2 targets are referred to as "trolley waits". A trolley wait of over 12 hours is classed as a "serious incident" which should never happen.
During the period of our visits:
Awaiting contextual information from CCG's
We were specifically asking patients how long they had been waiting in the corridor, we did not ask patients about the total time they had spent in the A&E Department. 35% of our sample reported they had been waiting in the corridor over 4 hours and 15% over 12 hours at WRH. During this project we made 13 visits to the Alexandra Hospital but we did not see any patients in corridor areas at the hospital. There may be learning or practice from the Alexandra Hospital or elsewhere that could help the situation at the WRH.
On one occasion we heard staff apologise to a patient for the long wait and provide reassurance that they had not been forgotten and would be seeing a doctor.
Recommendations / Points to Consider

i. Provide patients with an indication of how long they might be waiting in the corridor area and provide reassurance to patients whilst they are waiting
ii. Provide patients with a clear reason why they are waiting in the corridor area
iii. WAHT to provide information and reassurance to the public about the specific actions that are planned to ensure that WAHT is able to meet national standards for trolley waits, and the timetable for implementation

5.6 PATIENTS OVERALL EXPERIENCE
5.6.1. Have patients been well looked after by hospital staff
We asked patients "Overall do you feel you have been well looked after by hospital staff while you have been in this area of the hospital?" 74% replied they had always been well looked after, 18% had sometimes been well looked after and 9% answered no to this question.



There is a variation in responses to this question according to the age of the respondent, with 80% of those over 50 reporting they had always been well looked after compared to 58% of those under 50. More under 50's (18%) answered no to this question than over 50's (4%).

By Age - Well looked after by hospital staff

	Under 50	Over 50	All
Yes, Always	58%	80%	74%
Yes, Sometimes	24%	16%	18%
No	18%	4%	9%

This may be because, in HWW experience, people in the 50+ age group are more reluctant to complain about their care than younger respondents.

Patients Said ….

We received 23 comments about staff (as opposed to staffing levels which were reported at 4.2.e.). 18 comments were positive and 5 were negative.

Positive Comments

- Staff are kind/helpful/excellent (14)
- Staff have looked after me/care was good (4)

Negative Comments

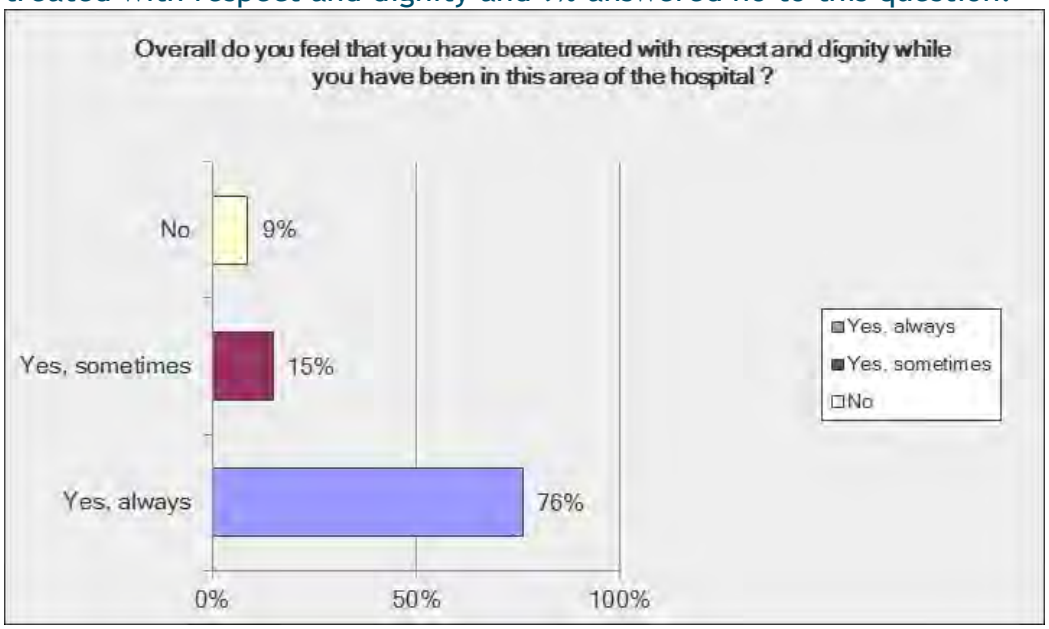
- Attitude and care provided by doctors (2)
- Lack of respect and compassion (3)

"Can't fault the staff, lucky to have the service and treatment" (A&E)	*"As hospital staff pushed past me, no one said "Excuse me". No one asked me how I was feeling for about 8 hours" (A&E)*
"I couldn't wish for anything better. If you are on a trolley there are other people worse than you. I have had very bad experiences at this hospital before but not here today" (A&E)	*"Some orderlies walked past when I was crying, I asked for help and they said you'd have to see a nurse. It took a member of the public visiting another patient to get me a nurse …*

	there has got to be a bit of compassion" (A&E)
"I am very satisfied, they cannot do enough for you. I have had two doctors, they have explained things to me and the nurse has been popping back" (A&E)	*"I repeatedly asked for someone to contact my wife. I left home seven and a half hours ago. Eventually a visitor to another patient let me use her mobile phone" (A&E)*
"Everyone has been extremely kind and thoughtful"	

5.6.2. Have patients been treated with respect and dignity

We asked patients "Overall do you feel you have been treated with respect and dignity while you have been in this area of the hospital?" 76% responded they had always been treated with respect and dignity, 15% they had sometimes been treated with respect and dignity and 9% answered no to this question.



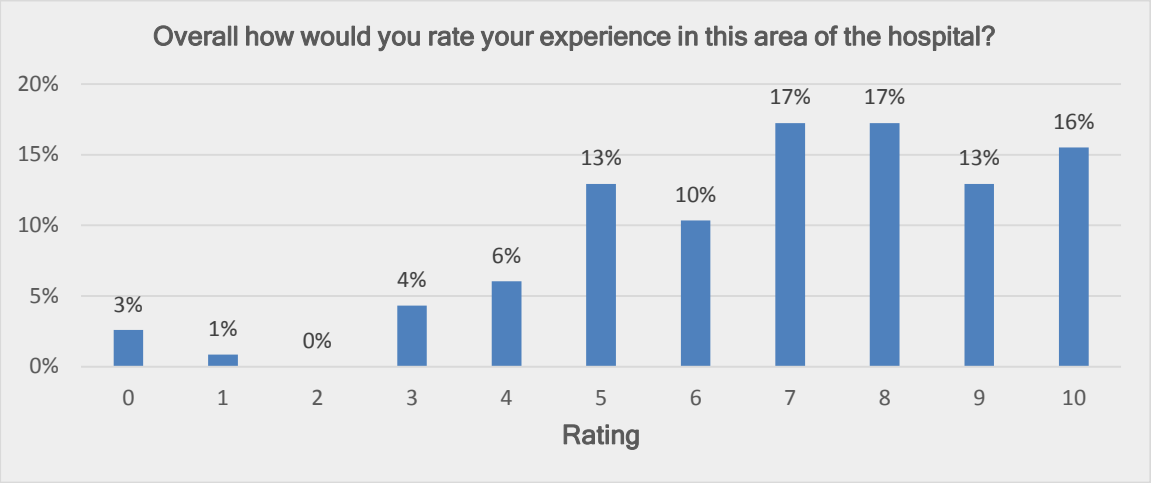
There is a variation in responses to this question according to the age of the respondent with 81% of those over 50 reporting they had always been treated with respect and dignity compared to 65% of those under 50. More under 50's (14%) answered no to this question than over 50's (7%).

By Age - Treated with respect and dignity

	Under 50	Over 50	All
Yes, Always	65%	81%	76%
Yes, Sometimes	22%	12%	15%
No	14%	7%	9%

5.6.2. Overall Rating

We asked patients to rate their overall experience in the corridor area of the hospital, where 0 = I had a very poor experience and 10 = I had a very good experience.



The chart shows that:
8% of patients rated their experience between 0-3
46% of patients rated their experience between 4-7
46% of patients rated their experience between 8-10
The table below shows **rating by Age**

Age	**Rating**		
No of respondents	**0 - 3**	**4 - 7**	**8 - 10**
Under 18 (No. 1)	0%	0%	100%
19 - 24 (No. 9)	11%	66%	22%
25 - 50 (No. 28)	22%	57%	22%
51 - 64 (No. 21)	5%	58%	38%
65 - 74 (No. 20)	0%	45%	55%
75+ (No. 34)	3%	30%	67%
All	**8%**	**46%**	**46%**

Of the patients who gave a rating of between 8 – 10 of their experience those aged under 18 and those aged 65+ gave the highest ratings.

The table below shows **rating by waiting times**

	Rating		
Waiting Times	**0 - 3**	**4 - 7**	**8 - 10**
Under 1hr	5%	65%	30%
1 - 4 hrs	3%	30%	67%
4 - 8 hrs	13%	66%	22%
8 - 12 hrs	15%	45%	39%
12+ hrs	6%	34%	61%
All	**8%**	**46%**	**46%**

Although there is no clear pattern between ratings and waiting times the findings suggest that patients waiting between 4 – 8 hrs rate their experiences lower (0 -7) than other patients (79%). The comparatively high number of patients who are waiting over 12 hrs and have rated their experience between 8 – 10 may be related to the age group of these patients.
Patient Said ….

We asked patients whether there was anything else they would like to tell us about their experiences in the corridor areas of the hospital. We received 33 comments. 3 were positive, 12 were neutral and 24 were negative

Positive Comment

- Being in corridor has been managed well / not a problem (3)

Neutral Comments

- Statements of appreciation for care provided, but unhappy about the situation of being in the corridor (10)
- Practical issues of being in corridor (no clock or phone charger available) (2)

Negative Comments

- Feeling left / forgotten / isolated (9)
- Situation of being nursed in the corridor poor / not acceptable (9)
- Poor environment for patients (4)
- Staff did not contact relatives (2)

"Annoying that I am here but people have looked after me. I cannot give them a gold star for putting me in a corridor. I think it is a sorry state of affairs to be in a bed in a corridor all night …. this is my first experience of being out in the cold" (MAU)	*"If no beds then I cannot be moved from the corridor and I have accepted it. It's not the staffs fault" (A&E)*
"I understand the pressure for beds but it's not ideal for elderly people, or for anybody. You would only find this in third world countries" (A&E)	*" I think they have worked well in how they have managed this, being in the corridor" (A&E)*
"No one really comes to me out here in the corridor" (A&E)	*" I have been quite happy here, it's not been a problem at all" (A&E)*
"Not nice being on a walkway. People going up and down. No privacy. Feel a bit forgotten round the corner (A&E)	*"The staff have been brilliant, but the corridor situation is not good!" (A&E)*
"From a staff point of view I would put 10, from a corridor point of view I would put 5" (A&E)	*"Care very good but the situation is not ideal" (MAU)*
"Care was fantastic until I was moved into the corridor. I was very upset for an hour and nobody came. I had to phone Mum. I had no pain relief and was crying. Around the corner I can hear others laughing and chatting while I am crying" (A&E)	*"I have heard a lot of things about trolleys being used in corridors. This is my first experience. I sympathise, if you can't fit everyone in what can you do? I can see the dilemma" (A&E)*
"I don't think anyone can be treated	*" It's not the staff, it's the*

with respect in a corridor" (A&E)	*environment" (A&E)*
"Don't know why I'm in the corridor. I just hate it. I feel like I am living here" (A&E)	*"Just need more beds …. situation, not the care that is the issue" (MAU)*

Commentary

In HWW experience patients, particularly older patients, are grateful for the NHS and the care they are receiving.

It is interesting to note that of the patients who gave an overall rating of 8, 9 or 10 in answer to survey questions these patients reported that 29% did not know the name of the person who was looking after them; 43% had not had it explained to them how to call for help; 6% had reported they did not think there were enough staff on duty to care for them and 15% were not sure about this. These patients also made 28 comments which have been themed as negative in response to questions on the survey. This suggests that patients are reluctant to give lower overall ratings and are taking other factors into consideration.

As can be seen from some of the "Patients Said" comments above patients appear to be making a distinction between the staff in the A&E Department and the situation they find themselves in of being nursed in the corridor area.

Patients appear to empathise with the pressure on staff in the Department whilst being unhappy about some aspects of the experience of being nursed on the corridor.

We also observed that patients seemed more reluctant to provide negative feedback than visitors. For example we received a follow up telephone call from a patient's relative saying the patient "didn't want to get anyone in trouble" and was reluctant to say anything bad about her care. The patient had been in A&E for a total of 28hrs (not all spent on the corridor).

6. FURTHER POINTS FROM OUR OBSERVATIONS NOT COVERED IN THE SURVEY

During our visits patients reported or we were told about the following issues that are not reported elsewhere in the Survey.

6.1 Relatives and Visitors

On 26 of our visits at least one patient in A&E had a relative or visitor with them. On 16 occasions there was nowhere for at least one relative or visitor to sit down. We observed 6 visitors sitting on the end of patient trolleys as there was nowhere else to sit down.

On at least three occasions we spoke with relatives or visitors who had remained with a patient overnight. One mentioned being unsure of the "rules" about visitors e.g. was it acceptable to stay overnight with a patient. We also noted that some of the relatives / carers we saw appeared themselves to be older people, but were reluctant to leave the patient unaccompanied overnight. We are concerned about the lack of facilities for people staying overnight.

There did not appear to be a clear policy about whether relatives / visitors, particularly of patients who have lengthy stays in A&E, were offered drinks, chairs or blankets.

"As a visitor I have been standing most of the day. It would have been nice if someone had offered me a chair" (A&E)	*"Porter offered Mum a chair" (A&E)*

"I am not sure what the rules are about being here or not. I don't want to go to the café in case I am not allowed back in or xx was moved" (A&E)	*"The nurse gave me a couple of blankets" (A&E)*

Recommendations

i. Provide basic facilities for relatives and visitors, including a seat and access to drinks

ii. Visitors who are staying overnight should be informed of where hospital facilities can be found and offered blankets

6.2. Record Keeping

On 3 occasions patients reported inaccuracies in their records. These related to:

- Patient challenging the accuracy of the record in relation to pain relief and hydration – this issue has already been raised with WAHT
- Patient reported being recorded as the wrong gender on their record – the patient pointed this out and the record was changed
- Patient reported their records showed they had allergies which they did not have

One patient reported being asked for the same information on a number of occasions

Recommendations

i. WAHT to provide reassurance that processes are in place to ensure records are accurate

6.3 Health and Safety

On 2 occasions we noted there was equipment in the A&E corridor area next to the sign: "No trolleys or equipment at this location. Caution fire evacuation route. No trollies or equipment".

On 2 occasions we observed trolleys outside the MAU corridor that were partially blocking the evacuation route.

Recommendations

i. Ensure that health and safety requirements in respect of the corridors are always complied with

7 CONCLUSION

It is widely recognised, and accepted by the Trust, that caring for patients in corridors does not provide the privacy and dignity that patients deserve.

Our Survey has identified that, whilst staff are doing their best to manage the situation of patients routinely being cared for in corridor areas, there are areas where patients experience indicates that care could be improved.

We have therefore made 38 recommendations which could and should improve the situation of patients who find themselves being cared for in corridor areas.

However this situation is not acceptable and rapid action needs to be taken to ensure that patients no longer find themselves being cared for in corridors.

To be completed following feedback on draft. To include work of A&E delivery board

APPENDICES

APPENDIX ONE – The Visit Programme

The table below summarises the number of visits that we undertook each week, the total number of patients that we observed in the corridor areas and the number of patients that we spoke with. Please note that the numbers of patients in the corridor could be fluid over the course of a visit as patients were taken for tests, allocated a bed or discharged. The total number of patients below is the maximum number that we observed during our visits.

Visit Summary

	WRH			ALEX		
Week	**Visits by HWW**	**Total Patients observed in corridors (A&E / MAU)**	**No of patients HWW spoke with**	**Visits by HWW**	**Total Patients observed in corridor**	**No of patients HWW spoke with**
1	4	25	15	1	0	0
2	5	38	26	2	0	0
3	6	44	23	2	0	0
4	6	34	17	2	0	0
5	5	35	24	3	0	0
6	5	24	14	3	0	0
TOTAL	**31**	**200**	**119**	**13**	**0**	**0**

The table below shows the **distribution of the visits over days of the week** across the two hospital sites.

Visits

Day	Visit	WRH	ALEX
Monday	AM	2	1
	PM	1	1
	EVE	2	1
Tuesday	AM	1	1
	PM	3	1
	EVE	2	0
Wednesday	AM	2	0
	PM	1	1
	EVE	2	0
Thursday	AM	2	0
	PM	0	2
	EVE	1	1
Friday	AM	1	1
	PM	1	0
	EVE	2	2
Saturday	AM	1	1
	PM	1	0
	EVE	1	0
Sunday	AM	2	0
	PM	1	0
	EVE	2	0
TOTAL		**31**	**13**

APPENDIX TWO - SURVEY QUESTIONS AND NUMBER OF RESPONDENTS (n =) TO EACH QUESTION

1. Have you been given any information about being in this area of the hospital? (n = 115)
2. Do you know the name of the nurse looking after you in this area of the hospital? (n = 117)
3. Has it been explained to you how to call for attention if you need it in this area of the hospital? (n = 116)
4. How many minutes did it take after you called for attention before you got the help you needed? (n = 106)
5. Have you been able to get a drink since being in this area of the hospital? (n = 118)
6. If YES how did you get a drink? (n = 104)
7. Did you get enough help from staff to have your drink? (n = 96)
8. Have you been offered any food since being in this area of the hospital? (n = 118)
9. IF YES what food have you been offered (n = 61)
10. Did you get enough help from staff to eat your food? (n = 59)
11. Did you get enough help from staff to use the toilet? (n = 104)
12. Have you been in pain since being in this area of the hospital? (n = 119)
13. If YES do you think the hospital staff have done everything they could to help control your pain since being in this area of the hospital? (n = 58)
14. Is there anything that could be done (excluding giving you pain relief) to make you more comfortable on this trolley? (n = 98)
15. In your opinion, are there enough staff on duty in this area of the hospital to care for you? (n = 116)
16. Do you feel that you are able to rest in this area of the hospital? (n = 116)
17. Do you feel that you are able to sleep in this area of the hospital? (n = 117)
18. Have you been bothered by noise since being in this area of the hospital? (n = 119)
19. How comfortable do you find the temperature in this area of the hospital? (n = 119)
20. Is there anywhere to safely keep your personal belongings in this area? (n = 116)
21. Were you given enough privacy when discussing your personal information, your condition or your treatment since being in this area of the hospital? (n = 116)
22. Were you given enough privacy when being examined or treated since being in this area of the hospital? (n = 119)
23. How long were you told you MIGHT be waiting in this area of the hospital for? (n = 116)
24. What is the REASON you have been given for why you are waiting in this area of the hospital? (n = 104)
25. How long, approximately have you ACTUALLY been waiting in this area of the hospital for? (n = 118)
26. Overall do you feel that you have been well looked after by hospital staff while you have been in this area of the hospital? (n = 117)

27. Overall do you feel that you have been treated with respect and dignity while you have been in this area of the hospital? (n = 114)
28. Overall how would you rate your experience in this area of the hospital? (n = 116)
29. Is there anything else you would like to tell us about your experience in this area of the hospital? (n = 33)

Appendix 2

	Recommendation	Action Plan	By Who	Timescale
Information	All patients being cared for in the corridor of the A&E Department to be given the letter prepared by WRH explaining about being in the corridor.	Learning disability patients to have an easier read version and large print version for those who have visual difficulties.	Dilly Wilkinson	1 month
	The WRH letter should be amended to briefly explain HWW role. The text for this can be supplied by HWW.	Letter re-drafted to include additional information and checked by Comms	Clare Bush	Completed 12.6.17
	All patients should be given a HWW leaflet so they are aware they can report their experiences to us independently of the hospital.	Ask for a supply from Healthwatch which will be made available to patients in the department wherever they are receiving their care.	Dilly Wilkinson	1 month
	The designated corridor nurse to be identified by wearing a specific coloured badge (similar to the Nurse in Charge badge) to clearly identify them to patients.	After discussion with the team who raised concerns about normalising corridor care, it has been agreed to create laminated signs where corridor nurses' names can be put in shift bu shift.	Clare Bush	1 month
	All staff to introduce themselves to patients by name, in line with the #hellomynameis campaign.	Comms team to create more information in the waiting room and more '# hello my name is' posters of ED staff.	Clare Bush Comms team	1 month
	Photos of A&E/MAU staff making this pledge could be shared in the A&E areas, subject to Health & Safety considerations.	Comms team to create more information in the waiting room and more '# hello my name is' posters of ED staff.	Clare Bush	1 month

Patient Care	WAHT to ensure it is explained to all patients how to call for attention in corridor areas of the hospital, including the MAU where there are no call bells available.	Laminated signage already in place but further signage to be put in place.	Comms team	1 month
	WAHT to consider whether patients who appear to be confused or living with dementia, or who have specific communication difficulties or sensory impairments should be nursed in corridor areas of the hospital.	No patient should be in the corridor, particularly those with dementia and/or frailty. All patients to be risk assessed as per SOP. Escalation as per process	Clare Bush Band 7 team	1 month
	WAHT to provide reassurance that best practice on nutrition and hydration of patients on wards is being followed in corridor areas when patients are waiting for lengthy periods.	Formal meals and drinks rounds are in place with: • Allocated HCA • Snacks available • Drinks machine and bottled water in corridor.	Clare Bush Band 7 team	In place
	Staff to check patients are able to reach food and drink placed at the end of the trolley and whether any assistance with this is required.	Reminder to staff at staff meeting. HCA training and action cards.	Clare Bush Band 7 team	1 month
	Consideration to be given to reinstating a refreshment trolley in the A&E corridor area similar to that in the MAU for patients and visitors.	There is one in place in the main department. Signage to ensure that patients and their relatives are aware of facility.	Clare Bush Band 7 team	Completed 12.06.17
	Refreshment trolleys to be easily identifiable to patients and visitors with clear instructions about their use.	A sign to be put in corridor. ISS to top up supplies more regularly.	Clare Bush Band 7 team	1 month
	WAHT to consider how signage could be improved to make this more visible to patients.	Briony Mills signage review. JF/CB to choose signs from company (reduce aggression in ED). Review original order	Clare Bush Comms team Briony Mills	1 month

	Patients to be routinely offered pillows and blankets when waiting on trolleys in the corridor areas.	Part of normal comfort and care. 200 pillows ordered a week Blankets to be always available	Clare Bush Band 7 team	1 month
	Patients to be told the location of the toilets and how to ask for assistance if they require it.	Improved signage as part of the signage action.	Comms team Clare Bush Band 7 team	1 month
	WAHT to provide reassurance that procedures are in place to control patient's pain whilst they are being nursed in corridor areas of the hospital.	Assessed <15 mins and pain score recorded 2 -4 hourly comfort rounding Domain on GRAT	Clare Bush Band 7 team	In place
	WAHT to provide reassurance that procedures are in place to provide patients with their prescription medication when they are subject to extended waits in the A&E Department.	• Seen and assessed within 15 minutes. • Pain scale 1-10 • Care and comfort 2 hourly. • GRAT tool at 6 hours. -A&E drugs on drug chart –trust drug chart not done until admission. • Patients to self-medicate if able- department to explore	ED team	1 month
	WAHT to provide information about how A&E and MAU staff will be clearly identified so that patients know who they can ask for assistance.	Reminder discussion with team at staff meeting to include; Nurses to introduce self – cultural work, uniform key chart.	Clare Bush Band 7 team	1 month
	WAHT to consider, in light of the findings and recommendations from this Survey, whether there is sufficient staff to care for patients in the corridor areas in A&E and the MAU throughout the 24hr period.	• Review staffing (workforce review 2016). • Bench marked against other areas. • NHSI workforce lead been reviewed in 2013, full recruited to posts	Clare Bush	Completed - March 2016

	Consider whether doors to the A&E Assessment corridor need to remain open throughout the day, accepting that this may be the least disruptive option for patients.	• Doors need to stay open for health and safety reasons • Patients and staff have report feeling isolated and forgotten when doors have been closed.	Clare Bush	1 month
The Environment	Consider whether doors to the staff toilets can be modified to prevent them from banging	Estates to evaluate door for soft door closures. Matron to contact estates.	Clare Bush Engie	1 month
	Relocate the electronic fob in the side corridor to the opposite wall to ensure patients are not disturbed by staff operating the doors into the hospital.	Completed	Clare Bush	Completed
	Monitor staff movement from the hospital side of the doors into A&E to reinforce the message that this should not be used as a short cut.	Completed – a sign has been put up.	Clare Bush	Completed
	Dim the lights in the corridor areas earlier at night to allow patients to rest and sleep.	This can be done when it is seen to be safe. To be discussed with staff at staff meeting with risk assessment shift by shift.	Clare Bush Band 7 team	In place
	WAHT to provide information about how noise will be controlled in corridor areas, particularly at night.	• Staff training and updates • Ear plugs are currently available – use to be advertised. • Trial of visual noise monitors to be undertaken – wall based 'ear' that changes colour if the noise gets too high.	Clare Bush Band 7 team	1 month
	Provide secure storage space for patient valuables and belongings when they are being nursed for extended periods in the corridor area of the hospital.	-Valuables locked away in safe if required. - Other property to be kept with patients and relatives (documented).	Clare Bush Band 7 team	Now available
	Consistently use private areas when providing patients with diagnosis or test results.	'M' cubicles available for discrete conversations and all examinations. Staff to reiterate this	Clare Bush Band 7 team	In place

		to all staff and corridor nurses to challenge inappropriate practice.		
Privacy and Dignity	Consistently use the reserved curtained cubicles within the A&E Department when examining or treating patients.	In place – cubicles M1 and M2.	Clare Bush Band 7 team	Complete
	When it is unavoidable to discuss patient's personal information in the corridor areas ensure patients are screened and voices are kept as low as practicable.	Reviewing portable screens. Current portable screens to be used as much as possible.	Clare Bush Band 7 team	1 month
	When it is unavoidable to examine or treat patients in the corridor areas ensure patients are screened sufficiently to protect their privacy and dignity.	Privacy and dignity reminder to all staff, use M1 and M2. Communicated to all Senior Practitioners – corridor nurse to challenge if inappropriate.	Clare Bush Band 7 team	
	Provide patients with an indication of how long they might be waiting in the corridor area and provide reassurance to patients whilst they are being nursed in the corridor.	Staff education to encourage honest conversations. Make patients expectations clear at start of journey and update regularly. Ensure patient has corridor letter	Clare Bush Band 7 team	
Waiting Times	Provide patients with a clear reason why they are waiting in the corridor area.	A corridor letter has been created and given to all corridor patients.	Clare Bush Band 7 team	In place
	WAHT to provide information and reassurance to the public about the specific actions that are planned to ensure that WAHT is able to meet national standards for trolley waits, and the timetable for implementation.	Letter to be modified for the addition of' actions'.	Clare Bush	Completed 12.06.17
	Provide basic facilities for relatives and visitors, including a seat and access to drinks.	Chairs in corridor and access to drinks in the corridor where safe and appropriate.	Clare Bush Band 7 team	Now in place

		Drinks trolley in main department for visitors use		
Other Recommendations	Visitors who are staying overnight should be informed of where hospital facilities can be found and offered blankets.	Staff to inform visitors: • Machines and facilities in waiting reception. • Drinks machine and bottled water in main department.	Clare Bush Band 7 team	
	WAHT to provide reassurance that processes are in place to ensure patient records are accurate.	Documentation audit - SNAP	Clare Bush Band 7 team	
	Ensure that health and safety requirements in respect of the corridors are always complied with.	Monthly Environmental audit. Weekly fire alarm check and safety check by fire officer. Signage for staff (adhere to H&S)	Fire officer Clare Bush Band 7 team	In place

Date of meeting: 5th July 2017 **Enc G2**

Report to Trust Board in Public

Title	Herefordshire and Worcestershire Sustainability and Transformation Plan (STP)
Sponsoring Director	Sarah Smith, Director of Planning and Development
Author	Sarah Smith, Director of Planning and Development
Action Required	In the light of the STP Partnership Board endorsement, the Trust Board asked to: • To approve the refreshed Sustainability and Transformation Plan (STP) for publication dated the 5th of July 2017 and agree to review the plan at least annually. • Note that STP delivery plans will now be developed to underpin delivery of the plan as published and that it is expected these plans will be coordinated through the STP Programme Office • Over the coming months, consider the how the Trust needs to engage in the light of the emerging Accountable Care environment that is being encouraged through national policy formulation.
Previously considered by	STP Partnership Board, Health and Wellbeing Boards

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

The Herefordshire and Worcestershire STP has undergone a planned refresh and is presented to the Trust Board today for approval to publish the refreshed version today (July 5th). The plan is broadly unchanged at this point but will be subject to an annual refresh.

Title of report	Sustainability and Transformation Plan
Name of director	Sarah Smith, Director of Planning and Development

Worcestershire Acute Hospitals NHS Trust

Date of meeting: 5th July 2017 **Enc G2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 5th July 2017

1. Situation

The STP was published in draft on November 22nd 2016 and has undergone a planned refresh following a period of public engagement and the publication of further national guidance in March 2017.

2. Background

On 22 December 2015, NHS England published the NHS Planning Guidance 2016/17 - 2020/21, setting out the mandatory planning requirements for all NHS organisations. This included a requirement for NHS organisations to come together across defined geographical areas to prepare a local health and social care system Sustainability and Transformation Plan.

While the guidance was mandatory only for NHS bodies, local authorities were encouraged to actively participate, given the interdependence between health and social care and their duties to cooperate. The basic philosophy of the plan is that long-term sustainability can be secured only through simultaneous achievement of the triple aim of (i) population well-being (ii) high quality service delivery, and (iii) efficient use of resources.

The development of the STP comprised three stages:

1) **Gap analysis** – Partners came together to assess the biggest challenges to the whole system across the three triple aim areas in order to identify where the focus of the STP should be. This analysis was completed in April 2016.

2) **Initial proposal development** – In response to the gap analysis, partners began to consider, in broad terms, the initiatives that would need to be developed in order to close the gaps and deliver good population health and high quality services within the financial envelope available. This stage was completed in June 2016.

3) **Draft STP publication** – Following further development and NHS England Assurance, the first draft published STP was approved by the relevant boards and governing bodies in November 2016.

The STP itself was published in draft on 22nd November 2016.At the time of publication all partners were acutely aware of the public's nervousness around the STP and how it would affect local communities and services that they rely on. Partners also recognised that due to the process and

timelines, the opportunities for public engagement before publication in November were limited.

For these reasons it was agreed that there be a period of public engagement and discussion on the contents of the STP. It should be recognised that this was not a consultation because we were not seeking views on specific worked up service changes. Specific service changes arising from implementing the STP will be subject to individual consultation exercises in line with the appropriate legislative requirements.

3. Assessment

Public engagement

An extensive process of public engagement was undertaken during the period November 2016 to the end of February 2017. Supported by active publicity through traditional means and social media, this included attendance at 140 engagement events within Worcestershire and resulted in 1,195 surveys being completed by people across the county. Similar activity was undertaken in Herefordshire.

The resulting report was published on the STP engagement website:

http://www.hacw.nhs.uk/yourconversation.

This report provided a summary of the engagement activity in each county and the issues that were raised through these processes, these have been aligned to 8 themes:

- Transport and Travel
- Community Beds
- Carers
- The detail of the plan
- A and E Alternatives
- Technology
- Staff Engagement
- Prevention and Self Care

Changes arising from the plan refresh process

The public engagement identified broad support for the direction of travel that we outlined in the draft STP. However, there were a number of areas that were highlighted as requiring further consideration as we develop further detail. In some areas, this position remains the case and further detail will be outlined in detailed delivery plans over the coming months and years.

In addition to responding to the engagement feedback, we have also refreshed other aspects of the plan to reflect changes that have happened over the winter period following the publication of further national guidance.

In summary, the vision and key priorities remain the same, but changes have been made to the following areas of the STP:

Public engagement (Pages 5 to 9)	A whole new section has been added to preface the original plan. This section outlines the key themes arising from the engagement and how we intend to address these as we develop more detailed proposals.
Financial context (Pages 17-23)	The financial landscape has changed over the last 6 months and this section has been refreshed to reflect this. The overall financial position has declined due to deterioration in the financial plans for all commissioners and providers, with the biggest changes affecting Redditch and Bromsgrove CCG and Wye Valley NHS Trust. In addition to this all commissioners are required to deliver more challenging QIPP plans.
Programme Management and Governance arrangements (Page 25)	We have refined our processes to oversee delivery of the STP and ensure that we use existing forums to take ownership for delivery of the plan. The slide outlines how the governance arrangements are now organised to support this.
Prevention and self-care (Pages 40 to 44)	We have updated the section to reflect emerging changes in the two counties health and well-being strategies.
Mental health (Pages 54 to 59)	Whilst the shared ambition to invest in mental health services and parity of esteem has not changed, partners have recognised that the increased financial pressures have meant we are not going to be able to achieve as much as we originally intended in the early years of the plan. The refreshed version reflects this and the revised timelines.
Urgent Care (Pages 60 to 70)	Following a challenging winter and the emergence of A&E Delivery Boards to oversee improvements in urgent care, we have refreshed this section to reflect the revised priorities and delivery arrangements. We have also refreshed the bed numbers for Worcestershire to reflect agreed changes that were implemented during 2016/17. Further work is being conducted on the demand and capacity modelling to identify the investments and operational service changes required to deliver the out of hospital care model that is necessary to reduce the demand for bed based care where it is not necessary.

Other than these areas and points of minor factual accuracy, this

document is broadly unchanged from the version published in November 2016.

Approval Process

The Board will be aware from previous reports and discussions that the STP Partnership Board assumes the role of leading the development of the STP. To remind Governing Body members, the STP Partnership Board is comprised of the following:

All CCG Accountable Officers (3)	All NHS Provider Chief Executives (4)	Senior Council Representatives from both counties (2)
Representatives from Primary Care providers in both Counties (2)	Representatives of Healthwatch in both Counties (2)	Representatives for the Voluntary Sector in both Counties (2)
A representative from the Royal College of General Practitioners (1)	A senior representative from NHS England (1)	A senior representative from NHS Improvement (1)

At the meeting of the STP Partnership Board on 20th June 2017, the Board endorsed this version of the plan and commended it to CCG Governing Bodies and NHS Provider Boards for approval and publication.

4 Recommendation

In the light of the STP Partnership Board endorsement, the Trust Board is asked to:

- To approve the refreshed Sustainability and Transformation Plan (STP) for publication dated the 5th of July 2017 and agree to review the plan at least annually.
- Note that STP delivery plans will now be developed to underpin delivery of the plan as published and that it is expected these plans will be coordinated through the STP Programme Office
- Over the coming months, consider the how the Trust needs to engage in the light of the emerging Accountable Care environment that is being encouraged through national policy formulation.

Appendices

Appendix 1 – The proposed final Sustainability and Transformation Plan (5th July 2017).
Appendix 2 – Health and Well-Being Board response (June 2017)

Name of Director: Sarah Smith
Title: Director of Planning and Development

Title of report	Sustainability and Transformation Plan
Name of director	Sarah Smith, Director of Planning and Development

Worcestershire NHS
Acute Hospitals NHS Trust

Board Assurance Framework
July 2017
Version 7

Risk Heat Map				Current Score (likelihood x impact, arrow indicates any movement since last report) No Movement since last report ⟷							
Strategic Objective	**Priorities**	**Risks**	**Outset Scores**	**<=9**	**10**	**12**	**15**	**16**	**20**	**25**	**Target Score**
1. **Deliver safe, high quality compassionate patient care**	P1.1 Embed and assure the revised ward to board governance structures and processes and improve the identification and management of risk	R1.1 If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	4x5=20						**4x5=20**		**2x4=8**
	P1.2 Develop a more robust improvement, quality and safety culture across the Trust, including learning when things go wrong	R1.2 If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.	5 x 4 = 20						**5 x 4 = 20**		**2x4 = 8**
	P1.3 Ensure the appropriate measures are taken to address all the quality and safety concerns identified by the CQC	R1.3 There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	5X4+20						5X4+20		
2. Design healthcare around the needs of our patients, with our partners	P2.1 Improve urgent care and patient flow pathways across the whole system to ensure the care is delivered by the right person in the right place first time P2.2 Ensure the Trust meets its agreed trajectories for patient access and operational performance improvement in urgent and elective care	R2 Unless we work with our health and social care partners to understand flow across the system, then we may have inadequate arrangements in place to manage demand (activity)- which may impact on the system resilience and internal efficiencies impacting on delivery of contractual performance (4hr access standard; RTT; Cancer etc)	4x5=20						**4 x 5 = 20**		**3x3=9**
3. Invest and realise the full potential of our staff to provide compassionate and personalised care	P3.1 Develop leadership capacity and capability at all levels within the organisation	R3.1 If we do not have in place a suitably qualified and experienced leadership team (across sub board levels including Divisional and Directorate) then we may fail to deliver the required improvements at pace- with the potential for further deterioration in patient care & experience & escalated regulatory enforcement actions	4 x 4 = 16					**4 x 4 = 16**			**2x2=4**
	P3.2 Develop at all levels an organizational culture and set of behaviours that embody the Trust's values	R3.2 If we do not deliver a cultural change programme we may fail to attract and retain staff with the values and behaviours required to deliver the high quality care we aspire to.	**3 x 5 = 15**				**3 x 5 = 15**				**2 x 2 =4**
4. Ensure the Trust is financially viable and makes the best use of resources for our patients.	P4.1 Systematically improve efficiency and sustain financial performance ensuring that the Trust delivers its financial control total.	R4.1 If we do not have in place effective organisational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern.	3x4=12			**3 x 4 = 12**					**2x3=6**

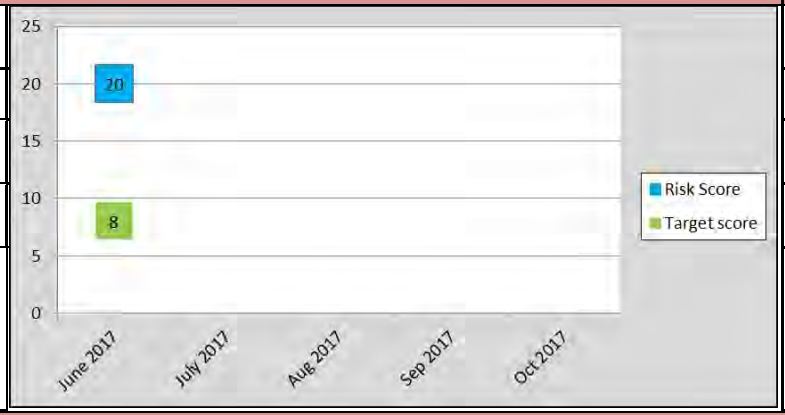
	P4.2 A compelling vision for the Trust and a workforce strategy that supports the retention of current staff,recruitment to vacancies and development of new roles	R4.2 If we do not resource our clinical staff rotas at ward/departmental level then we will not meet patient needs consistently- with the potential for reduced quality & co-ordination of care provision, negative impact on patient flow & access targets: long term impact on staff resilience; poor retention of staff & inability to attract staff.	**5 x 4 = 20**						**5 x 4 = 20**		**3 x 3 = 9**
		R4.3 If we do not have a workforce strategy that addresses organizational development, values and behaviours as well as workforce development and recruitment we will not be able to provide care that meets the needs of our patients; meets the internal workforce demands and fills our vacancies.				**4 x 3**					**2 x 3 = 6**
5. Develop and sustain our business	Develop a 5 year clinical service strategy that supports the clinical and financial sustainability goals described in the Herefordshire and Worcestershire STP. Strengthen our collaboration and partnership working with other providers in Worcestershire and beyond to ensure local access to a full range of high quality services.	R5 If we are unable to secure the support of our clinical workforce, community and STP stakeholders for the 5 year clinical strategy, we may not be able to make the changes required to ensure long term viability of services.	4x4=16					**4 x 4 = 16**			**3x3=9**

Mapped to Single Oversight Framework

1. Leadership and Improvement Capability	2. Operational Performance	3. Quality of Care	4. Finance and use of resources	5. Strategic Change	6. Stakeholders
Invest and realise the full potential of our staff to provide compassionate and personalised care	**Design healthcare around the needs of our patients, with our partners**	**Deliver safe, high quality compassionate patient care**	**Ensure the Trust is financially viable and makes the best use of resources for our patients.**	**Develop and sustain our business**	**Design healthcare around the needs of our patients, with our partners**

Risk Description	**Principal Risk:** The Trust fails to deliver safe, high quality compassionate patient care to our patients							Risk ID	R1.1
Risk Details	If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.								
Executive lead	Chief Medical Officer	Last Reviewed		Target Date		Review Group			
CQC Domain(s)	Safe	Caring		Responsive		Effective		Well Led	
Corporate Objective(s)	1	2.		3		4		5	

Risk Rating: Likelihood x Severity		
Initial Risk Score	20	
Current Risk Score	20	
Target Risk Score	8	
Risk Appetite	TBA	
Direction of travel	⟷	



Relevant Key Performance Indicators		
Metric	**Trust compliance March 2017**	**Target**
Complaints responded to within 25 days	56%	80%
Number of serious incidents	4	0
Primary Mortality Review completion	45%	>60%
Secondary Mortality Review completion	0%	>20%
Friends and Family Test A&E Score Acute Score Outpatients Score	 71.9% 80.0% 77.5%	 >71% >71% -

Rationale for current score
The Trust Clinical Governance systems are not fully embedded from ward to Board. There is a lack of understanding of risk within the organization. The current process for managing complaints is in need of review. The Trust has been rated as Inadequate by the CQC and is currently in Special Measures.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Quality Improvement Plan reviewed at fortnightly Quality & Safety Improvement Group.(QSIG) Quality Governance Committee receives monthly reports from Divisions. National SI reporting system	Review of KPIs at the following :Divisional performance and Accountability meetings QSIG Clinical Governance Group Quality Governance Committee

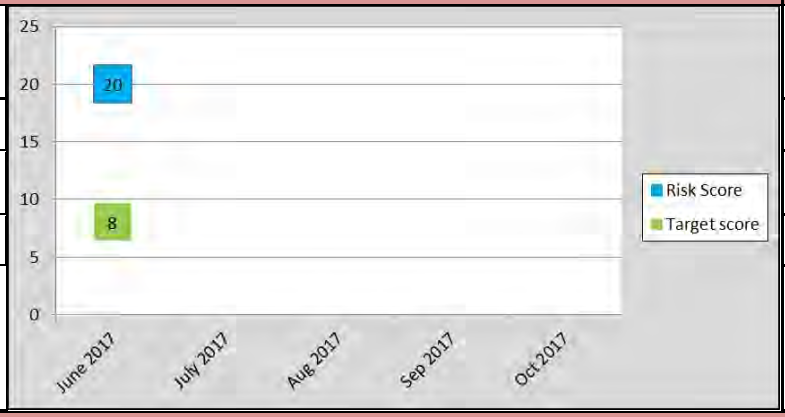
Trust BAF identifying risks to Trust objectives Corporate Risk Register Risk Management Strategy	Quality Improvement Review Group NHSI performance Review meetings
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Corporate Governance systems and process under review. Risk awareness session to be held with the Board 6/06/17. Exploring support required to strengthen Clinical Governance systems and processes. Engaging support of NHSI to develop a patient experience strategy	Review Divisional Governance meetings to ensure capability exists within the Divisions and provide training as required. Develop agreed proforma with KPI's that all Divisions must report on through their Clinical Governance meetings up to CGG.

Related High Risks (>14 and DATIX ID)

3419	**Corporate Risk Register:** There is a risk of avoidable harm if improvements are not made following mortality review	16
2591	**Medicine Risk Register:** EDS's not completed in a timely manner	20
3428	**Corporate Risk Register:** There is a risk that patients may suffer avoidable harm if deterioration is not recognised and escalated via NEWS	15
3325	**Corporate Risk Register:** There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.	16
3340	**Corporate Nursing, Governance and Risk:** Risk of non-compliance to MRSA policy leading to bacteraemia or wound infection resulting in patient harm.	15

Worcestershire NHS
Acute Hospitals NHS Trust

Risk Description	**Principal Risk:** The Trust fails to deliver safe, high quality compassionate patient care						Risk ID	R1.2
Risk Details	If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.							
Executive lead	Chief Nurse	Last Reviewed		Target Date		Review Group		
CQC Domain(s)	Safe	Caring		Responsive		**Effective**		**Well Led**
Corporate Objective(s)	**1**	2		3		**4**		5

Risk Rating: Likelihood x Severity		
Initial Risk Score	20	
Current Risk Score	20	
Target Risk Score	8	
Risk Appetite	TBA	
Direction of travel		

Relevant Key Performance Indicators		
Metric	**Trust compliance March 2017**	**Target**
F&F Test (Q4 16/17) Re care & treatment Re place to work	Likely/extremely likely 63% 46%	n/a
Discharges before 10:00	9%	10%
Number of staff training in improvement methodology	TBC	TBC
CQC Well Led Domain	Inadequate	Good
		TBC

Rationale for current score
The Trust does not currently have a Quality Improvement Strategy and agreed QI methodology. There is limited QI capability within the organization.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Some QI methodology being applied to specific projects such as Red to Green. PMO in process of being set up to support delivery of improvements, initial focus on CIP's ensuring link to quality.	KPI's for Red to Green programme KPI's for PMO projects Annual staff survey report

Gaps in controls and assurances: what additional controls and assurances should we seek?	Mitigating Actions: what more should we do?
Lack of Strategy, first draft due July 2017 Lack of capability, Board development starts 6/7th June with session from AQuA	Develop links with West Midlands Academic Health Science Network to agree programme of training and development for staff linked to patient safety.

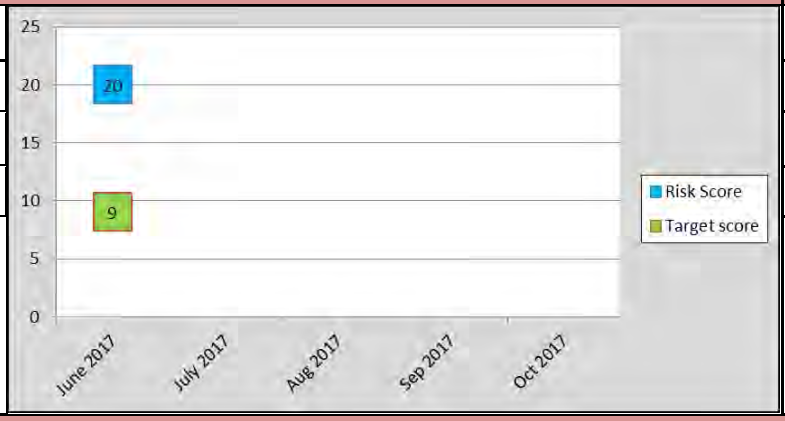
Related High Risks (>14 and DATIX ID)

3428	**Corporate Risk Register:** There is a risk that patients may suffer avoidable harm if deterioration is not recognised and escalated via NEWS	15
3419	**Corporate Risk Register:** There is a risk of avoidable harm if improvements are not made following mortality review	16
3340	**Corporate Nursing, Governance and Risk:** Risk of non-compliance to MRSA policy leading to bacteraemia or wound infection resulting in patient harm.	15
2976	**SCSD Risk Register:** Failure to achieve JAG Accreditation	16

Worcestershire NHS
Acute Hospitals NHS Trust

Risk Description	**Principal Risk:** There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes					**Risk ID**	R1.3
Risk Details	There is a risk that patient safety and performance against objectives may be adversely affected. This is caused by weaknesses in Trust systems and processes that are unknown or undetected prior to an incident occurring. The effect has potential for delays in, communication, diagnosis, treatment and follow up within and without of the organisation. The impact is an increased patient safety issue, increased reputational risk, failure to meet objectives and likelihood of complaint/claim.						
Executive lead	**Chief Nursing Officer**	**Last Reviewed**	Awaiting approval	**Target Date**		**Review Group**	
CQC Domain(s)	**Safe**	Caring		Responsive	**Effective**		**Well Led**
Corporate Objective(s)	1	2		3	4		5

Risk Rating: Likelihood x Severity		**Relevant Key Performance Indicators**		
		Metric	**Trust compliance June 2017**	**Target**
Initial Risk Score	16			
Current Risk Score	20			
Target Risk Score	9			
Risk Appetite	TBA			
Direction of travel	⟷			



Rationale for current score

Recent serious incident has highlighted significant weaknesses in a communication system with external stakeholders. At present, it is unclear whether this has resulted in patient harm.
The Trust needs to be assured that adequate controls are in place to prevent serious incidents within Trust systems and processes. It is unknown when a similar incident could occur.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

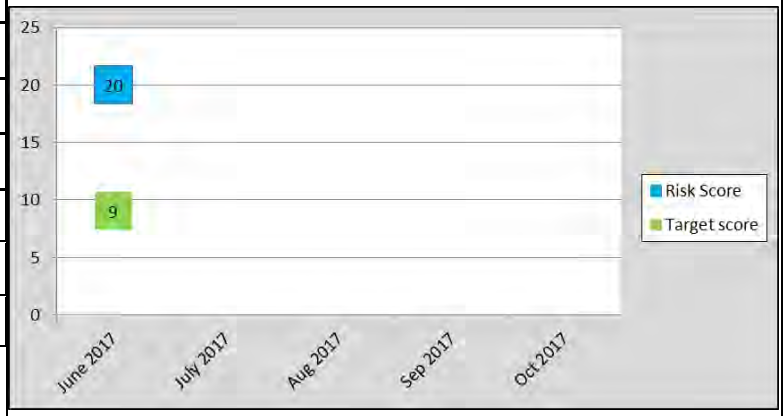
Audit of electronic system for clinic letter generation and circulation with an associated action plan Harm review where communication with patients and or GPs has failed	Monthly backlog reports from Bluespier
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Unclear whether other systems may fail No audit of electronic reporting systems Staff training position unclear	Staff training is required to reduce the existing problem Identification of current systems and audits already undertaken to formulate gap analysis.

Related High Risks (>14 and DATIX ID)

	No other similar high risks	

Risk Description	**Principal Risk :** The Trust is unable to design healthcare around the needs of our patients, with our partners					**Risk ID**	R2
Risk Details	Unless we work with our health and social care partners to understand flow across the system, then we may have inadequate arrangements in place to manage demand (activity)- which may impact on the system resilience and internal efficiencies impacting on delivery of contractual performance (4hr access standard; RTT; Cancer etc)						
Executive lead	**Chief Operating officer**	**Last Reviewed**		**Target Date**		**Review Group**	
CQC Domain(s)	**Safe**	Caring		**Responsive**		**Effective**	Well Led
Corporate Objective(s)	1		**2**	3	4		5

Risk Rating: Likelihood x Severity	
Initial Risk Score	20
Current Risk Score	20
Target Risk Score	9
Risk Appetite	TBA
Direction of travel	⟷



Relevant Key Performance Indicators		
Metric	**Trust compliance June 2017**	**Target**
Emergency Access Standard	82.67%	95%
Stranded patients	38.46%	45%
12 hour breaches	6	0
Number of DTOC patients	32	n/a
Referral to Treatment	84.07%	92%
Cancer 62 day	61.40%	85%
Diagnostics	6.07%	1%

Rationale for current score
The Trust is not currently meeting any of the national performance standards and has significant problems with flow of urgent care patients.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

Daily sit rep reporting of Emergency Access Standard. 3 x daily bed meetings Escalation plans ? weekly review of DTOC patients with system partners Regular review of planned admissions Daily review of breaches of EAS Red to Green project and focus on Stranded patients. A&E delivery Board A&E escalation meeting with NHSI Jim to review	Performance against the EAS Numbers of 12 hour breaches Number of complaints re: waiting times Conversion rates Number of DTOC's and stranded patients
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Failure to escalate and follow escalation policy Lack of whole system working Lack of out of hospital pathways	Ensure all internal processes are followed in line with internal policies. Continue to push system partners to develop strategies to ensure patients receive care in the right place at the right time. Ensure robust Winter plan in place in a timely manner.

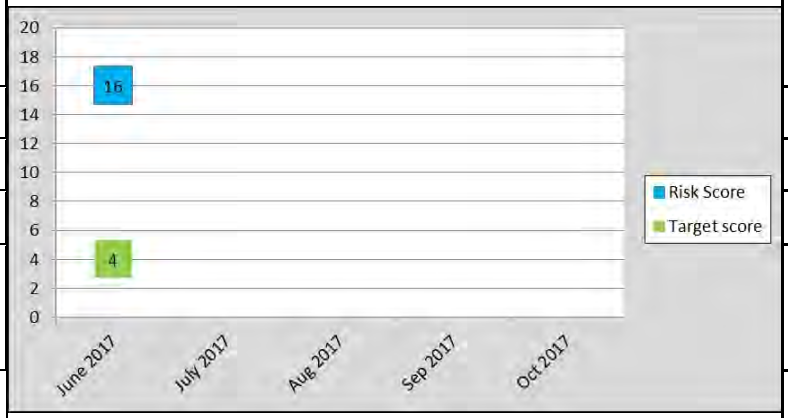
Related High Risks (>14 and DATIX ID)

2148	**Corporate Risk Register:** Patients may be harmed following a delay in diagnosis due to lack of appointment capacity within Endoscopy	20
2709	**Corporate Risk Register**: Risk of delayed admission to critical care from full unit	16
2790	As a result of high occupancy levels, patient care may be compromised (previous BAF risk so ? remove)	20
2981	**Medicine Risk Register:** Capacity	20
3289	**Corporate Risk Register:** Risk that patient safety may be compromised as Trust will be unable to meet contracted activity (RTT) within Gynaecology service	20
3331	**Surgical Risk Register:** There are high levels of patients that are not in the right specialty bed. Leading to delay in specialty review.	15
3482	**Corporate Risk Register:** There is a risk that patient safety, effectiveness and management may be compromised in ED.	20
2299	**Corporate Risk Register:** Patients not receiving follow-ups within clinically stipulated timescale, may result in loss of vision	15

3361	**Medicine Risk Register:** SIAN area -ED WRH	20
3483	**Corporate Risk Register:** Patients may be harmed due to delays in treatment/waiting times	16

Risk Description	**Principal Risk:** Failure to invest and realise the full potential of our staff to provide compassionate and personalised care					**Risk ID**	R3
Risk Details	If we do not have in place a suitably qualified and experienced leadership team (across sub board levels including Divisional and Directorate) then we may fail to deliver the required improvements at pace- with the potential for further deterioration in patient care & experience & escalated regulatory enforcement actions						
Executive lead	**HR Director**	**Last Reviewed**		**Target Date**		**Review Group**	
CQC Domain(s)	**Safe**	**Caring**		Responsive		**Effective**	**Well Led**
Corporate Objective(s)	1	2		**3**	4		5

Risk Rating: Likelihood x Severity	
Initial Risk Score	16
Current Risk Score	16
Target Risk Score	4
Risk Appetite	TBA
Direction of travel	⟷



Relevant Key Performance Indicators		
Metric	**Trust compliance March 2017**	**Target**
CQC well led domain rating	Inadequate	Good
F&F Test (Q4 16/17) Re care & treatment Re place to work	Likely/extremely likely 63% 46%	n/a
Vacancies	437	<200
Mandatory Training	80.5%	>90%
Pulse	Sep 17	Sep 7
% Of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	81.9%	85%

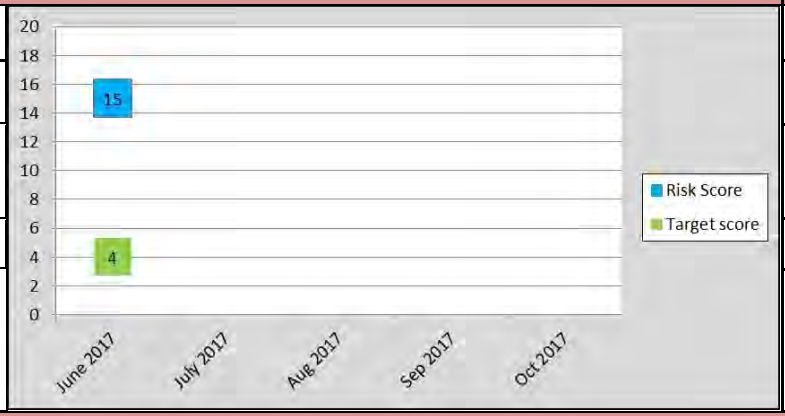
Rationale for current score	
The Trust has only recently appointed substantively to the majority of its Executive Director positions and a number of the NEDs are new in post. In addition there are significant gaps in capability within the current divisional leadership teams.	
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Executive Team appointed- COO only interim post. NEDs appointed. Board development Programme Staff Engagement programme (Pulse) Trust Leadership Group	Accountability Framework in development Staff survey results FFT CQC rating on Well Led domain Appraisal and mandatory training KPI's Net Leadership scores
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Vacancies remain with no comprehensive recruitment plan in place. Lack of overarching OD strategy Lack of Trust wide Training Needs analysis	Develop workforce strategy that addresses recruitment issues and has a clear OD element within it to address leadership gaps

Related High Risks (>14 and DATIX ID)		
2932	Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services BAF risk	16
2678	If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels BAF risk	16
3079	**Medical Director Corporate Risk:** Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care	16

Worcestershire NHS
Acute Hospitals NHS Trust

Risk Description	**Principal Risk:** Failure to invest and realise the full potential of our staff to provide compassionate and personalised care					**Risk ID**	R3.1
Risk Details	If we do not deliver a cultural change programme we may fail to attract and retain staff with the values and behaviours required to deliver the high quality care we aspire to.						
Executive lead	**HR Director**	**Last Reviewed**		**Target Date**		**Review Group**	
CQC Domain(s)	**Safe**	**Caring**		Responsive	**Effective**		**Well Led**
Corporate Objective(s)	1	2		**3**	4		5

Risk Rating: Likelihood x Severity	
Initial Risk Score	15
Current Risk Score	15
Target Risk Score	4
Risk Appetite	TBA
Direction of travel	⟷



Relevant Key Performance Indicators		
Metric	**Trust compliance March 2017**	**Target**
Pulse 1 (Oct 17)	HB	HB
Mandatory training compliance	80.5%	90%
F&F Test (Q4 16/17) Re care & treatment Re place to work	Likely/extremely likely 63% 46%	n/a
Staff Turnover	12.6%	<>10-12%

Rationale for current score

There are significant cultural and behavioural issues within the Trust that require action. The Trust has engaged external support to deliver a cultural change programme over the next two years.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Pulse Australasia appointed to deliver cultural change programme Culture Board in place. Board development Programme Trust Leadership Group	Accountability Framework in development Staff survey results Staff FFT CQC rating on Well Led domain

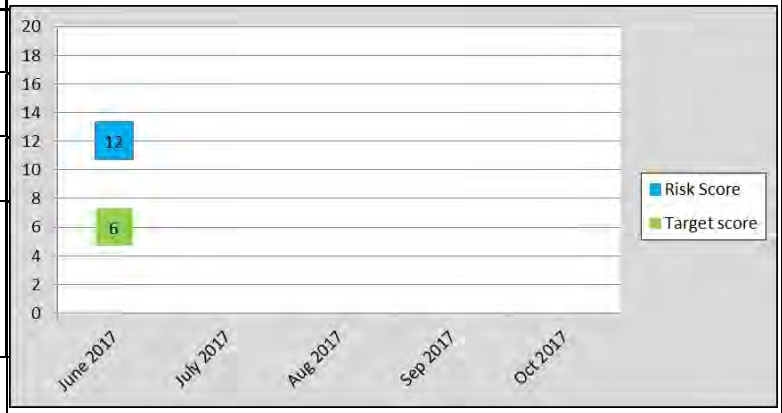
	Appraisal and mandatory training KPI's Net Leadership scores Patient feedback, themes from complaints
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of overarching workforce and OD strategy Pulse programme not fully rolled out Signature behaviours not yet agreed	Develop workforce strategy that addresses recruitment issues and has a clear OD element within it to address leadership gaps. Deliver cultural change programme.

Related High Risks (>14 and DATIX ID)

2678	If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels BAF risk	16
2711	**Corporate Nursing Governance and Risk:** Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	16
2873	**Corporate Nursing Governance and Risk:** Staff do not complete appropriate Safeguarding Training, opportunities to identify patients at risk of harm will be missed	20
3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
2791	**Medicine Risk Register:** Inappropriate staffing levels	20

Risk Description	**Principal Risk:** .The Trust is unable to ensure financial viability and make the best use of resources for our patients.					**Risk ID**	R4.1
Risk Details	If we do not have in place effective organizational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern.						
Executive lead	**Chief Finance Officer**	**Last Reviewed**		**Target Date**		**Review Group**	
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	1	2	3	**4**			5

Risk Rating: Likelihood x Severity	
Initial Risk Score	12
Current Risk Score	12
Target Risk Score	6
Risk Appetite	TBA
Direction of travel	⟺



Relevant Key Performance Indicators		
Metric	**Trust compliance June 2017**	**Target**
Compliance with monthly control total	Not compliant at End of May	Per the financial plan
CIP delivery in Line with Plan	Not complaint at End of May	Per the financial plan
Operational Metrics linked to STF	Not complaint at End of May	Per the agreed trajectories
Compliance with Capital Rsource Limit (Forecast)	Not compliant at end of May	Per the financial plan
Carter productivity data through model hospital	The Trust is evaluating this data to ensure that appropriate measures are included as the data evolves and is improved	TBA
Better Payment practice Code	Not compliant at end of May but improved performance	95%

Rationale for current score
The Trust has robust monitoring of financial management in place reported through the Performance and Accountability meetings up to Finance and Performance Committee. There are risks to the control total due to the scale of improvement required within the Trust and the high use of temporary staff.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

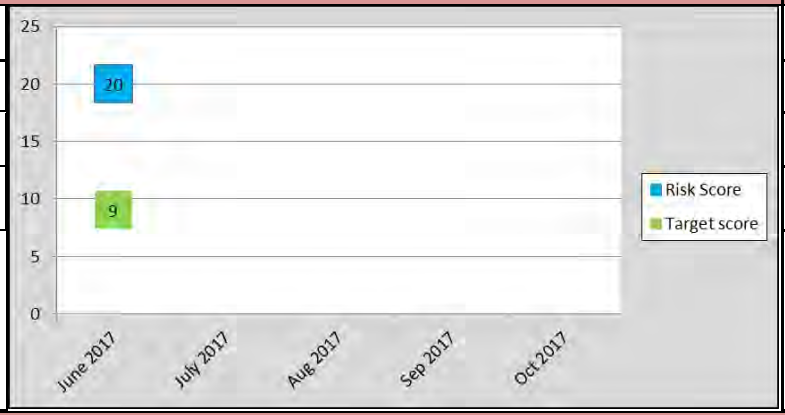
Finance and Performance Committee ensuring that risks are being acted on Cost Control – Medical Staff, Job Planning, Additional Sessions & Agency control, Nurse roster management, Agency Cap, automated procurement system Activity Data Quality, recording and coding Directorate Accountability, Business Planning Finance Training delivered as part of current leadership programme to Directorates/Budget Holders CIP programme Monitoring performance against capital programme Daily Cashflow forecasting	Monitoring of development and performance against CIP targets Monthly finance reports with detailed analysis of performance v control total Numbers of breaches of agency cap External review through NHSI, internal audit and benchmarking Better Payment Practice Code performance Capital spend variance to CRL
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
QIA process for CIPs not embedded Further use of resources of model hospital	Ensure QIA meetings in diary and process agreed.

Related High Risks (>14 and DATIX ID)

3481	**Corporate Risk Register:** Lack of capital resources prevents the Trust from transforming operations	16
3486	**Corporate Risk Register:** If the Trust does not achieve patient A&E Targets, there will be significant impact on finances	16
3487	**Corporate Risk Register:** There is a risk that there will be insufficient funding available to open 2 extra wards this winter 2017/18	16
3342	**SCSD Risk Register:** Potential failure to the operational Xray service for WRH A&E/In patients as CR/XR units are failing and beyond usable life	16
2744	**Corporate Risk Register:** There is a risk that the CR units could fail. This could be catastrophic for plain film service delivery to the Alexandra site	16
2856	**Corporate Risk Register:** Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury	16

Worcestershire NHS
Acute Hospitals NHS Trust

Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.						**Risk ID**	R4.2	
Risk Details	If we do not resource our clinical staff rotas at ward/departmental level then we will not meet patient needs consistently- with the potential for reduced quality & co-ordination of care provision, negative impact on patient flow & access targets: long term impact on staff resilience; poor retention of staff & inability to attract staff.								
Executive lead	**Director of HR**	**Last Reviewed**		**Target Date**		**Review Group**			
CQC Domain(s)	Safe	**Caring**		**Responsive**		**Effective**		**Well Led**	
Corporate Objective(s)	1	2		3		**4**		5	

Risk Rating: Likelihood x Severity		
Initial Risk Score	20	
Current Risk Score	20	
Target Risk Score	9	
Risk Appetite	TBA	
Direction of travel	⟺	

Relevant Key Performance Indicators		
Metric	**Trust compliance June 2017**	**Target**
Vacancies	437	<200
Turnover rate	12.6%	10<>12%
NHSP - Agency Fill Rate	35.1%	n/a
Safer staffing	96.2% (day) 103% (night)	95%
Agency Staff - Medics (WTE) Indicative	134.3	<=85

Rationale for current score

The Trust lacks a comprehensive workforce strategy and does not have robust recruitment plans in place for the levels of vacancies that currently exist. The Trust is in Special Measures so will struggle to attract and retain staff .

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Prospective staff rotas Some recruitment plans in place. Use of temporary staff to cover vacancies where possible. Vacancy rates monitored through Performance and Accountability meetings	HR workforce reports Agency use/ shift fill rate. Performance against recruitment trajectory Staff survey

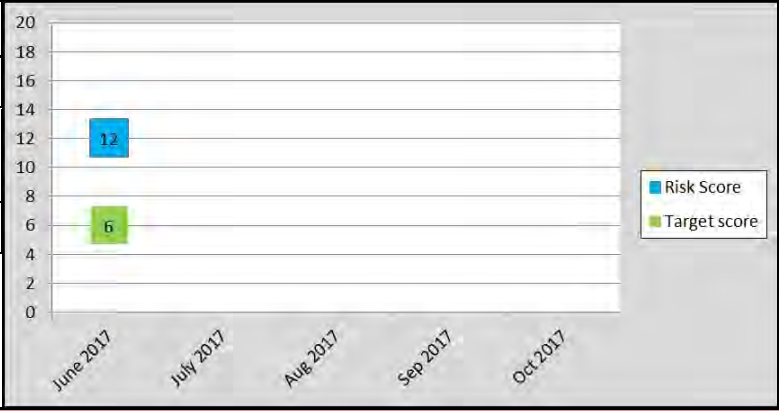
Business cases agreed for new Consultant posts in xxxx	FFT Recruitment KPIs Turnover rate
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of Sub Board Workforce Committee Lack of workforce strategy and robust recruitment and retention plan.	Establish a Workforce Assurance Committee Develop a workforce strategy Secure additional support for recruitment.

Related High Risks (>14 and DATIX ID)

2678	If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels BAF risk	16
2711	**Corporate Nursing, Governance and Risk:** Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	16
2791	**Medicine Risk Register:** Inappropriate staffing levels	20
3079	**Medical Director Corporate Risk:** Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care	16
3170	**Medicine Risk Register:** Lack of seven day Consultant review in respiratory high care	15
3292	**Corporate Nursing, Governance and Risk:** Poor fill rate from our temporary staffing provider NHSP resulting in reduced staffing levels below the required and safe level.	16
3296	**Medicine Risk Register:** Gastroenterology cover at the Alexandra Hospital	16
3327	**Surgical Risk Register:** Gaps in the workforce within the Surgical Division may have an adverse impact on patients care	15
3484	**Corporate Risk Register:** Potential sub optimal care in overflow wards due to staffing	16
3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
3505	**Human Resources Risk:** Inability to recruit Clinical Staff	20

Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.						**Risk ID**	R4.3	
Risk Details	R4.3 If we do not have a workforce strategy that addresses organizational development, values and behaviours as well as workforce development and recruitment we will not be able to provide care that meets the needs of our patients; meets the internal workforce demands and fills our vacancies.								
Executive lead	**Director of HR**	**Last Reviewed**		**Target Date**		**Review Group**			
CQC Domain(s)	Safe	**Caring**		**Responsive**		**Effective**		**Well Led**	
Corporate Objective(s)	1	2		3		**4**		5	

Risk Rating: Likelihood x Severity		
Initial Risk Score	12	
Current Risk Score	12	
Target Risk Score	6	
Risk Appetite	TBA	
Direction of travel		



Relevant Key Performance Indicators		
Metric	**Trust compliance June 2017**	**Target**
Vacancies	437	<200
Turnover rate	12.6%	10<>12%
F&F Test (Q4 16/17) Re care & treatment Re place to work	Likely/extremely likely 63% 46%	n/a

Rationale for current score
The Trust lacks a comprehensive workforce strategy and does not have robust recruitment plans in place for the levels of vacancies that currently exist. It also lacks a workforce development strategy that identifies new roles and plans to develop these. In addition the relationship with HEE, the West Midlands Academic Health Science Network and local Universities needs strengthening.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Prospective staff rotas Some recruitment plans in place. Use of temporary staff to cover vacancies where possible.	HR workforce reports Agency use/ shift fill rate. Performance against recruitment trajectory

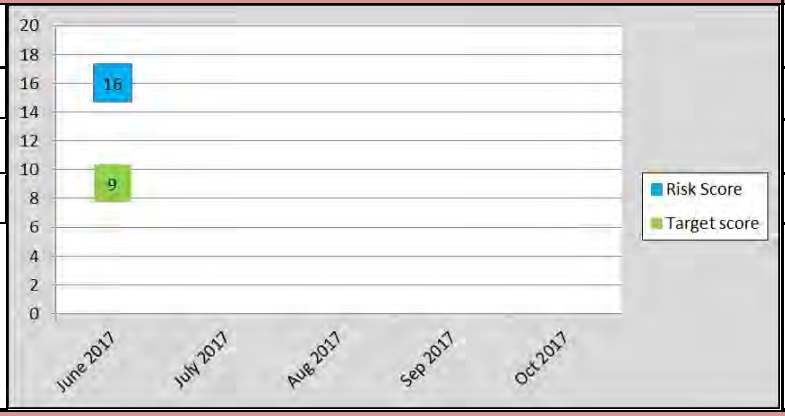
Vacancy rates monitored through Performance and Accountability meetings Business cases agreed for new Consultant posts in xxxx The Trust does have a small number of Physicians Assistants in place and a clinical lead identified to progress this work.	Staff survey FFT Recruitment KPIs Turnover rate
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of Sub Board Workforce Committee Lack of workforce strategy and robust recruitment and retention plan. Weak relationships with HEE and local Universities	Establish a Workforce Assurance Committee Develop a workforce strategy Secure additional support for recruitment. Strengthen links with HEE and local Universities. Set trajectories for developing new roles

Related High Risks (>14 and DATIX ID)

2678	If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels BAF risk	16
2711	**Corporate Nursing, Governance and Risk:** Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	16
2791	**Medicine Risk Register:** Inappropriate staffing levels	20
3079	**Medical Director Corporate Risk:** Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care	16
3170	**Medicine Risk Register:** Lack of seven day Consultant review in respiratory high care	15
3292	**Corporate Nursing, Governance and Risk:** Poor fill rate from our temporary staffing provider NHSP resulting in reduced staffing levels below the required and safe level.	16
3296	**Medicine Risk Register:** Gastroenterology cover at the Alexandra Hospital	16
3327	**Surgical Risk Register:** Gaps in the workforce within the Surgical Division may have an adverse impact on patients care	15
3484	**Corporate Risk Register:** Potential sub optimal care in overflow wards due to staffing	16
3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
3505	**Human Resources Risk:** Inability to recruit Clinical Staff	20

Risk Description	**Principal Risk: Principal Risk:** The Trust is unable to develop and deliver a long term sustainable clinical services strategy					**Risk ID**	R5
Risk Details	If we are unable to secure the support of our community and STP stakeholders for the clinical services strategy, we may not be able to make the changes required to ensure long term viability of services						
Executive lead	**Director of Strategy and Planning**	**Last Reviewed**		**Target Date**		**Review Group**	
CQC Domain(s)	Safe	**Caring**		**Responsive**	**Effective**		**Well Led**
Corporate Objective(s)	1	2		3	4		**5**

Risk Rating: Likelihood x Severity		**Relevant Key Performance Indicators**		
		Metric	**Trust compliance June 2017**	**Target**
Initial Risk Score	16		Unable to determine meaningful metrics	
Current Risk Score	16			
Target Risk Score	9			
Risk Appetite	TBA			
Direction of travel	⟷			



Rationale for current score
Public consultation on the clinical services model developed under the Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme concluded in March 2017. The outcome and publication of the recommendations have been delayed by the period of purdah surrounding the General Election. There remain a large number of key stakeholders to engage with and secure support from in order to deliver the full range of changes required, at a time when the Trust is under significant pressure just to improve on its ability to deliver business as usual.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

The Trust has at all levels supported the FoAHSW programme through the required stages of assurance leading up to and beyond public consultation and continues to work with the CCGs, NHSI and NHSE and other stakeholders and through the STP to secure support for the clinical model and the capacity changes required at the two acute hospital sites.	The Trust has little control over the outcome of the public consultation and the remaining assurance processes that need to be satisfied.
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
The Trust needs to elicit greater confidence in its ability to improve performance and delivery in terms of operational and quality improvement.	Develop robust quality, operational and financial improvement plans

Related High Risks (>14 and DATIX ID)

	I have not seen anything within the high risks to reflect this.	

Corporate Risk Report

Risk	**2148 Patients may be harmed following a delay in diagnosis due to lack of appointment capacity within Endoscopy**
Date opened	15/08/2011
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Quality and Safety
Initial Risk Level	Major Likely 16 High

Director/Committee	/ Clinical Governance Group
Description/Impact	RISK There is a risk patients may be harmed following a delay in diagnosis due to lack of appointment capacity within the Endoscopy service. CAUSE This is caused by an increase in the number of 2ww referrals leading to a lack of capacity. In addition there is an increase in demand for all procedures. EFFECT The Directorate cannot achieve the 2ww standard for Endoscopy within normal working hours. WLI are required to avoid delay in diagnosis and treatment and to achieve the 2ww standard. This has resulted in increased activity affecting surveillance patients, waiting times and JAG accreditation. NB: Change in JAG standard (the waiting times for 'urgent' patients has been reduced from 3-4weeks to 2weeks). 9/1/17 there are 2300 patients on the waiting list without a TCI date. 2ww, 31/62 day cancer pathway, routine diagnostic and surveillance waiting times. National waiting time standards are not being met. IMPACT Patients may be harmed due to delay Sub-optimal patient experience Delay in diagnosis Staff are covering weekend WLI lists in addition to normal working week leading to tiredness and possible increased sickness rate.
Key Controls	WLI introduced to address capacity on all 3 sites 3rd room at WRH commissioned - introduction of some lists, 26/06/15 environmental work completed. Nurse Endoscopist at WRH who undertakes additional lists and backfills when Consultant absent. 26/06/15 update - Nurse Endoscopist vacancy, out to advert. Weekly review of templates to ensure appointment slots are used appropriately Outsourcing to Southbank Private hospital to minimise risk of breach Outsourcing to Droitwich BMI Private hospital to minimise risk of breach
Sources of Assurance	

Performance Monitoring	Internal Audit-Waiting list monitored continuously and reported to Monthly Directorate Performance meetings. Currently approx. 1330 patients without a TCI - this total include surveillance patients.
Gaps in Control	Vacant Nurse Endoscopist post Funding for second locum doctor
Gaps in Assurance	Case for change on hold – identify why

Current Risk Level Major Almost certain 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Development of business case for increasing endoscopy capacity	Lynne Mazzocchi General Manager	23/05/2017	The case is in draft format and has been circulated to Divisional teams 30/1/17 to be presented to Executive team 14/2/17 -this did not take place on the 14th February. The business case is complete circulated to divisonal team and exec. Case for change on hold. 09/05/17 DR this is still under review with further options being considered	
Consider use of second locum Dr	Lynne Mazzocchi General Manager	24/05/2017	Email request made to medical division DM Caroline Lister to request support to fund second locum Dr to support capacity issues. No response received escalated to Deputy Director of Operations 09/05/17 DR - other options continued to be considered.	
Continue to follow RAP see document section	Kirsty Hinton Endoscopy	22/06/2017	RAP continues to be followed an updated d	

Service specification for outsourcing endoscopy activity	Lynne Mazzocchi General Manager	03/07/2017	Service specification has been developed and a tender process is due to commence within next 7 days. The trusts intention is to outsource additional activity.	
Complete case for change for additional six sessions to be funded and staffed	Kirsty Hinton Endoscopy	29/07/2016	Completed and sent accordingly.	11/07/2016
Recruitment of additional locum from locum Drs agency	Lynne Mazzocchi General Manager	24/10/2016	Directorate are routinely using additional resources from locum agency. This clinician is undertaking regular weekend sessions.	31/08/2016
Increase two of the Nurse Endoscopist's lists from 10 points to 12 points for a 3 month trial period.	Lynne Mazzocchi General Manager	18/11/2016	List increased for 3 month period remains ongoing	09/12/2016
Recruit to vacant Band 7 Nurse Endoscopist position	Dawn Robins Matron	31/01/2017	Out to advert week commencing 31/10/16. Interviews planned for 29/11/16.	09/12/2016

Target Risk Level	Moderate	Almost certain	15	High

Progress	Outsourcing a number of patients to the private sector. Update by Kirsty Hinton 26.11.15 - WLI's continue to be undertaken and outsouring to private sector continues. Working with finance to review nursing requirements and establishment, looking at sessions available and funding to try and reduce number of patients sent to private sector and completed on WLI's.Directorate are working up a capacity plan to address the shortfull. Updated by Kirsty Hinton 26.01.16 - WLI's continue to be undertaking, although outsourcing has been reduced. Continuing to work with Finance and pulling together a Case for Change to staff the vacant sessions within Endoscopy to ensure activity is undertaken during the working week, reducing WLI's. Case fo change completed and submitted to PMO 11/7/16. Updated by Kirsty Hinton 07.09.2016 - Waiting times are still not being met and there is still a significant shortfall in capacity requirements. All endoscopy lists are scrutinized and booked to maximum capacity, waiting list initiatives are being undertaken regularly, although have reduced since 2015 due to controls in place with WLI's (ie only undertaking double sessions at weekends no longer triples) and outsourcing has been re-introduced and endoscopy continue to outsource to both SPIRE Southbank and BMI Droitwich. Updated 31.10.16 - Plan to increase two of the Nurse Endoscopists lists from 10 points to 12 points, for a 3 month trial period - commencing mid-November to assist with capacity. Currently using agency doctor in order to increase capacity. Business case in development to increase endoscopy capacity in short and long-term. This is due to be finalsised in early January 2017.

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**2709 There is a risk of potential harm to critically ill patients requiring admission to critical care**
Date opened	19/08/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Quality and Safety
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Operating Officer / Operational Executive Group
Description/Impact	RISK There is risk of potential harm to critically ill patients requiring admission to critical care. CAUSE Transfer of patients ready for ward step-down is often delayed due to capacity pressures across the site. EFFECT Patients who do not need critical care are occupying critical care beds potentially delaying admissions for patients who do have critical care needs. Linked standards Guidelines for the Provision of Intensive Care Services (GPICS). Standard 2.11 states that Discharge from Critical Care to a general Ward must occur within 4 hours of the decision. Standard 2.12 states that Discharge from Critical Care must occur between 0700hrs and 2159hrs. Time from decision to admit to admission should be less than 4 hours. IMPACT Increased safety risk to patients. GPICS guidelines are not currently being met by the Trust. Potential reputation damage.
Key Controls	Escalation of wardable patients by the Divisional representative at the daily bed meetings. Patient flow managed via PCIP urgent care plan SOP in place for capacity management teams to ensure review of ITU patients x4 daily – stood down
Sources of Assurance	

Performance Monitoring	Delays in admission >4h On-going monthly monitoring and reporting of delayed discharges >4h to Operational Executive Group Delayed discharges DATIXd and referred to bed management team for investigation SOP in place for capacity management teams which requires review of ITU patients ready for ward stepdown at every capacity meeting undertaken 4 times daily and documented at every capacity meeting, and forms part of the site capacity bed state. All teams are aware of the need to expedite patients stepping down from ITU. Reported on at Monthly Performance Reviews.
Gaps in Control	April 2017 SOP stood down.
Gaps in Assurance	Report demonstrating a reduction in reportable incidents

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Monitor performance and report to Operational Executive Group	Stephen Jezard Divisional Director of Nursing - Medicine Division	30/11/2016	There has been a session with capacity and critical care to review working arrangements and develop a SOP	
Risk to be included in Exception report to QGC	Faye Rafferty Quality Governance Manager	08/02/2016		08/02/2016
Improve clinical site coordination at AH and WRH through Hospital at Night and Clinical Site Coordination Team	Rab McEwan Chief Operating Officer	19/08/2016	New team appointed. Agreeing SOPs and performance management process. Action completed	08/09/2016
Escalate risk consequence to COO and Steve Jezard	Edwin Mitchell Consultant	14/02/2017		14/02/2017
Escalate risk to Divisional Governance Team	Edwin Mitchell Consultant	22/02/2017	Risk taken to division on 22 March 2017	12/04/2017
Capacity team and critical care team to meet to develop	Stephen Jezard Divisional Director	31/01/2017	SOP agreed and pathway explained to ICU consultants 08/02/17	12/04/2017

improved ways of working and SOP for ITU bed management	of Nursing - Medicine Division

Target Risk Level	Major	Unlikely	8	Moderate

Progress	Currently there are on-going delays of stepping down level 1 patients to their respective wards due to emergency/capacity pressures across the sites. It is anticipated that re-establishment of assessment areas and improved patient flows will resolve these delays. There has been no progress made by the Trust in addressing failure to step down from the intensive care units. This is highlighted in the July 2015 critical care dashboards. The Trust is a National outlier in intensive care discharge performance. 02.03.2015. High level of patients remaining on ITU but ready for discharge to ward highlighted to Division at QG meeting. 27.07.2015 Stepdown process being actively managed from September as part of CQUIN. Risk level reduced on basis that overall activity on the ICU has diminished and there have been only two incidences of delayed admission in the past year due to the lack of a critical care bed. 31.10.16 Stepdown process being actively monitored, but units are still experiencing high levels of delayed discharges. No further incidents of delayed admission due to lack of space however. There has been a session with capacity and critical care to review working arrangements and develop a SOP. 14.02.2017 EM- The SOP has no impact on delayed discharges from ICU, and is widely ignored in the face of wider bed pressures by the Trust. Delayed admission to critical care beds is becoming a regular feature of bed management in the Trust, and the risk rating has been increased to reflect this. 12.04.17 EM - SOP stood down from ICU point of view as it currently does not have buy in from capacity team. New chief nurse focussing on mixed sex breaches, with a view to improving patient dignity and ICU flow should improve as a result of this. Paper submitted to board outlining problems with delayed admissions and with attached harm review.

Next Review Date 31/08/2017

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 2744 There is a risk that the CR units could fail.

Date opened 18/11/2014

Strategic goal

Strategic objective(s)

Initial Risk Level Moderate Likely 12 Moderate

Director/Committee	/
Description/Impact	RISK There is a risk that the CR units could fail. This is an approved risk and was discussed at Radiology Governance. I have added it back to approved DH. CAUSE There are 4 CR units purchased in 2002/2006. There is a lack of parts for these units nationally because of their age and the manufacturer has advised us that they cannot guarantee to be able to keep these units running and serviceable. Replacement is becoming a priority to ensure viability of a plain film service. These units were identified as requiring replacement 2012/2014 with an 8 year expected life. NB: same issue exists in the community but WHCT have started talks to replace at Evesham and Bromsgrove with DR (the Evesham and Bromsgrove sites have replaced with DR, Malvern and starting on a replacement package) EFFECT This could lead to failure of the CR units meaning that radiology would be unable to process an image. This would have knock on effects to A&E patients. Equipment is still running but there are breakdowns. One of the CR units now has no spares at all. Evesham and POWCH have both suffered service issues and total failure due to breakdown of CR units and old X-ray rooms. At one point Evesham was out of action totally and they are still running on a reduced service whilst awaiting delivery of new DR equipment. POWCH was also out of action whilst awaiting a new tube replacement. It is possible that The Alexandra site could hit a similar situation. Whilst additional X-ray rooms and CR units make it less likely than the single room community sites, nevertheless service delivery remains at risk. Multiplate reader in A&E rooms is now having frequent breakdowns IMPACT Patient safety/harm issue This could lead to an impact on waiting times, backlog, diagnosis and treatment. Capital equipment replacement programme is behind. This will cause a large amount of Trust capital to be replaced together which is a huge financial burden.
Key Controls	Planned preventative maintenance is in place All incidences of equipment failure are reported and investigated. 3 CR units reduces risk of failure of all The contingency would be take image cassettes down to the Orthopaedic centre for processing – unsustainable. Escalated to corporate risk register
Sources of Assurance	

Performance Monitoring	Still no progress and links to capital equipment plan risk. Capital plan redone and forwarded to NR and JT. NR has requested a small addition to list items by year - DH to do. Lease costs now received by Radiology Feb 17 Item discussed at radiology Governance Feb 17 and the intention is for this to go onto the Corporate risk
Gaps in Control	Managed equipment service
Gaps in Assurance	Contingency plan is in draft.

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
contigency plan in the event of equipment failure	Deena Smith Access and Admin Manager	29/06/2017	currently in draft	
Prioritised in capital equipment bid for 15/16 so we now need the Trust to approve this	Jeremy Thomas Consultant	31/08/2017	The entire non PFI radiology replacement plan has been raised as a potential loss of service risk at the Capital Planning Group and minuted as such. There is no capital to allow replacement. There are ongoing legal discussions by the trusts solicitors to expand the existing managed equipment service to encompass these items. There remains an issue that even the revenue to allow this path to replacement remains unidentified. Updated 31st October 2016- Any incidences of mechanical	

			failure are reported to Datix. Any delays in patients receiving their investigation will be assessed for degree of harm. DDN and QGM. 19.04.2017 - There is an understanding that equipment like this may need to be leased until a managed equipment service is available to provide its on-going servicing and replacement. Equipment will be reviewed again during 2017.	
link 3005 as same risk	Julia Rhodes Radiology	05/08/2016		05/08/2016
review in an effort to make time to support this	David Hill Chief Radiographer	29/07/2016	There are currently 4 DR rooms being installed in the county, this is quite intensive on management support. There is insufficient radiology management support to pick this up as a project. Therefore it will be reviewed at the end of November 15 to establish if any time can be made for this amongst the many pressing requirements upon radiology, targets and savings etc.	11/11/2016
control measures	David Hill Chief Radiographer	08/11/2016	To reduce the risk planned preventative maintenance is in place all incidences relating to equipment failure and impact on patient is reported through Datix. Interrogation of the incident data has shown incidences of failure with no patient harm.	15/11/2016
Equipment providers asked to give quotation for replacement leased equipment	Christine Williams Deputy Site Supertintendant	08/03/2017	Imaging equipment providers have been asked to provide quotes for DR equipment replacement.	01/12/2016
Incident to be raised with Fuji	Christine Williams Deputy Site Supertintendant	16/12/2016	Incident raised with Fuji 26th October see document section in Datix.	16/12/2016

Target Risk Level	Moderate	Almost certain	15	High

Progress	This was approved as essential in the divisional Capital plan. It has been put on hold. Xray room 1 chest stand fell onto a patients foot last week and the patient # her toe. This is because the equipment is old and has been pushed hard for use. In addition the failure at KTC proves how disastrous delay is to the safe operational running of the TRUST and its patients There are currently 4 DR rooms being installed in the county, this is quite intensive on management support. There is insufficient radiology management support to pick this up as a project. Therefore it will be reviewed at the end of NOV 15 to establish if any time can be made for this amongst the many pressing requirements upon radiology, targets and savings etc. To go out to procurement to get lease costs - meeting planned on 16/11/2016 we have lease costs back and these have been submitted to Nikki Reid 3/52 ago. We have also asked that this risk goes on the corporate risk register due to the consequences of total service failure which we are unable to fully mitigate against.

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**2856 Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury**
Date opened	07/04/2015
Strategic goal	Ensure the Trust is sustainable and financially viable and makes the best use of resource
Strategic objective(s)	Quality and Safety
Initial Risk Level	Major Possible 12 Moderate

Director/Committee	Chief Executive /
Description/Impact	Capital Programme Resource having to be used to repay loans leading to potential plant and equipment failure resulting in loss of service.
Key Controls	Increased reliance on specialist contractors Increased holding of stock and spares Emergency arrangements in place with contractors (e.g. Heating, Fire and Air Con) Use of comprehensive specialist contractors Use of emergency basck supplies from specialist sub contractors e.g. boilers, chillers and generators
Sources of Assurance	

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

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Plan targeting expenditure of the P&W budget to be submitted	Ray Cochrane Directorate support manager	26/04/2017	Plan generated for submission to CPG targeting expenditure of the available P&W Budget of £1.3M for FY 2017/18. The expenditure is specifically being applied to urgent asset renewal schemes and Statutory requirements to minimise risk of prosecution although with a critical backlog of c£6M it cannot be guaranteed that critical assets will not fail in the Financial Year that are currently not allowed for in the 2017/18 budget.	
Conditions survey by MG to be incorporated into the revised trust and estates improvement strategy	Ray Cochrane Directorate support manager	15/05/2017	Plans developed from historic surveys and known fail reports received from Estates Teams. Engie has submitted their condition survey for 2017 which incorporates a look-forward over the next 5 years. This will be incorporated into the revised Trust Estates and Improvement Strategy being prepared by PHD in conjunction with Estates. It is proposed to have a condition survey carried out at the Alex and KTC during 2017/18, this will better inform the current strategy and Backlog Plan, this will project improvements derived from the EPC and ASR schemes as well as take account of risks mitigated by expending the Emergency Loan Capital and Distressed Capital Funding received during FY2016/17 and 2017/18.	
Distressed Capital Funding being sought from NHSI	Ray Cochrane Directorate support manager	25/05/2017	Bid submitted 22/10/16 - awaiting confirmation. NO news received to date on the emergency bid. Capital meeting to be convened in December. Emergency Loan granted Q4 2016/17 allowed for specific high risk items to be rectified. Additional distressed capital loans submitted for 2017/18 if approved by NHSI this will allow significant additional risk to be mitigated and/or removed. We are engaging with external agencies to provide an energy performance contract (EPC) this is currently	

			withinits investment grad audit (IGA) stage with the audit due to complete by November 2017 this will be put forward for Board approval and ultimately will remove further risk items from the Trusts backlog. Additionally the Acute Services Review (ASR)is well under way and when finally ratified and completed will reduce the Trusts backlog considerably. In the meantime essential capital funding is being allocated from the property and works (P&W) budget on an annual basis, this process is risk and condition based and only allows for emergency and urgent requirements to be addressed.	
Capital loan to be prepared with finance and submitted to NHSI	Ray Cochrane Directorate support manager	26/05/2017	Distressed Capital Loan for 2016/17 NOT received in 2016/17 therefore will be resubmitted in 2017/18	
Ongoing investment grade audit by cynergin	Ray Cochrane Directorate support manager	15/11/2017	Investment Grade Audit (IGA) on-going by Cynergin, this will continue until November 2017 at the latest whereupon a decision will be made by the Trust to move forward with Salix funding based on the schemes ability to self-fund through projected savings.	
Detailed capital and backlog plans developed for 2015/16	Ray Cochrane Directorate support manager	30/06/2015		31/12/2015
Distressed capital bid being prepared	Ray Cochrane Directorate support manager	30/06/2015	Bid complete and requested	31/12/2015
Funding being sought through CPG	Ray Cochrane Directorate support manager	26/05/2017	Ongoing, due date updated to April 2016. Final adjustments being made to Capital Programme mtg between CT, JI & HK w/c 21 March with view to being considered at next CPG April 2016. Note this is an ongoing risk and will remain for many years to come. It is wholly dependant on receipt of sufficient funds to clear down estates backlog. Due date updated to reflect this. Distressed capital loan applied for which will allow major upgrades to plant and equipment	09/09/2016
Salix Funding sourced for major equipment replacement	Ray Cochrane Directorate support manager	04/07/2016	Ongoing - Cynergin selected as supplier for EPC and board have committed a £150K to a study of potential energy saving proposals, which they will present to the board along with funding options	27/01/2017

Target Risk Level	Major	Unlikely	8	Moderate

Progress	Paper presented to Risk Executive Group 7th December 2015 Have a contractor on board who is looking at obtaining Salix funding for major equipment for all three sites Update Contactor selected for EPC will start major study of potential energy saving projects Emergency Loan granted Q4 2016/17 allowed for specific high risk items to be rectified. Additional distressed capital loans submitted for 2017/18 if approved by NHSI this will allow significant additional risk to be mitigated and/or removed. We are engaging with external agencies to provide an energy performance contract (EPC) this is currently withinits investment grad audit (IGA) stage with the audit due to complete by November 2017 this will be put forward for Board approval and ultimately will remove further risk items from the Trusts backlog. Additionally the Acute Services Review (ASR)is well under way and when finally ratified and completed will reduce the Trusts backlog considerably. In the meantime essential capital funding is being allocated from the property and works (P&W) budget on an annual basis, this process is risk and condition based and only allows for emergency and urgent requirements to be addressed. We continue to provide best endeavors at mitigating our risk as far as is reasonably practical, ring fencing capital to cover essential requirements and applying for loans to clear the remaining essential backlog though not ideal is in the given circumstances our only option. We use a fair mix of experience, failure reports and direct management of contractors to achieve our goals however find ourselves more frequently relying on the need for Distressed Capital Funding to properly address the requirements. As we cannot rely on these loans being approved, it places the Estates Team and therefore the Trust in a position of risk of failure to deliver a clinical service should a critical item of equipment fail in service.

	To this end, the Risk has been reviewed and categorised from "Unlikely" to "Possible or Likely" even with the mitigation measures currently in place, if the Distressed Capital Loan(s) are granted, this will allow the overall Risk to be categorized back to "Unlikely".

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**3289 Risk that patient safety may be compromised as Trust will be unable to meet contracted activity (RTT) within Gynaecology service**
Date opened	16/08/2016
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Quality and Safety
Initial Risk Level	Major Almost certain 20 High

Director/Committee	Chief Operating Officer / Trust Board
Description/Impact	RISK There is a risk that the Trust will be unable to meet contracted activity (RTT) within the Gynaecology service. CAUSE This was caused by the emergency maternity reconfiguration which required a Gynaecology inpatient ward to be converted into antenatal ward. This has led to a reduction in Gynaecology inpatient capacity. EFFECT Loss of the EGAU previously located on lavender Gynaecology ward has led to services being transferred to an area previously used solely for outpatients. Transfer of EGAU to Clover suite has impacted on patient experience within the co-located services of EGAU, EPAU, Colposcopy and Outpatients. The Clover suite is a non-inpatient area which now accommodates EGAU patients overnight when there is a lack of bed capacity on the acute side. Lack of inpatient Gynaecology beds prevent the full utilization of surgical lists resulting in loss of capacity, impacting negatively on the financial status of the Women's directorate. Late cancellation and lack of capacity negatively impacts on the financial performance of the directorate. The requirement to staff separate Consultant level Obstetrics and Gynaecology on call rotas on the Worcester site post reconfiguration has negatively impacted on the Alexandra Hospital out of hours cover. IMPACT Gynaecology outliers are frequently cared for by non Gynaecology trained nursing staff this has led to a number of patient safety incidents. Specialist patients may not receive appropriate specialist nursing care, e.g. women experiencing miscarriage on mixed sex wards. Lack of inpatient capacity has had a detrimental effect on patient's experience leading to an increase in complaints, especially regarding late cancellation of elective surgery. Staff morale, recruitment and retention have been negatively affected by the loss of a dedicated Gynaecology ward. Cancellation of contracted activity. Potential for negative media attention.
Key Controls	A 4 bedded bay was created within the maternity template for inpatient Gynaecology beds. Monday - Friday with strict adherence to inclusion and exclusion criteria Utilisation of inpatient facilities and inpatient lists with junior doctor cover out of hours provided by hospital at night team on the AH site. Senior cover provided by Gynaecology consultants in addition to regular O&G on call at WRH. Implementation of pathways such as rapid hydration to reduce admission of Gynaecology emergency admissions Engagement in Listening in Action in order to improve Clover environment for utilization as EGAU EPAU Colposcopy and Outpatients. Separate Obs & Gynae Consultant on call and development of hot week, has improved availability and consistency of senior Gynaecology advice and review. Weekly review of waiting lists to reschedule patients with the aim to meet RTT standards and avoid breaches. Review of job plans within the Women's Directorate to optimise cross site working and theatre utilization. Utilisation of inpatient facilities and inpatient lists with junior doctor cover out of hours provided by hospital at night team on the AH site. Utilisation of inpatient facilities and inpatient lists with junior doctor cover out of hours provided by hospital at night team on the AH site. Senior cover provided by Gynaecology Consultants in addition to regular O&G on call at WRH Trust long term plans include development of a Women's surgical unit on the WRH site. Capturing data relating to incidents and complaints in association with lack of inpatient capacity.
Sources of Assurance	

Performance Monitoring	* Financial performance * Performance against RTT * Complaints * Incidents * Recruitment & retention * Patient experience
Gaps in Control	Gynaecology patients being cared for by non specialist nurses. Bed capacity across the Trust is affected by emergency activity. Previously agreed to ring fence 6 female surgical beds on Chestnut ward, this is not robust. Theatre utilisation on both sites is affected by capacity constraints. Junior and middle grade medical staff establishment has vacancies due to HEWM allocations Non-existence of 6 ring fenced beds following directive from HEWM visit.

Corporate Risk Report

Gaps in Assurance	RTT / financial performance. RTT Health Education West Midlands (HEWM) report

Current Risk Level Major Almost certain 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Workforce review inline with RCOG document Oct 2016	Samson Agwu Consultant Obstetrician / Gynaecologist	24/05/2017	Establish a working party, circulated document to all members of T&F group. Contact pilot sites for examples of rotas.	
End to end pathway review required for infertilty.	Mamta Pathak Consultant Obstetrician	31/05/2017	Plans to allocate action to Kiri Brown (New consultant)	
Contact GP if a patient is waiting longer than 12 weeks for initial OP	Rachel Duckett Obstetric Consultant WRH	06/06/2017	DMT to devise a standard letter to send to GPs if a patient is waiting longer than 12 weeks for initial outpatient appointment 25.11.16 Letter to send to GP's has been drafted. Needs review by DMT and agreeing by Women's Directorate. 3/2/17, draft letter to GPs presented by DMT at Women's Directorate 20/1/17, general agreement from consultants obtained. Agreed letter to be signed by DMT, now requires discussion at executive level prior to taking to CCGs. March 2017 - awaiting trust board and CCG approval. April update - no update on trust or CCG approval for the letter. Due date extended.	
Ongoing recruitment and change of job descriptions.	Samson Agwu Consultant Obstetrician / Gynaecologist	26/07/2017	Clinical fellow JDs in development. Jan 18-19 2017 JD planning meetings held, 60% progress. Action date extended. Employed MTIs with plans for additional post in 2017. Discussed at directorate 3 March 2017 April 2017 update - advert out for 4 middle grades. Interviews planned. Launch of new job plans and guidance 12 May 2017	
Directorate to scope the use of Harm Reviews.	Rebecca Williams Directorate Manager	27/07/2017	Governance lead reviewing other divisional harm reviews to identify a system fit for woman's directorate . April 2017 update, Harm review documents need to be developed specifically for gynae speciality. Action extended.	
Acute Services Review new build plans 2019	Cathy Garlick Director of Operations - Women & Children	31/01/2019	Ongoing ASR weekly meetings where outline planning has been agreed by the divisions in terms of activity projections costing and workforce requirements. Outline BC is in development.	
Pilot for use of 4 antenatal beds for Gynae inpatients.	Tracy Baldwin Sister- Day Surgery Unit	27/06/2016	Pilot carried out for 1 week, this proved successful	11/07/2016
Escalate risk to Trust Board for inclusion on corporate risk register	Cathy Garlick Director of Operations - Women & Children	26/08/2016	New risk added to divisional and directorate level. Amalgamation of the following risks ID 3130, 3156. 3068, 3060, 3064, 3070, 3206.	23/08/2016
LiA meeting with CEO plans to scope a reconfigured environment for EGAU and EPAU	Angus Thomson Consultant Obstetrics and Gynae	30/09/2016	Estates reviewing potential reconfiguration of Clover to allow gynaecology expansion. 18/7/16 Meetings ongoing further meeting on 12/7/16 to review plans. Estates to re design and recost changes. Liked to other action - Closed	23/08/2016
Include new overarching risk in Trust Board report (QGC)	Fay Baillie Interim Director of Nursing & Midwifery	21/09/2016	Risk ID3289 approved by C Garlick, This will be included in DDNM QGC report Sept 2016.	14/09/2016
Ring fance beds for 6 female surgical beds on Chestnut Ward	Janice Kerr Directorate Manger Women & Children	28/09/2016	To be discussed at Divisional Management Board meeting on 28th September 2016. It had been identified as an action by the deanery.	28/09/2016
Explored the possibility of utilisation of vacant space at AH for outpatient procedures.	Tracy Baldwin Sister- Day Surgery Unit	30/11/2016	Additional capacity to relieve pressure on WRH site 8/8/16 Awaiting costing from estates at the Alex for work required to move EJU. Update agreed within TMC to convert the former DS environment at Redditch to become a Women's unit where outpatient procedures day case and OP activity can be provided. Costs have been agreed and the environment is currently being decorated and should be receiving pts in 2 weeks time. 20th September 2016 - Walk around by Matron, Rob Game, C Garlick & Liz Court. Reviewed outstanding work required. R Game to take forward with estates.	24/10/2016

			Additional capacity identified, works underway Oct 2016	
Discussion with commissioners regarding alternative referral pathways for infertility.	Cathy Garlick Director of Operations - Women & Children	11/10/2016	Commissioners aware 11/10/2016 of the capacity restraints within infertility service, New gynae consultant with specialist interest commences March 2017.	27/10/2016
Retain fixed term locum consultants	Mamta Pathak Consultant Obstetrician	27/10/2016	Agreed to extend contracts until Feb 2017. Action closed.	27/10/2016
DMT to escalate to Board regarding lack of ring fenced female surgical beds.	Cathy Garlick Director of Operations - Women & Children	31/10/2016	Need agreement with G.James & M Markell for joint escalation between W&C & Surgery.	27/10/2016
Clinical director to formalise the activity of consultants on site at AH to include daily review of inpatients.	Mamta Pathak Consultant Obstetrician	30/11/2016	Responsibilities to include daily patient reviews , appropriate review, complete care plan including discharge plans. Other reviews to include on site review of Gynae and maternity patients.	28/11/2016
Refresh data for RTT national tool.	Janice Kerr Directorate Manger Women & Children	02/12/2016	First refresh completed 28.10.16 - needs input from information department to develop further remedial action plan.	01/12/2016
Actions to control RTT.	Cathy Garlick Director of Operations - Women & Children	16/12/2016	Approached consultants for additional clinics and lists within the planned sessions. Waiting list initiatives surgical and OP sessions offered. Additional admin support to ensure full utilisation of lists and management of pooled lists. Approach has been made to an external provider to see if they are able to take activity. Private sector approached, outcome limited appropriate cases to move to private sector.	16/12/2016
Clinical review of patients waiting for operation/procedure post outpatient appointment	Rachel Duckett Obstetric Consultant WRH	01/02/2017	Case note review for long waiters on a weekly basis with each secretary. Write directly to the patients to make sure there is no change in symptoms and advise them to get in touch if any concerns. Women's CD is in discussion with Consultant body regarding formal process for review of waiting lists for surgery. his review is ongoing on a weekly basis.	20/01/2017
Matron and DDNM ongoing discussion relating to recruitment.	Tracy Baldwin Sister- Day Surgery Unit	31/01/2017	DDNM to discuss plans with matron and escalated to executives the impending issues 3/6/16 Agreement reached to appoint 5 WTE trained nurses ATR in progress 18/7/16 Interviews to appoint 4 trained nurses will take place 5/8/16. 16.08.16 interviews took place, one nurse recruited. No others attended for interview. 22/9/16 - further interviews to recruit staff will take place on 30/9/16. 27/10/16 - four offers were made at last recruitment event, they are currently being processed. Due to start pre Christmas 2016. Surgical DDN & DDNM have agreed that Chestnut ward with be managed by Surgery & this will enable recruitment to advertise as a mixed sex surgical ward. To achieve this W&C given 5.5WTE registered vacancies & 1WTE non registered vacancy to Surgical Division. Matron for Gynae retains her professional oversight of the ward. Due to changes one nurse has agreed to stay as deemed to be more attractive to work in 2 dedicated areas, this has increased moral.	26/01/2017

Target Risk Level	Minor	Unlikely	4	Low

Progress	Linking all risks pertaining to the overarching risk of the "Lack of gynaecology inpatient capacity" Escalated to executive team for inclusion on corporate risk register. Project director to support moves to vacant space at AH. 2nd week September 2016. April 2017 CD divisional report presented, risk remains around the middle grade rota. Agreement regarding MTIS acting up to registrar grade day time but not overnight. 13.01.2017 Gynae governance meeting. DMD R Duckett asked the directorate to consider suspending new referrals on a temporary basis. Ongoing Acute Services Review. Merged risks ID3151 & 3299. 4 consultants commenced in post (2 Gynae)

	ID 3192 merged onto overarching risk. 3/4/2017 Work commenced on WRH Clover Suite expected timeline 10 weeks.

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**3325 There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.**
Date opened	26/10/2016
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Quality and Safety
Initial Risk Level	Catastrophic Likely 20 High

Director/Committee	/
Description/Impact	RISK There is a risk that stroke patients may not get timely assessment, diagnosis and treatment. CAUSE Not all patients are pre alerted to ED CT Scans are not always requested in a timely fashion Specialist stroke assessment is only available in working hours and 5 days a week Beds are not always available on Stroke or Hyper acute stroke unit Ongoing community rehabilitation is not readily available causing delayed transfers of care. There is a backlog of follow up letters (approx. 860 at 24/4/17) EFFECT They may not receive optimal care which may lead to long term disability and increased mortality. Delays in diagnosis of Stroke Patients at risk of not being given Thrombolysis in a timely manner Patients managed in a non-specialist environment High length of stay in acute stroke unit and fragmentation of ongoing care Patients develop a long term disability High mortality of acute stroke patients Delays in accessing specialist care Lack of supporting information to GP's to provide ongoing continuity of care, possible increase in re-attendance as a consequence. Lack of follow up letters impact on follow up clinics/consultant not aware of reason for attendance. IMPACT Failure in Stroke National Audit Standards (SSNAP) Damages the reputation of the service and the Trust Poor patient experience and potential increase in complaints and litigation Increased safety risk to patient.
Key Controls	Stroke dashboard populated with validated information which aligns Trust performance to SSNAP Member of Avon/Glos Stroke network which provides out of hours Thrombolysis support. All medical Regs trained in administering Thrombolysis and can contact the network for out of hours support. All network consultants have remote access to PACS to CT scans. Patients undergoing Thrombolysis currently managed within ED resus area. Patients brought by WMAS with an onset time are pre-alerted to ED Therapy outreach provided to outlying patients Clinical Guideline on Administration of Thrombolysis available Additional substantive Consultant recruitment underway with locums being sought for short term cover Member of Avon/Glos Stroke network which provides out of hours Thrombolysis support.
Sources of Assurance	

Performance Monitoring	SSNAP - see attached documents Swallow assessments - see attached email with report
Gaps in Control	Limited CNS in reach into ED Data collected to measure our performance against national standards is retrospective Posts may not be filled in a timely manner There is no SOP currently developed and in use
Gaps in Assurance	Lack of resilience and issues around validation process Internal Stroke dashboard is in draft format

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Band 6&7 Nurses to undertake swallow assessments on Acute Stroke patients	Morag Inglis Speech and Language	02/05/2017	Training being delivered by SLT. Competency review to be completed. To be included in new Band 6/7 induction programme. Competencies completed awaiting sign off by SaLT. 19/4/17 - Update at Speciality meeting today. Majority of staff now trained. Morag Inglis to provide current status	

			and update action. Email sent. Email and report attached to documents. Trajectory requested	
Recruitment of additional CNS	Jane Rutter Matron for Medicine	02/05/2017	Advert out internally and externally 25/10 closing date 8/11 19/4/17 Closing date 19/4, 6 applicants, interviews scheduled shortly ? date.	
Recruitment process for additional Stroke Consultant post ongoing	Jo Kenyon General Manager	02/05/2017	Job description at Royal College for approval. Stroke work force group with H&CT and CCG to develop countywide service. Locum to replace existing vacancy recruitment in progress Interviews scheduled for post 19/4/17 - Update from Stroke Speciality meeting - 1 part time consultant recruited and due to commence in June 17. Recruitment strategy to continue as 1 Consultant post will become vacant shortly.	
Ensure backlog of follow up letters is cleared (letters sent out)	Jo Kenyon General Manager	30/05/2017	help offered ? Band 3 Support for Geriatric Medicine being recruited, ? 1 day a week. Agency typist CV's to be scanned for possible candidates.	
Contact WMAS identify FAST+ to CT pathway and develop a pathway	Trevor Hubbard Deputy Divisional Director of Operations Medicine (Interim)	28/10/2016	M Brotherton (WMAS)contacted 26/10	26/10/2016
Protect a stroke bed and have available 24/7	Stephen Jezard Divisional Director of Nursing - Medicine Division	16/11/2016	Discussed at Trust board 25/10 with agreement to protect the HASU bed and provide 2 assessment trollies on ASU.	07/11/2016
Develop and implement SOP Hyperacute Sroke Unit	Ana Garcia Consultant Neurologist and Stroke Physician	29/12/2016	SOP drafted - going to Stroke directorate meeting on 16th November for approval SOP approvied at Divisional Governance meeting 29/11/2016.Scheduled for discussion at Medicine DMB for final approval.	19/12/2016
Convene a Task and Finish Group to develop early assessment and diagnostics to improve the Acute Stroke pathway	Trevor Hubbard Deputy Divisional Director of Operations Medicine (Interim)	25/01/2017	Work remains in progress Meetings taking place with Consultant paramedic and visit external trust Visit to Dudley on 13th Feb 2017	14/02/2017
Scope and review the patient pathway for the on going care following an acute stroke	Jane Rutter Matron for Medicine	25/01/2017	19/4/17 Stroke Speciality meeting requested that this action be closed as this work was completed as part of the Stroke Strategy work.	19/04/2017

Target Risk Level	Moderate	Unlikely	6	Low

Progress	see actions and controls 19/4/17 Risk and actions reviewed and updated during Speciality meeting today. Remaining meeting to define direction and any potential risks that are identified. Jo Kenyon to review risk following meeting.

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**3419 There is a risk of avoidable harm if improvements are not made following mortality review**
Date opened	10/02/2017
Strategic goal	
Strategic objective(s)	Quality and Safety
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Medical Officer / Clinical Governance Group
Description/Impact	RISK There is a risk that failure to undertake secondary mortality reviews will lead to unidentified safety/harm issues which could be addressed in enhancing clinical practice if known. Failure to undertake secondary mortality reviews could lead to further patient harm. CAUSE Whilst there are established systems and processes in place to undertake mortality reviews primary review completion dates fall below trajectory with little performance management. EFFECT The Trust cannot be assured that the Trust standard that 75% of deaths will be screened and undergo a mortality review with associated action and learning. Primary review completion rates < 75% - errors in care may be missed due to low screening rates Secondary review completion rates – very low reported review of incidents graded B- D – opportunities for learning and improvement not identified Divisional reports do not contain any detail relating to issues or themes identified and consequently no improvement plans. IMPACT Potential increased safety risk to patients. Lost opportunities for Trust wide learning.
Key Controls	All deaths identified through automated processes and collated onto a database Primary reviews are allocated to a Consultant to complete A standard pro-forma for primary mortality reviews is used Divisional Governance teams have access to mortality database to facilitate identification of cases requiring MDT review Compliance metrics by Division in place W&C Division agreed to implement Standardised Clinical Outcome Review (SCOR) perinatal institute system. March 2017
Sources of Assurance	

Performance Monitoring	Primary review completion rates MDT/Secondary review completion rates Audit of compliance with approved system and process
Gaps in Control	Primary review completion rates below trajectory with little performance management Secondary/MDT review rates low with little evidence of performance management Little evidence of scheduling of M&M meetings Little evidence of output from M&M meetings
Gaps in Assurance	Outcomes of mortality reviews completed by Divisions have provided assurance on the quality of care or the actions taken to act and learn where there are gaps in care.

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Create primary review e-form that autopopulates database	Steve Graystone AMD Patient Safety	31/03/2017	E-form completed, testing in place to ensure links to OASIS & patient first to identify all deaths and auto-populates database	
Create log of themes identified and actions taken	Steve Graystone AMD Patient Safety	28/04/2017	Core agenda for M&M meetings developed to include MDT review of all primary reviews not graded as good care. Template for capturing outcome of these meetings developed and shared	
Create M&M meeting outcome form	Steve Graystone AMD Patient Safety	17/02/2017	Completed - modified by medical division	17/02/2017
Create schedule of M&M meetings	Steve Graystone AMD Patient Safety	28/02/2017	Some information available from medical specialities, little from other directorates. Schedule completed and reviewed at MRG on 13/03/2017	13/03/2017

Create schedule of M&M meetings for 2017	Steve Graystone AMD Patient Safety	28/02/2017	Outline provided by Medical division - some directorates have schedule, gaps identified. Schedule created and reviewed at MRG on 13/03/2017	13/03/2017
SCOR perinatal Institute system to be implemented March 2017.	Karen Kokoska Governance Lead	31/03/2017	Trust Caldecott guardian (S Graystone) sent information from Perinatal Institute. Response sense to SCOR team indicating approval 14/03/2017	14/03/2017
Review of perinatal deaths by Womens directorate.	Fay Baillie Interim Director of Nursing & Midwifery	19/04/2017	Look back and scoping exercise to capture perinatal death IDs. CDOP, paediatric and obstetric reviews of these cases will identify any themes to assure the morbidity and mortality committee.	10/04/2017
Review TORs for perinatal mortality meetings	Baylon Kamalarajan Consultant Paediatrician	24/05/2017	TORs need to evidence learning, SCOR will provide assurance for the clinical review. ToRs to be updated to include SCOR / trust mortality reviews as learning at QIM.	20/04/2017

Target Risk Level	Major	Rare	4	Low

Progress	March 2017 W&C Divisional agreement to implement SCOR Perinatal Institute system to review all perinatal deaths. W&C actions added to risk register.

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**3428 There is a risk that patients may suffer avoidable harm if deterioration is not recognised and escalated via NEWS**
Date opened	16/02/2017
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Quality and Safety

Initial Risk Level Catastrophic | Possible | 15 | High

Director/Committee	Chief Medical Officer /
Description/Impact	RISK There is a risk that if there is a failure to recognise the deteriorating patient and appropriately escalate through NEWS, the patient may suffer avoidable and irreparable harm. CAUSE This could be caused by reduced staffing levels, inappropriate skill mix or lack of knowledge, training. EFFECT This would have a negative effect on a patient's condition due to either delay in escalation or no escalation of a high NEWS. IMPACT Increased safety risk to patients. Increased likelihood of a poor outcome Increased likelihood of a complaint or litigation Reputational risk.
Key Controls	Recognising and responding to early signs of deterioration in adult hospital patients using NEWS score guideline in place. Monthly NEWS audit undertaken on all adult wards by ward staff via a SNAP tool NEWS link nurse on every ward, and quarterly meetings held for support and updates Monthly audit of unplanned admissions to ICU, by critical care outreach sister, regarding the use of the guideline. Monthly audit of medical emergency calls of inpatients, by critical care outreach sister Regular mandatory training of management of the deteriorating patient Monthly exception report produced and sent to the preventing deterioration expert forum
Sources of Assurance	

Performance Monitoring	Monthly audit data available
Gaps in Control	Currently no action plans in place for underperforming areas
Gaps in Assurance	Reporting to clinical governance group

Current Risk Level Catastrophic | Possible | 15 | High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Identification of how to ensure action plans are produced for under performing areas.	Dilly Wilkinson Interim Deputy Chief Nursing Officer	25/05/2017	Risk discussed with CNO and deputy CNO. Audit results will be discussed with matrons and ensure that under performing areas are being supported. Due date extended until end May 2017, and risk assigned to deputy CNO	
Plan to tender for electronic system for recording NEWS	Alison Spencer Critical Care Outreach Sister	21/06/2017	Attended CHEC 9.05.17 to see 3 E-Obs systems - Nerve Centre, VitalPac and Patientrack	
Ongoing actions are contained in the monthly exception report, which will be uploaded monthly	Alison Spencer Critical Care Outreach Sister	23/08/2017		
Create SNAP tool for Unplanned Admissions to ICU audit	Alison Spencer Critical Care Outreach Sister	30/09/2017	Met with Sarah Wardle and discussed SNAP tool construction - aim for pilot at end of MAY	

Target Risk Level Moderate | Unlikely | 6 | Low

Progress	03.03.17 Highlight report added to 'documents' 07.03.17 Risk discussed a Clinical Governance Group and agreed that that this should be on the corporate risk register. 30.03.17 Highlight report added. Attended Senior nurse and Sisters meetings to disseminate NEWS audit results

	23.04.17 Email to Chief Nurse, DDNs and Matrons re: NEWS audit results for March 17 8.05.17 Attended CHEC to see 3 companies presenting E-Obs 11.05.17 Met with Sarah Wardle to construct SNAP tool for UPA to ICU audit

Next Review Date 31/08/2017

Corporate Risk Report

Risk 3481 Lack of capital resources prevents the Trust from transforming operations

Date opened 20/04/2017

Strategic goal

Strategic objective(s)

Initial Risk Level Major Likely 16 High

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	There is a lack of capital resource within the NHS financial system. Demand for resources is greater than the capital funding available. It is highly likely this will reduce what the Trust has available to spend on capital projects. This will either reduce the investment that Trust can make in capital to transform services, or if assets are leased as an alternative, then it instead places the revenue control total at risk. The Trust needs to do all it can to secure appropriate capital resources.
Key Controls	Monthly reports to Finance and Performance Committee Capital Prioritization Group Engagement with STP groups Working with NHSI Submitting capital bids and bids for emergency loans as soon as possible Regular monthly monitoring of capital spend and commitments
Sources of Assurance	

Performance Monitoring	Financial Reports to Finance and Performance Committee and Trust Board Monthly and Quarterly Performance Reviews Capital Prioritization Group
Gaps in Control	Lack of a register outlining when equipment (outside of PFI) needs to be replaced Uncertainty over costs on significant projects related to FOAHSW More robust controls over capital expenditure approvals at a strategic level
Gaps in Assurance	Unknown level of capital funding and loans available to the Trust in 2017/18 and future financial years Uncertainty of future of STP process

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop a process to ensure that all equipment leases are signed off by finance to ensure best use of capital resources	Joanne Kirwan Head of Finance	31/03/2018		
Ensure appropriate bids and applications are submitted asap for capital funds	Katie Osmond Assistant Director of Finance	31/03/2018		
Ensure no unauthorized capital expenditure	Katie Osmond Assistant Director of Finance	31/03/2018		

Target Risk Level Major Possible 12 Moderate

Progress	

Next Review Date 31/08/2017

Corporate Risk Report

Risk 3482 There is a risk that patient safety, effectiveness and management may be compromised in ED.

Date opened 24/04/2017

Strategic goal

Strategic objective(s)

Initial Risk Level Major | Almost certain | 20 | High

Director/Committee	Chief Operating Officer / Urgent Care Oversight Team (UrCOT)
Description/Impact	RISK There is a risk that patient safety, effectiveness and management may be compromised in ED. CAUSE This could be caused when patient clinical demand in ED department exceeds capacity; ED becomes overcrowded and overwhelmed due to delays in patient flow for both admission and discharge. EFFECT This would lead to patient privacy and dignity being affected and an overriding negative impact on the patient experience. Staff working under extreme pressure Delay in diagnosis and treatment IMPACT Increased patient safety risk Increased likelihood of 12 hour breaches Reputational damage Increased media attention Increased likelihood of incidents and complaints
Key Controls	Escalation policy for when department reaches capacity Harm reviews for patients who are waiting for >12 hours in ED Clinical teams escalate appropriately according to policy in order to manage patient care Safety briefings/handover Bed meetings
Sources of Assurance	

Performance Monitoring	Monitoring of compliance with escalation policy Reduction in 12 hour waits Monthly directorate performance reviews
Gaps in Control	To be completed with clinical lead
Gaps in Assurance	To be completed with clinical lead

Current Risk Level Major | Almost certain | 20 | High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done

Target Risk Level Major | Unlikely | 8 | Moderate

Progress	This new risk is replacing risk 1941

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**3483 Patients may be harmed due to delays in treatment/waiting times**			
Date opened	24/04/2017			
Strategic goal	Deliver safe, high quality, effective and compassionate care			
Strategic objective(s)	Quality and Safety			
Initial Risk Level	Catastrophic	Possible	15	High

Director/Committee	Chief Operating Officer / Clinical Governance Group
Description/Impact	RISK There is a risk of inappropriate patient pathway management and extended waiting times CAUSE Poor data quality, lack of training and/ or utilisation of reports by end users EFFECT This has resulted in a historic backlog of non RTT pathways that require significant validation Data quality issues remain on RTT pathways IMPACT Patient treatment can be delayed if the pathways are not managed consistently and to the waiting list rules. This can result in patient harm due to delayed treatment. Also reputational risk to the organisation. This risk is linked to risk 2871.
Key Controls	Weekly Patient Target List meetings to track patients through treatment pathways- head of patient access Non RTT validation workstream tracked through RTT steering group, led by CFO Intensive Support Team recommendations have been translated into a project plan, monitored through RTT steering group.
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level	Major	Likely	16	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Executive led harm review panel to be established to review all breaches of statutory standards	Vicky Morris Chief Nursing Officer	30/06/2017		
System wide review of the health economies ability to identify an agreed process for all patients waiting longer for their RTT and non RTT appointments, and identify actions to mitigate potential harm with those partners.	Jim O'Connell Interim Chief Operating Officer	31/05/2017	New controls added to ensure a system wide review plan is in place	23/05/2017

Target Risk Level	Major	Unlikely	8	Moderate

Progress	New risk added to Corporate Risk Register. Linked with Risk 2871, which is being managed by information team

Next Review Date 31/08/2017

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 3484 Potential sub optimal care in overflow wards due to staffing

Date opened 24/04/2017

Strategic goal

Strategic objective(s)

Initial Risk Level Major | Almost certain | 20 | High

Director/Committee	Chief Nursing Officer / Clinical Governance Group
Description/Impact	RISK There is a risk that patients receive sub optimal care when being cared for in overflow wards CAUSE According to full hospital protocol, there will be additional areas used to support patient care. Without additional staffing, in care could be compromised EFFECT This will result in sub optimal care for patients Potential for delays Potential omissions in care IMPACT Increased likelihood of patient harm Poor patient experience
Key Controls	Safer staffing analysis- managed in real time through the safe staffing App Individual patient risk assessments prior to patient being transferred to the ward Ward environmental risk assessments
Sources of Assurance	

Performance Monitoring	Daily review of any escalated clinical areas along with Daily review of staffing for each shift- through Divisions Compliance against SOP for safe staffing App and Ward Standard Operating procedures- rapid review Incident and serious incident reviews where appropriate
Gaps in Control	Lack of embedded operational rigor with the shift by shift review of staffing Finalised SOP for the safe staffing App Ward environmental risk assessments are being drafted and will need formal review
Gaps in Assurance	Ward environmental risk assessments not finalised. Evidence of rapid review of any patient transferred to a ward prior to an individual risk assessment being documented

Current Risk Level Major | Likely | 16 | High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Ward environmental risk assessments to be completed	Katherine Leach Patient safety and risk manager	31/05/2017		

Target Risk Level Major | Possible | 12 | Moderate

Progress	This risk is linked to risk 2981 (medicine division)

Next Review Date 31/08/2017

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 3485 There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies

Date opened 24/04/2017

Strategic goal

Strategic objective(s)

Initial Risk Level	Major	Likely	16	High

Director/Committee	/ Workforce Assurance Group
Description/Impact	RISK There is a risk that the trust is unable to deliver safe and effective care. CAUSE This is caused by the significant number of medical and nursing vacancies which have arisen due to difficulty in recruiting and sustaining medical and nursing posts despite a raft of initiatives being implemented EFFECT This has led to an increased reliance on locum and agency staff with difficulty releasing substantive staff for mandatory training. There is also an associated increase in sickness levels due to staff working additional hours leading to fatigue and increased stress levels IMPACT Patient safety and effectiveness of care will be compromised. Increased likelihood of incidents and complaints Reputational damage A negative financial impact associated with increased use of agency and locum staff
Key Controls	Workforce Strategy- Divisional retention and recruitment plans- Sub specialty specific plans for retention, recruitment and Agency/ Locum fill rate Divisional profile of medical and nursing staffing vacancies and workforce plans to provide required fill rate, with HR and Finance support. Trust Management Group which formally review critical gaps in staffing as a forward view to support timely management of temporary staffing, so that clear plans agreed regarding IR35 and requirements with Cap rate are considered alongside patient safety concerns.
Sources of Assurance	

Performance Monitoring	Safe staffing App and shift review and escalation process Divisional reports and profile
Gaps in Control	Weekly profile of remaining gaps in medical staffing and escalation to COO and Exec Medical Director in order to risk assess service impact regarding safety and effectiveness
Gaps in Assurance	Ongoing gaps in WTE required in specific specialties. Recruitment and retention strategy requires review in the light of sustained challenges in medical and nursing vacancies

Current Risk Level	Major	Likely	16	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done

Target Risk Level	Major	Unlikely	8	Moderate

Progress	Linked to risks 2678,3079,2791 and 2711 at divisional level

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**3486 If the Trust does not achieve patient A&E Targets, there will be significant impact on finances**
Date opened	24/04/2017
Strategic goal	Ensure the Trust is sustainable and financially viable and makes the best use of resource
Strategic objective(s)	Stabilising our finances

Initial Risk Level	Major	Likely	16	High

Director/Committee	/ Finance and Performance Committee
Description/Impact	As part of the Sustainability and Transformation Funds (STF) process, a proportion of Trust income is dependent on the delivery of the 4 hour Emergency Access Standard (EAS). We are awaiting confirmation nationally for the proportion that would be applicable to A&E but it could be up to £3.8m. This will be challenged by a number of factors, including: staffing, high occupancy levels, delayed transfer of care, working with IR35/agency rates and overall patent flow including ambulance conveyance rates.
Key Controls	Monthly review of capacity and utilization at senior level across the system Full capacity protocol Monitoring of patients > 10 days LOS on a weekly basis A&E Delivery Board Exec level escalation process around 12 hour breaches
Sources of Assurance	Management Assurance-Daily reporting on A&E performance Management Assurance-Routine reporting to A&E Delivery Board

Performance Monitoring	Daily A&E report Monthly Performance report to F&P committee
Gaps in Control	Consultant workforce numbers Management of Demand Speed of flow through hospital for specialty review
Gaps in Assurance	

Current Risk Level	Major	Likely	16	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
A&E Action Plan	Jim O'Connell Interim Chief Operating Officer	31/03/2018	The action plan has been established through A&E Delivery Board	

Target Risk Level	Moderate	Possible	9	Moderate

Progress	

Next Review Date 31/08/2017

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 3487 There is a risk that there will be insufficient funding available to open 2 extra wards this winter 2017/18

Date opened 24/04/2017

Strategic goal

Strategic objective(s)

Initial Risk Level Major Likely 16 High

Director/Committee	/ Finance and Performance Committee
Description/Impact	RISK There is a risk that there will be insufficient funding available to open 2 extra wards this winter. CAUSE This is caused by the additional beds opened in winter 2016/17 remaining open with limited funding remaining. If there is a significant requirement for extra beds this winter this will create a financial pressure. EFFECT Potential inability to open sufficient beds to meet winter pressures IMPACT Reduced patient flow Negative impact on patient safety and effectiveness of care Potential media attention Financial pressure
Key Controls	Continued focus on flow and bed occupancy. Careful scheduling of elective activity through the winter period.
Sources of Assurance	Management Assurance-Full capacity protocol Management Assurance-Early planning for winter

Performance Monitoring	Regular reporting to TMG Regular reporting to F&P Reporting on stranded patients
Gaps in Control	Robustness and timeliness of winter plan Liaison with commissioners
Gaps in Assurance	Robustness and timeliness of winter plan

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop a comprehensive winter plan	Jim O'Connell Interim Chief Operating Officer	30/06/2017		

Target Risk Level Moderate Possible 9 Moderate

Progress	

Next Review Date 31/08/2017

Corporate Risk Report

Risk	**3522 There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes**
Date opened	26/06/2017
Strategic goal	This risk has yet to be reviewed and is awaiting approval
Strategic objective(s)	

Initial Risk Level	Major	Likely	20	High

Director/Committee	Vicky Morris, Chief Nursing Officer/ Trust Board
Description/Impact	There is a risk that patient safety and performance against objectives may be adversely affected. This is caused by weaknesses in Trust systems and processes that are unknown or undetected prior to an incident occurring. The effect has potential for delays in, communication, diagnosis, treatment and follow up within and without of the organisation. The impact is an increased patient safety issue, increased reputational risk, failure to meet objectives and likelihood of complaint/claim.
Key Controls	Audit of electronic system for clinic letter generation and circulation with an associated action plan Harm review where communication with patients and or GPs has failed
Sources of Assurance	Monthly backlog reports from Bluespier

Performance Monitoring	Quarterly report to risk management committee and Trust board Oversight by CNO and CMO
Gaps in Control	No audit of electronic reporting systems Staff training position unclear
Gaps in Assurance	Unclear whether other systems may fail

Current Risk Level	Major	Likely	20	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done

Target Risk Level	Major	Unlikely	8	Moderate

Progress	

Next Review Date 27/06/2017

Worcestershire Acute Hospitals NHS Trust

Risk Management Strategy

Department / Service:	Clinical Governance & Risk Management
Originator:	Katherine Leach Patient Safety and Risk Manager
Accountable Director:	Vicky Morris. Chief Nursing Officer
Approved by: **Ratified by:** **Endorsed by:**	Clinical Governance Group Quality Governance Committee Trust Board
Date of approval: **Date Of Ratification:** **Date Endorsed:**	2nd May 2017 25th May 2017
Revision Due:	Every 3 years or sooner if circumstances dictate
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Departments
Target staff categories	All staff

Strategy Overview:
This strategy sets out the Trust's risk management framework and the arrangements for the identification, evaluation, ownership, management and reporting of risks and the key responsibilities for individuals, directorates, divisions and committees. It describes the Trust's appetite for risk for a range of circumstances and objectives. The form and functions of the Board Assurance Framework, which is informed by strategic risks and the risk register structure for operational risks, are also set out. The strategy is written in the context of good governance, business planning, performance management and assurance.

Key amendments to this Document:

Date	Amendment	By:
Jul 05	Revision with more detail about Risk Registers, targeted training, revised risk management objectives, Directorate Performance reviews etc.	C. Rawlings
Nov 06	Revision includes actions to meet the requirements of the pilot NHSLA Risk Management Standards, including the need for risk management strategies for all areas and a revised risk escalation process.	C. Rawlings
Jan 08	Editing to define the strategy and policy elements. Revision of the means of monitoring compliance with / implementation of this strategy. Revised objectives. Requirement for Directorate Risk Coordinators removed although GMs, CDs or equivalents have a responsibility for managing risk by having processes in place and allocating	C Rawlings

	specific roles in supporting them. Addition of identification of partnership risks	
July 08	Revisions made for FT application. Review and changes include: risk scoring matrix; risk escalation process; corporate risk register process; training requirements; monitoring arrangements; creation of the Risk Validation Group	C. Rawlings
Sep 08	– Board Assurance Framework section re-established at section 5. Risk Validation Group added to risk management process in Appendix B Inclusion of Chief Operating Officer to replace Director of Operations. DoF associated with business risks and COO with business continuity risks.	C. Rawlings
Jul 09	Revisions made to accommodate the changes to the Trust's Management and Committee structures Risk Scoring Matrix (Appendix C) revised and re-issued Board Secretary now responsible for the BAF	C. Rawlings
Sep 09	Objectives revised and provided in appendix D	Executive Team
Jul 10	Minor changes made to: reflect operational structure and responsibilities and the extended life of the ERMC; Clarification of the Executive Team role in receiving new significant risks; Addition of Fraud risk identification; amendment to the escalation process. Approved by Executive Team	C. Rawlings
Jun 12	Revisions made to reflect operational structure, Monitor requirements and to separate this document out into a strategy and separate 'policy'. Monitoring / KPIs improved.	C. Rawlings
Sep 12	Clarification of 6.3 training. Minor change approved by Chairman	C. Rawlings
Jul 14	Revision and explanation of the risk management framework Widespread changes to the process and responsibilities to reflect the new Trust structure Description of the new approach to the Board Assurance Framework Revised risk scoring matrix	C. Rawlings
Feb 15	Revised likelihood definitions and formatting of Appendix 3 Risk Scoring Matrix	J.King
Apr 15	Minor update following annual review, titles, committees and implementation plan updated.	J.King
Nov 16	Minor amendments to reflect the changes to the Trust governance structure and Trust Risk Officer post	W. Huxley Marko
April 17	Amendments to escalation process for adding risks to the Corporate Risk Register	C.Geddes
May 17	Amendments to objectives, references and risk description. Additions made to reflect changes to structure.	S Lloyd

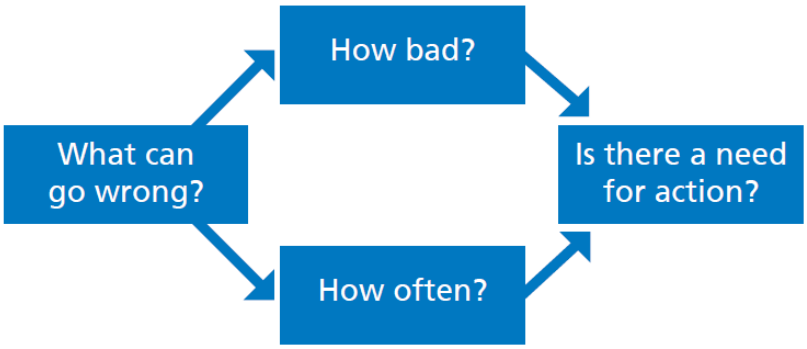
Contents page:

1. Introduction

In order to comply with its statutory and NHS duties and ensure that the services it delivers are as safe and effective as possible and its assets are protected, it is essential that NHS Trusts have risk management systems and practices in place. These must eliminate risk wherever possible and reduce the impact of those risks which cannot be eliminated to an 'acceptable' or 'tolerable' level. However, it is also understood that risk is also about taking opportunities to maximise benefits.

Risk management is not a separate, specialist activity. The management of risk is a continuous process and is part of the overall management approach to achieving objectives. Its focus is the management of things that might happen, or might happen again e.g. where incidents have the potential to reoccur, in which case the potential reoccurrence is the risk.

Risk Management is in essence a simple concept. The National Patient Safety Agency (2007) described healthcare risk assessment as seeking to answer four simple questions:



"It is not usually possible to eliminate all risks but healthcare staff have a duty to protect patients as far as 'reasonably practicable'. This means you must avoid any unnecessary risk. It is best to focus on the risks that really matter – those with the potential to cause harm. Keep risk assessment simple – do not use techniques that are overly complex for the type of risk being assessed."

"For each threat identified, it is important to decide whether it is significant and whether appropriate and sufficient controls or contingencies are in place to ensure that the risk is properly controlled."

The aim of the strategy is to build on this concept and set out an approach for the whole business that integrates risk management activity effectively with business planning, governance, performance management and assurance into a process that:

1. Defines the organisational risk appetite in categories to provide flexibility in our approach e.g. by allowing a higher appetite for risk when seeking innovation while having a low appetite for risks to patient safety.
2. Proactively protects patients and staff from harm and reduces the likelihood of adverse (harmful) events
3. Provides accurate, real time information on the Trust's risk profile and potential impact to achieving the Trust's strategic objectives.
4. Supports better planning and informed decision making
5. Makes more efficient and effective use of capital and resources
6. Identifies where performance improvement should be focussed
7. Identifies where the quality of service we provide must be improved

8. Provides assurance to the organisation and external stakeholders
9. Protects and enhances the organisation's reputation through early identification of potential significant risks.

Objectives

The Risk Management Strategy is a key strategy for the organisation and its objectives are to:

- provide a Strategy that assures Trust Board that the actions set out in its plan are being delivered;
- clarify responsibility and accountability for management of risk throughout the organisation from Trust Board to the point of delivery (from 'board to ward') and support greater devolution of decision-making as close to the user of Trust services as possible;
- define the processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust;
- promote a culture of performance monitoring and improvement, which informs the implementation of the Business Plan and ensure risks to the delivery of the Trust's plans are identified and addressed;
- ensure staff are appropriately trained to manage risks within their own work setting and clear processes are in place for managing, analysing and learning from experience, including incidents and complaints;
- ensure approaches to individual risk assessment and management balance the rights of individuals to be treated fairly, the rights of staff to be treated reasonably and the rights of the public in relation to public protection;
- support Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislative responsibilities, including standards of clinical quality, NHS Improvement compliance requirements and the Trust's licence.

1.1 Risk Management Framework

The Risk Management Strategy is part of a wider **framework**, all parts of which must be in place and supported for risk management to be effective. The framework comprises the following elements:

Mandate & Commitment	**Architecture:**	**Strategy:**	**Risk Protocols:**	**Monitor and improve:**
• From the Board	• Responsibilities & accountability • Resources • Integration into organisational processes • Communication mechanisms – internal/external • Risk reporting structure	• Risk appetite • Attitudes & philosophy • Risk Management Objectives	• Rules, procedures, guidelines - specifying risk management methodologies, tools and techniques	• Monitor effectiveness of the framework • Improve the framework
	↓	**Implement:**		↑

	• Risk Management Framework • Risk management Process ○ Require the Risk Management processes to be used ○ Train and support managers, clinicians and staff ○ Champions / set expectations

This strategy will be further revised as the risk management system is embedded and improved through experience.

2. Scope of this document

- This Strategy covers risk management for all the activities and services provided by the Trust through its clinical Divisions and Corporate Directorates.
- It applies to all those working in the Trust in whatever capacity (including contractors).
- A failure to follow the risk management arrangements described here may result in appropriate investigation and management action

3. Definitions

Risk	*"An uncertain event or set of events which, should it occur, will have an effect upon the achievement of objectives"* or *"the probability or chance that harm from a particular hazard will occur".* The extent of the risk includes the number of people affected, the consequences for them and the impact across the organisation – the level of risk represents the consequences (severity) of harm and the likelihood of it occurring.
Risk Management	*"The activities required to identify, understand and control exposure to uncertain events which may threaten the achievement of objectives."* Risk management involves managing to achieve an appropriate balance between realising opportunities for gains while minimizing losses. It is an integral part of good management practice and an essential element of good corporate governance. (AS/NZS ISO 31000-2009 Risk Management – Principles and Guidelines).
Risk Description	Risk should be clearly described to enable understanding and appropriate action. The following format is helpful in describing the risk as cause, event, and impact: *"If X happens, this will lead to Y and the result will be Z"* e.g. **If** training is inadequate, staff may fail to correctly use equipment resulting in patient harm e.g. **If** pricing is uncompetitive, the contract may be awarded to another provider resulting in loss of income and the service becoming unsustainable. Another format to describe risk can be: *"There is a **risk** of X, **caused** by Y, with the **effect** that ….leading to potential to an **impact** on Z"*
Risk Scores or Rating	A risk score is calculated using a 5x5 risk scoring matrix which considers the consequences (severity) of harm and the likelihood of it occurring. A risk will have three risk scores identified: • **Initial Risk Score** – The initial risk score will take into account the existing controls which are already in place.

	• **Current Risk Score** – At first this will be the same as the Initial Risk Score. As additional actions are implemented and new controls put in place the current risk score should reduce. • **Residual (Anticipated) Risk Score** – Rarely can all risks be reduced to a score of zero and so when the risk is first assessed it is also important to consider what is a reasonable score to accept for the risk when all the actions are completed. This will be influenced by the risk tolerance or appetite for the category of risk.
Risk Owner	It is essential to have clear ownership of risks for them to be effectively managed. Risks identified at a corporate, division, directorate, ward or departmental level will be owned by the person with management responsibility at that level. Risks on the Board Assurance Framework will have an Executive risk owner who may also allocate an operational lead. If a risk score is above the agreed risk tolerance it will be referred to the next level of management with the appropriate authority level and the risk owners will be supported to manage the risk. The owner of an objective will also be the owner of the risks to that objective. (see responsibilities).
Risk Categories	The broad categories of risk faced by the Trust are: • **Strategic risk** – achievement of the Trust strategy and strategic/corporate objectives • **Clinical risk** – impact on the quality and safety of care and services provided for patients • **Operational risk** – impact on the operational running of the organisation e.g. staffing, capacity, performance; and on health & safety • **Environmental risk** – infrastructure: property, plant and equipment, security • **Financial risk** – impact on financial objectives and key financial loss e.g. an event which may result in financial loss • **Information risk** – collection, storage and use of data • **Reputational risk**- events that may lead to negative publicity, which impact on public confidence in the organisation
Risk Appetite.	All successful organisations need to be clear about their willingness to accept risk in pursuit of their goals – the risk/return. This is explained in section 4 Risk appetite may vary over time and between individual risks but essentially is *"The level of risk that an organization is prepared to accept, before action is deemed necessary to reduce it."*
Board Assurance Framework (BAF)	The **BAF** provides a structure and process that enables the organisation to focus on strategic risks that might compromise achieving its most important (principal) objectives. It maps out the key controls that should be in place to manage those risks and confirm the Board has received sufficient assurance about the effectiveness of these controls. It provides structured assurances about where the (strategic) risks are being managed effectively (Good Governance Institute – 2009).
Risk Register	The Risk Register is a log of all risks identified in the organisation. Each record includes a summary of the risk, details of its severity and

	likelihood of harm, location and "ownership" of the risk, controls that are in place, mitigation actions which have been agreed or planned and progress achieved in reducing risk. The Trust has a single, unified risk register, hosted within the Trust's electronic risk management application - **Datix**. The information available to staff at different levels and areas of the organisation is dependent upon agreed access permissions.
Corporate Risk	Significant Trust wide risks scoring 15 and above should be reported via the Trust Corporate Risk Register. Identification of a corporate level risk will result in particular involvement and attention at Executive Level to manage and monitor the risk, but will not override local responsibilities for managing the risks.
Divisional / Directorate Risk	A risk of whatever severity, that impacts primarily upon one Division or Corporate Directorate, or for which the means of controlling the risk lies largely with a single Division or Corporate Directorate. These risks are collated into the **Trust Risk Register** which is accessible to staff at different levels and different areas of the organisation. Divisions/Directorates/Departments are always able to add, view, and update records relating to risks which directly affect them, regardless of the severity of the risk. The divisional management team must identify key staff within their division to approve risks and give them the appropriate scrutiny to ensure the controls and assurances and any appropriate actions are suitable.
Controls	A control is any measure that is in place which deliberately reduces either the likelihood of the risk materialising or the impact it will have on the relevant objective. Controls vary in their strength and effectiveness. Those which rely on human action (training) or administrative processes (policies) are weakest while those which rely on natural barriers eg. time, distance, placement (WHO Checklist) and physical barriers (E-prescribing) are strongest. This is because they are designed to perform consistently, removing the opportunity for variation.
Assurances on Controls	Assurances are where the organization can gain evidence that the controls are effective. The most objective assurances are derived from independent sources such as CQC inspections, external audit, deanery visits. These are supplemented from non-independent sources such as clinical audit, internal management reports and self-assessment reports. A list of possible sources of assurance are included at Appendix 3.

4. Risk Management

4.1 Risk Appetite

The risk appetite defines the level of risk that the Trust is willing to take in pursuit of its objectives before action is required to reduce it. Defining a risk appetite for an organisation is complex. It is not a single fixed concept. There will be a range of appetites for different categories of risk which will need to align and will vary over time. It also needs to be measurable and integrated with the control culture of the organisation. A simple line drawn on a risk matrix, while attractive, ignores this complexity.

The levels of risk appetite are described as:

Risk Appetite Level	Risk Maturity	Risk Appetite Description
NONE	Avoid	Avoidance of all risk and uncertainty
LOW	Minimal	Preference for ultra-safe, well established/evidence based delivery options that have a low degree of risk.
MODERATE	Cautious	Preference for safe delivery options, also used by other organisations that have some degree of known risk outweighed by potential benefit.
HIGH	Open	Willing to consider all potential delivery options, established and new, and make a choice which also provides an acceptable level of reward.
SIGNIFICANT	Seek Mature	Eager to be innovative and to choose options offering potentially higher rewards despite greater potential risk. Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

In determining its risk Appetite, the Board has considered the following:

- Objectives / aims / vision / mission
- The risks that can be taken and those that should be avoided – specific targets and tolerances
- Ability to take risks – capital management plan, business management plan, clinical strategy
- Capturing data to allow us to assess performance against our risk appetite at business unit and individual level e.g.
    - Incident and issue reporting
    - Clinical performance
    - Financial performance
    - Operational performance
- The zero tolerance risk exposures e.g. Never Events

The Board has agreed the levels of risk appetite for the following categories of risk:

CATEGORY	APPETITE	DESCRIPTION
Patient Safety	Low	We will not accept any activity that causes avoidable harm or abuse. It is understood that there are risks associated with providing clinical treatment, but these risks are known and will only be taken if the patient is in agreement. We will not accept any unnecessary risks with patient care. Never events will remain on the register regardless of the rating and will be subject to a minimum of annual assessment and assurance of adequacy of controls. Assessments will occur more frequently for higher rated Never Events.
Clinical Effectiveness	Low	We will only provide treatments and services which are based on the best available evidence, have been proven to be of benefit to patients and which have been authorised for use.
Patient Experience	Low	We will not accept any activity that results in patients

		having a poor experience whilst in our care. Patients will be treated with compassion, dignity and respect at all times. We aim to score highly in the Friends & Family Test and all areas of patient feedback.
Financial	Low	We have been entrusted with government funds and must remain financially viable. We will make the best use of our resources for patients and are not prepared to accept the possibility of any financial loss. Investment or increased costs will only be considered to ensure patient safety, for protecting our market share or linked to improving the financial position.
Strategic	Moderate	At all times, our delivery plans for achieving our objectives will be appropriately considered in terms of the feasibility (capacity, capability, performance) of success and the investment required. We will accept some degree of "known" risk in pursuit of achieving our objectives
Workforce	Moderate	We are innovative in developing and creating new posts but would not accept risks in relation to the suitability of employees. We will be proactive in meeting and maintaining recognised safe staffing levels.
Reputational	Moderate	Our reputation for integrity and competence should not be compromised with the people of Worcestershire, the CCG, Area Team and Government. The appetite for risk taking is limited to those events where there is little chance of any significant repercussion for the Trust should there be a failure. Mitigations are in place for any undue interest.
Compliance	Moderate	Due to the complexity of the services and business we provide we accept that minor compliance breaches may occur from time to time. However there will be no acceptance of substantive breaches at any time.
Innovation	High	Where projects are identified that will address future needs and demonstrate benefit to patient services we will pursue and support these - with demonstration of effective management control. Where these projects require large investments, they will be considered on a case by case basis. We will actively seek high risk, high return projects.

Risks assessed as 'moderate' or 'high', i.e. those scoring 9 or above on the risk matrix will be considered above 'tolerance' and will require reporting to the next level of management. Directorate (specialty risks) scoring 9 or above must be reviewed quarterly to the divisional management board so that review, support, scrutiny and challenge can take place. They can still be managed at local level but must not be managed in isolation. Those scoring below 9 will continue to be managed at the local level, with annual scrutiny by the division.

4.2 Context:

Before applying the risk management process, it is important to establish to context within which the process operates and set the criteria against which the risks will be assessed.

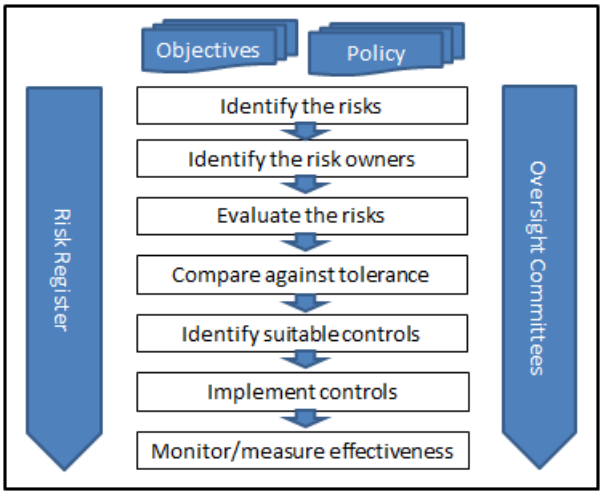
The context is Trust business - the provision of healthcare and its organisational objectives.

Risks are uncertainties that affect the achievement of business objectives, so risks cannot fully be identified if these objectives and strategies are unclear. For this reason, risk management is integrated into the objective setting and business planning process.

4.3 Risk Management Process

The process builds on the simple concept provided by the NPSA and is based on the Australian/New Zealand Risk Management Standard (4360:2004) and guidance both from the Department of Health and the Health & Safety executive (Successful Health & Safety Management HSG65) but adapted for use in Worcestershire Acute Hospitals NHS Trust. The assistance of Amberwing in developing this strategy is acknowledged.

The Trust process for managing risks is described fully in the Risk Management and Assessment Procedure (WHAT-CG-002) and is set out in the diagram, text and table below:



At its simplest the process involves:

Identify the Risks- from a range of internal, external, proactive and reactive sources. Time spent in clearly describing the risk at this point will help to ensure that appropriate controls are identified, the risk is assessed accurately and effective actions are put in place if required.

Identify the Risk Owners - It is essential to have clear ownership of risks for them to be effectively managed. Managers at each level of the organisation are responsible for achieving their own objectives and for managing the risks to achieving them i.e. they are the risk owners.

Evaluate the Risks - The Trust uses a 5x5 risk scoring matrix to evaluate risks. The risk rating takes into account the controls which are already in place. The number of controls which exist and whether they are strong or weak should be considered together with any evidence that the controls are effective i.e. assurance.

Compare Against Tolerance - The result of the risk evaluation will be checked against the Trust's risk appetite for that particular category of risk or objective. If it lies within it, the risk will be tolerated. If it lies above then the risk will be referred by the risk owner to the next level of management for a decision on management.

Identify Additional Controls and Actions Required - The Trust uses four types of risk control as described in the Treasury's (2004) Orange Book to guide risk owners in their response to risk assessments:

- **Terminate** – stop the activity
- **Transfer** – pass the activity to a third party e.g. insurance
- **Treat** – further actions to reduce the harm or likelihood of harm occurring or a contingency to enact should the event occur
- **Tolerate** – accept the risk subject to monitoring.

All Action Plans must be Specific, Measurable, Achievable, Realistic, Timely (SMART) and the risk owner is responsible for ensuring the control is implemented.

Implement Controls - Actions to reduce risk exposure will be implemented by the risk owner or allocated to an appropriate individual or group to do so.

Monitor/Measure Effectiveness (of Controls) - The risk owner will be responsible for monitoring the effectiveness of the controls in managing the risk and for taking additional action when required. External and internal assurances will provide evidence of how well the controls are working and these must be factored in to the overall risk assessment and risk scoring process.

Some assurances will provide actual evidence i.e. weekly vacancy reports whereas others may be planned to provide future evidence i.e. annual national clinical audits. Example sources of assurance are included in Appendix 3.

4.4 The Risk Register

The "Risk Register" is a log of all risks which have been identified within the organisation. Entries in the risk register are made as risks are identified and updated as progress is made in controlling the risk. It is a single, integrated database, hosted on the Trust's electronic risk management application, (Datix).

Users in different areas and at different levels of the Trust have access to different subsets of records within the register. All Divisions and Directorates enter and update their risks on this register making the electronic register the central repository for risk information across the organisation. The section below sets out how a risk will be described in the risk register.

Describing risks

Risks are described in a clear, concise and consistent manner to ensure common understanding by all. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

When wording the risk, it is helpful to think about it in four parts. For example:

"There is a risk that….. This is caused by ….. and would result in…. leading to an impact upon……

The Trust's standard for recording risks is to define risks in relation to:

• A **Risk** is described as something uncertain that may happen and could prevent us from meeting its objectives.
• The **Cause** is the problem or issue that 'could' cause the risk to happen.
• The **Effect** is the result of something that will happen if we do nothing about the risk
• The **Impact** is the wider impact of the risk on the objectives if we do nothing.

Approving risks
The divisional management team must identify key staff within their division to approve risks and give them the appropriate scrutiny to ensure the controls and assurances and any appropriate actions are suitable.

The risk register includes details of the risk, the severity, likelihood and overall rating, the manager / service(s) which "owns" the risk, the controls currently in place, the forum where progress in mitigating the risk is monitored, and progress achieved.

The risk registers produced for all levels of the organisations comprise the open, approved risks and can be extracted for the organisational unit (e.g. Division, Directorate, ward), by category (e.g. Health & Safety)

- "**Approved**" risks are those that have been validated by an appropriate manager or committee and marked as 'approved' in Datix and are being actively controlled or tolerated.

Trust wide risks which score 15 and above are selected for inclusion in the **Corporate Risk Register**. The Trust has overview of these risks through a quarterly report/ presentation to the Risk Management Committee, which will then inform the Trust Management Group and the Board.

When the risk is no longer relevant (e.g. the risk has ceased to be a threat to the objective, (possibly due to control actions, completion of the objective or the passing of the risk's lifetime) the entry may be signed off at the appropriate level of the organisation and the entry will then be closed, although it will remain on record.

Training in risk evaluation and use of the risk register
All managers will be trained in risk evaluation and use of the risk register. This will be provided by the Clinical Governance & Risk Management Department.

4.5 Risk Register Reporting & Review

Directors and Senior Managers in all areas are responsible for monitoring the risks that they individually own and for the area that they manage e.g. a Divisional, Directorate or Department risk register.

Risk Registers are monitored by:

- Divisions at their monthly Governance meetings (risks 9+)
- Clinical Directorates monitor their risk registers at monthly Governance meetings
- Executive Director's review their risk portfolio monthly and ensure that these are considered at Corporate Directorate and committee meetings

- Risk Management Committee- to provide scrutiny and support to divisions and corporate teams on risks scoring 12 and above

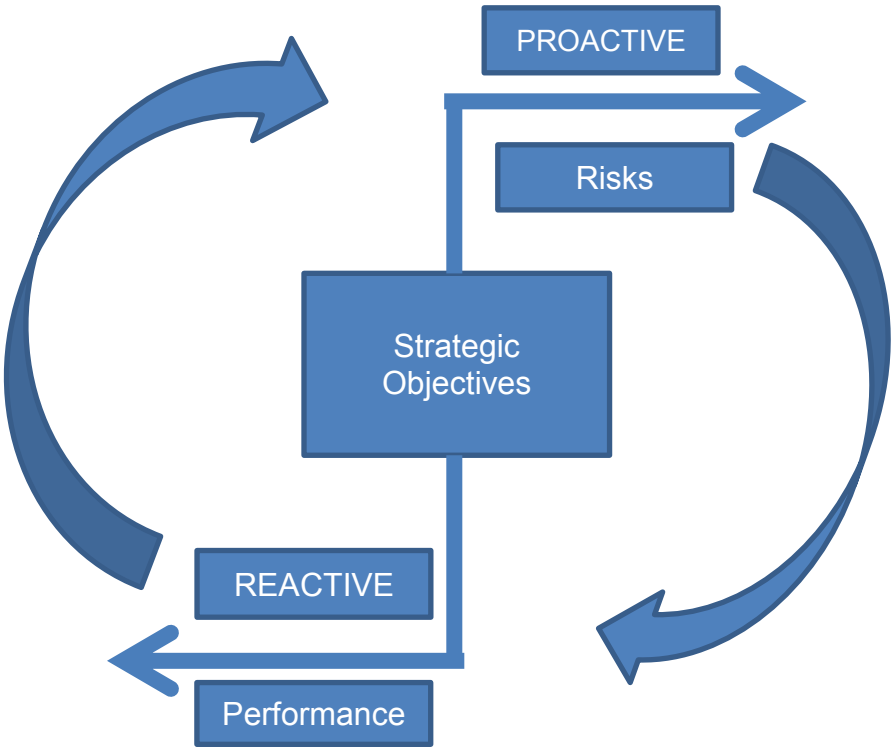
The **Corporate Risk Register** contains those risks which have the potential to impact on the organisation as a whole, score 15 and above & exceed the risk appetite for that category of risk. They may be identified at Division, Directorate or Executive level. The Corporate Risk Register is reviewed by the

- Risk Management Committee – Quarterly
- Trust Management Group- Quarterly following the Risk Management Committee
- Trust Board – Quarterly following Trust Management Group
- Individual risks assigned to committees – Quarterly
- Audit & Assurance Committee will commission an annual review of the effectiveness against practice.

4.6 The Board Assurance Framework

The Board Assurance Framework is an information tool that allows for detailed analysis of all strategic risks which could impact on the Trust achieving its objectives. It requires the Trust to consider the effectiveness of each control through a process of obtaining assurances that the mitigation is in place and operating effectively. This will also identify which of the Trust's objectives are at risk because of gaps in controls or assurance.

The Trust is working towards an integrated Assurance Framework report which brings together information on achievement of milestones/targets, performance and risks to enable the Board to evaluate progress in meeting objectives. This will form the assurance cycle, considering both reactive (performance) and proactive (risk) information.



4.7 Board Assurance Framework Reporting & Review

The **Board Assurance Framework** is reviewed by the:

- Risk Management Committee – Quarterly
- Trust Board – Quarterly following Risk Management Committee
- Individual risks assigned to committees – Quarterly
- Audit & Assurance Committee will commission an annual review of the effectiveness against practice.

4.8 Exception Reports

Exception reports are provided where required by the risk owner on a standard template to the relevant meeting to demonstrate the risk factors and actions being taken to reduce the risk rating.

5. Implementation

5.1 Plan for implementation

A plan for the implementation of this strategy is attached as Appendix 1.

5.2 Dissemination

Following approval, changes to the Risk Management Strategy will be included on the agendas of relevant Trust Committees and Divisional Governance meetings for discussion of the pivotal role they play in implementation of the strategy through established governance arrangements.

5.3 Training and awareness

Part of the implementation of this strategy is dependent on raising awareness and training key groups of staff to both use and champion the process described within it. Training will be delivered to the following groups in the general areas listed below. This training will be further refined with refresher sessions provided.

Trust Board

- Risk management in the context of the achievement of objectives, governance and performance
- The risk management process employed by the Trust
- Expectations for implementation, management of risk, reports and assurance.

Divisional Management Teams, Corporate Directorates & Committee Chairs

- Risk Management Process to include:
- The Trust framework for risk management
- Risk Assessment
- Controls and assurance
- Risk registers – purpose and use as a risk management tool
- Responsibilities for risk ownership, management and reporting
- Management of risks within Datix

Divisional Clinical Governance / Quality Support staff

- Risk Management Process to include:

- The Trust framework for risk management
- Risk Assessment
- Controls and assurance
- Risk registers – purpose and use as a risk management tool
- Responsibilities for risk ownership, management and reporting
- Management of risks within Datix

6. Monitoring and compliance

Monitoring demonstrates whether or not the process for managing risk, as described in this strategy, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

The table below details the 'Who, What, Where and How' for the monitoring of this strategy.

Key control:	Checks to be carried out to confirm compliance with the strategy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Governance structure that allows for identification and management of risks	Internal Audit of risk management process	Annual	Internal Audit	• Divisional Management Boards • Risk Management Committee • Trust Management Group	Annual
	Comparison of committee terms of reference and reporting requirements for high level committees from sub-committees / Divisions with this strategy. Review of Committees review and management of risks to comply with this strategy	Annual	Patient Safety and Risk Manager	• Risk Management Committee • Trust Management Group	Annual
Risk register – risks are being updated	Performance data to ensure that all risks are within review date.	Monthly	Patient Safety and Risk Manager	• Weekly sitrep • Risk Management Committee	Quarterly
Division / Corporate Directorate implementation of this strategy	Review of Division and Corporate Directorate compliance with this strategy / risk management process: performance report	Quarterly	Patient Safety and Risk Manager	• Risk Management Committee	Quarterly
	Divisional presentation of risks 12 and above	Quarterly	Divisional Leadership	• Risk Management Committee	Quarterly

Review of risks in the different categories to determine whether any emerging risks or risks affecting several functions need to be considered for aggregation	Review risks recorded in Datix in the different categories to identify themes for further review and consideration of aggregation	Six monthly	Patient Safety and Risk Manager	• Risk Management Committee	Six Monthly
Achievement of the specific objectives of this strategy described on page 5	- Risks are assessed consistently by staff and responded to in an informed, proactive manner; - Risk management is a standing agenda item on all executive and divisional committees and meetings - The BAF is developed into one integrated report	Annual	Patient Safety and Risk Manager	• Risk Management Committee • Trust Management Group • Trust Board	Annual

7. Responsibility and Duties

Risk management is a task carried out by managers. Responsibilities are therefore set out under specific management roles. However, some cross-cutting risks apply across the organisation and lie outside the remit of any one business unit. In this case a Trust committee will be assigned its ownership, management and reporting.

7.1 Individual's Duties and Responsibilities

Risk Owner:
The owner of the objective is also the owner of the risks to meeting that objective. They have accountability and authority to manage the risk and MUST:

- Understand and monitor the risk
- Be able to report on the status of the risk
- Ensure appropriate controls are enacted
- Ensure the risk management strategy is followed

Chief Executive
The accountable officer with overall responsibility for risk management including Health and Safety. As such, the Chief Executive must take assurance from the systems and processes for risk management and ensure that these meet statutory requirements and the requirements of the regulators. Responsibility is delegated through the Executive Team. The Chief Executive shall attend the Audit Committee to discuss matters pertaining to the management of risk as required.

He / she shall ensure via the **Director of Asset Management & IT**, that risks arising from activities related to Information Technology, and Estates & Facilities management are identified and managed and coordinate compliance with relevant Fire & Safety legislation and related regulations.

Chief Nursing Officer (CNO)
The Board lead for quality, risk management, patient experience, nursing and midwifery practice, Infection Prevention, Safeguarding, and also professional lead for allied health professionals. He/she is accountable to the Chief Executive for risks arising from these areas. He/she is responsible for the Trust's risk management and incident reporting system, administration and maintenance of the Datix system, the production of incident reports and for the management and investigation of complaints and liaison with the Coroner. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Chief Medical Officer (CMO)
The Board lead for patient safety, clinical quality, clinical effectiveness, education & research and medical practice (including professional lead for pharmacists). The CMO is responsible for the management of the Central Alert System, arrangements for incident investigation, clinical audit, overseeing compliance with NICE guidelines and the Human Tissue Act. He/she is the Caldicott Guardian. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Director of Finance
The board lead for finance, information, business planning and performance. He/she shall ensure that activities are controlled and monitored through effective audit and accounting mechanisms that are open to public scrutiny and presented annually

He/she shall also fulfil the function of **Senior Information Risk Officer (SIRO)** and so be responsible for the Information Risk Policy, management of information risks and provision of leadership and training for Information Asset Owners. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Chief Operating Officer
The Board lead for operational performance. He/she is accountable to the Chief Executive and has a specific responsibility for identifying, recording, advising on and coordinating actions around operational and performance risks, health and safety and emergency planning. He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Director of Human Resources & Organisational Development
Responsible for risks arising from the workforce. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

Company Secretary
The lead for corporate governance and is responsible for the production and maintenance of the high level committees terms of reference.

Chair of the Audit Committee
He/she is responsible for keeping the Trust Board informed of any material matters which have come to the committee's attention. He/she will provide the Board with an opinion letter about the proposed Annual Governance Statement, and report to the Board on the effectiveness of the risk management system.

Divisional Directors
With reference to the Trust's risk appetite, Divisional Directors are responsible for applying the Risk Management Strategy within their divisions – this includes the identification, assessment, response, reporting and review of all risks to the achievement of objectives and delivery of services in line with the requirements set out in this document. They shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

All Clinical Directors, Directorate Managers, Ward Managers, Departmental Managers, General Managers or Heads of Service
Are responsible for identifying, assessing, responding, reporting and reviewing risks within their ward, department or service. They shall ensure risks are identified, evaluated, controlled, decisions on treatment/tolerance escalated where necessary, reviewed and updated at least quarterly. In addition, they will ensure that all their employees have an understanding of the risks to their service and at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

All Employees, partners and contractors have a responsibility to:

- Observe and comply with the policies and procedures of WAHT;
- Take reasonable care for the health, safety and welfare of themselves and others;
- Co-operate on matters of risk management and health and safety;

- Participate in induction and all relevant mandatory training as defined by the Trust policies;
- Comply with the requirements of WAHT policy, procedure and approved guidance;
- Report all identified hazards and adverse incidents;
- Undertake reasonable actions as required to reduce or eliminate risks associated identified hazards or adverse incidents.

Head of Clinical Governance & Risk Management - is accountable to the Chief Nursing Officer. He/she is specifically responsible for providing systems to support the Trust's risk management activities including:

- Developing risk management strategy, procedures and guidance
- The Trust's Risk Management Database
- The Incident Reporting System
- Ensuring the analysis of reported incidents and the identification of trends.
- Overseeing the management of serious incidents and reporting to external agencies
- Ensuring the provision of expert advice on risk management and patient safety as required
- Ensuring the provision of risk management training and patient safety as required

He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

Patient Safety and Risk Manager –is accountable to the Head of Clinical Governance & Risk Management and supports them in the implementation and embedment of the risk management framework. They are responsible for:

- Providing a strategy and assurance systems for risk management and patient safety.
- Influencing senior management to develop both a risk and safety culture within the Trust
- Providing direction and support to lead managers, Executive Directors, Divisional Directors and support staff to implement and maintain systems for risk management and patient safety and .prepare for assessments and inspections.
- Managing the teams providing corporate level support for patient safety and risk management
- Training and supporting the Trust's staff to improve their understanding of risk management and patient safety and the effective use of tools and techniques to deliver effective systems and achieve the desired outcomes.
- Maintaining the Trust's Risk Management Database
- Writing and revising the Trust's Risk Management Strategy, associated policies, procedures and forms and lead on their implementation
- Leading on and preparing the Board Assurance Framework for Significant Risks (including the integrated assurance & performance framework) and the Corporate Risk Register, with an accompanying paper for the relevant committees to review.
- Provision of expert advice on risk management and patient safety as required

Health & Safety Manager and Local Security Management Specialist - is accountable to the Chief Operating Officer and is responsible for

- Development of the Health & Safety Strategy, Health & Safety policies, procedures and guidelines
- Leadership, co-ordination and overseeing compliance with Health & Safety legislation and regulations
- Provision of expert advice to managers and staff on all aspects of health and safety management
- Provision of training on health & safety and security management as required

- Overseeing the management of non-clinical incidents
- Reporting notifiable incidents to relevant external agencies or regulators as required
- Liaison with WAHT's PFI partners, service providers and enforcing authorities (for example Environmental Health, HSE).
- The post also encompasses the role of Local Security Management Specialist as required by NHS Standard Contract.

He/she shall at all times ensure compliance with health and safety policies/ procedures and all relevant legislation and regulation.

Non-executive Directors - The Non-executive Directors have an important part to play in risk management. They are represented on and chair the Audit & Assurance Committee and the Quality Governance Committee. Both these committees provide reports to the Board on the suitability and effectiveness of systems to manage risk.

7.2 Committee Responsibilities

The Trust's risk management structure is led by the Trust Board and supported by the following sub-committees and groups:

- **Trust Board** - Executive and Non-Executive Directors share responsibility for the success of the organisation including the effective management of risk and compliance with relevant legislation. They have a collective responsibility as a Board to:
  - Protect the reputation of the WAHT and everything of value;
  - Provide leadership on the management of risk;
  - Reduce, eliminate and exploit risk in order to increase resilience;
  - Determine the nature and extent of the significant risks it is willing to take in achieving its strategic objectives
  - Ensure the approach to risk management is consistently applied; and all reasonable steps have been taken to manage them effectively and appropriately.

  Following review at TMG, the Board will receive a quarterly Executive Summary of discussions and assurance that the organisation is effectively managing risk
- **Trust Management Group (TMG)** – is the Trust's high level committee responsible for the management of risk and the principal management committee attended by the Executive and Divisional Directors. TMG will receive an executive summary every quarter from the Risk Management Committee, highlighting progress to divisional and corporate risks and areas where further discussion and decisions are required. Any updates to the Board Assurance Framework and Corporate Risk Register will also be provided and agreed.

  The TMG will make decisions about the treatment or tolerance of risks that lie beyond a Division's ability or responsibility to control effectively, informing the Board of its decisions and, when the nature of the risk requires it, requesting the Board to make a decision.
- **Risk Management Committee (RMC)** - is established to provide oversight and scrutiny of the management of risk throughout the Trust and reports to Trust Management Group. The divisions (including corporate teams) will present a report quarterly outlining risks of 12 and above, paying particular attention to those that they have specific concerns about and where they require more senior support. The patient safety and risk manager will also provide a report on the Board Assurance Framework and Corporate Risk Register to allow for discussion at this group and to ensure that the controls and actions are effective in managing the risk.

- **Clinical Governance Group (CGG)** will review divisional clinical risks in line with the Trust's clinical governance agenda. Each division will be required to discuss key areas of concerns relating to the safety, effectiveness and experience of patients and ensure these are aligned with the risk register.
  It will also review corporate nursing and governance risks and any risks that are linked to expert forums:
  - Mortality Review Group
  - Clinical Audit and Effectiveness Expert Forum
  - Patient and Carer Expert Forum
  - Trust Infection, Prevention and Control Expert Forum
  - Research and Development Expert Forum
  - Safeguarding Expert Forum
  - Medicine Optimisation Expert Forum
  - Incident Review and Learning Expert Forum
  - Resuscitation and deteriorating patient expert forum

  A quarterly report will be provided to the CGG, detailing all the moderate and high clinical risks to provide assurance that the risks are being effectively managed.
- **Quality Governance Committee (QGC)** – will receive an executive summary every month detailing assurance and escalation relating to governance and risk management functions discussed at CGG.
- **Finance and Performance Committee** – oversees the identification, evaluation, response to and monitoring of financial risk.
- **Workforce Operational and Assurance Group** – oversees the identification, evaluation, response to and monitoring of risks to the workforce. This will feed into the Risk Management Committee

The Trust's **oversight committee** with a responsibility for seeking assurance on the management of risk is the:

- **Audit & Assurance Committee (AAC)** - reviews the establishment and maintenance of an effective system of internal control and risk management, including the Board Assurance Framework.

  The AAC will receive the corporate risk register on a quarterly basis along with the Board Assurance Framework (BAF). At this meeting non-executive scrutiny and challenge will take place around the organisations
  - appetite for risk.
  - ability to identify and manage strategic and operational risk.
  - future strategic risks, namely assurance around identification and mitigation with a forward view of at least two years.

8. Strategy Review

The Risk Management Strategy will be reviewed by the Patient Safety and Risk Manager, with input from key executives on an annual basis

9. References

The references relating to this strategy are:
• The Care Quality Commission Fundamental Standards: The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
• Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013
• Home Office Risk Management Policy and Guidance, Home Office (2011)
• A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
• NHS Audit Committee Handbook, Department of Health (2011)
• UK Corporate Governance Code, Financial Reporting Council (2010)
• Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance, Audit Commission (2009)
• The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)
• Risk Management Assessment Framework, HM Treasury (2009)
• Understanding and Articulating Risk Appetite, KPMG, (2008)
• Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
• Good Practice Guide: Managing Risks in Government, National Audit Office (2011)

Internal supporting policies and procedures
The Trust has the following policies and documents which also relate to risk management and should be referred to for further information:

• Health & Safety Strategy (which includes security management)
• Incident Reporting Policy
• Risk Assessment Procedure
• Concern and Complaint Policy and Process December 2016
• Investigation Policy
• Business Planning process
• Standing Financial Instructions

10. Background

10.1 Consultation

The revisions to this document have been reviewed with key individuals who hold risk management responsibilities:

- Executive Team

10.2 Approval process

The Clinical Governance Group and Risk Management Committee is responsible for the critical appraisal and review of this strategy

The strategy is endorsed by the Trust Board. Minor changes can be approved by the Lead Executive.

10.3 Equality requirements

There are no equality impacts associated with this strategy

10.4 Financial risk assessment

Completion of the financial risk assessment identified the requirement for additional revenue for manpower for which a business case was completed and approved.

Appendix 1 - Implementation Plan

The work to implement this revised framework has commenced but will take some time to complete. This will be overseen by the Risk Management Committee. The outline implementation plan below describes the key tasks to perform and milestones to achieve to embed this across the Trust.

No.	Action	Person responsible for operational delivery of action	Target date for delivery	Individual or committee responsible for authorising closure	Status at the time of publication
1	Review of all divisional risk (including corporate) to ensure wording accurately reflects the risk and the grading is accurate	Patient Safety and Risk Manager with Divisional and Corporate Teams	End May 2017	Risk Management Committee	All divisions have met with Patient Safety and Risk Manager, and advice on wording/ grading discussed. Partial implementation. Corporate teams: work in progress
2	Establish quarterly meetings with divisional teams to provide peer support on review of risks and progress/ operational issues	Patient Safety Manager	End April 2017	Risk Management Committee	Complete: all meetings scheduled for 2017
	Executive scrutiny of divisional risks prior to commencement of Risk Management Committee	CEO	End April 2017	Trust Management Group	Complete: all divisions have met with executive leads to discuss risks
3	Re-establish the Risk Management Committee and Terms of Reference agreed.	Patient Safety and Risk Manager	First meeting to be held June 2017	Trust Management Group	

4	Risk Management Committee to include: • Report on CRR and BAF • Presentation/reports from divisions relating to risks of 15+ and any moderate risks of concern • Presentation/reports from corporate relating to risks of 15+ and any moderate risks of concern	Divisional Management Team Patient Safety and Risk Manager Corporate Team Leads	June 2017	Trust Management Group	
5	Executive Summary to be prepared to TMG following RMC	CNO	30.06.2017	Trust Management Group	
6	Executive Summary to be prepared to Trust Board following TMG	CNO	31.07.17	Trust Board	
7	Develop Training Needs analysis for risk management/ risk assessments- present to Risk Management Committee	Patient Safety and Risk Manager	June 2017	Risk Management Committee	
8	Once TNA approved, establish training sessions / workshops to meet needs	Patient Safety and Risk Manager	30.06.17	Risk Management Committee	
9	Continue regular reports to highlight overdue risks and actions- and ensure discussion in divisional and corporate governance meetings	Patient Safety and Risk Manager Divisional Management Teams	30.06.17	Risk Management Committee	Reports are sent weekly- fortnightly. Limited assurance currently of discussion of overdue risks/ actions and DMB.
10	Quarterly report to Clinical Governance Group of: • Moderate and high clinical risks and levels of assurance following discussion at RMC.	Patient Safety and Risk Manager	CGG in July 2017	Clinical Governance Group	

Appendix 2 – Risk Scoring Matrix

SECTION 1 – HARM / CONSEQUENCE SCORING

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/28rganiza Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ 29organizational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1

					million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Ref: NPSA

SECTION 2 - LIKELIHOOD OF OCCURRENCE

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

SECTION 3 - RISK SCORING MATRIX

		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
Consequence	1 Negligible	1	2	3	4	5
	2 Minor	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 Major	4	8	12	16	20
	5 Catastrophic	5	10	15	20	25

SECTION 4 - ACTION AND REPORTING REQUIREMENTS

Score	Risk	Action	Reporting Requirements
1-3	Risk is within tolerance	Within risk appetite / tolerance Managed through normal control measures at the level it was identified	Within tolerance so no reporting Record on risk register at the level the risk was identified
4-6		Within risk appetite / tolerance Review control measures at the level it was identified	Within tolerance so no reporting Record on risk register at the level the risk was identified
8-12	**Risk Exceeds tolerance**	Exceeds risk appetite / tolerance Actions to be developed, implemented and monitored at the level the risk was identified	Record on Risk Register at the level the risk was identified Report to next level of management
15-25		Exceeds risk appetite / tolerance **Immediate action required**	Record on Risk Register at the level the risk was identified Report to next level of management With Executive Director approval - enter onto

		Treatment plans to be developed, implemented and monitored at the level the risk was identified	Corporate Risk Register

APPENDIX 3

Internal sources of assurance	External sources of assurance
• Internal audit • Performance reports to Board and its Committees • Clinical audit • Staff satisfaction surveys • Staff appraisals • Training records • Results of internal investigations • Serious Incident investigation reports • Complaints records • Infection control reports • Information governance toolkit self-assessment • Patient advice and liaison services reports • Staff sickness reports • Internal benchmarking • Local Counter Fraud work • Local Security Management Specialist work • Patient environment action team reports • Health and safety reports • Maintenance records	• Intelligent Monitoring Report • Friends and Family Test • Care Quality Commission inspections • External audit • NHS Litigation Authority reports • CCG reports/reviews • Area Team reports • HSE Reports • Royal College visits • Deanery visits • External benchmarking • Patient environment action team reports • Accreditation schemes • National and regional audits • Peer reviews • Feedback from service users • External advisors • Local networks (for example, cancer networks) • Dr Foster reports

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age		
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	n/a	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	n/a	
7.	**Can we reduce the impact by taking different action?**	n/a	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	Yes – but covered in the implementation plan and to be delivered within existing resource
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

Date of meeting: 5th July 2017 **Enc H1**

Report to Trust Board

Title	Risk Management Strategy
Sponsoring Director	Vicky Morris, Chief Nursing Officer
Author	Sonia Lloyd, Clinical Risk and Governance Lead
Action Required	Approve the Risk Management Strategy
	To be Endorsed
Previously considered by	Trust Management Group and Quality Governance Committee

Priorities (√)

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

Related Board Assurance Framework Entries	Risk R1.1 The Trust fails to deliver high quality compassionate patient care to our patients.
Legal Implications or Regulatory requirements	Issue- Governance and Management Domain – Well led Regulation 17 – Good governance.
Glossary	

Key Messages

The risk management strategy has been revised to ensure there are clear objectives set and an escalation process to the corporate risk register described. The introduction of a risk management committee within the risk management structure is included with its relationship to Board sub committees and groups set out. The references section has also been updated.

Date of meeting: 5th July 2017 **Enc H1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 5th July 2017

1. Situation

The Trust's current risk management strategy v 14.3 does not reflect the recent revisions to the risk management process.

2. Background

The risk management process within the Trust has been reviewed and amended to provide staff with a clear escalation process for risks where further support is required to manage the risk safely.

3. Assessment

The changes to the risk management strategy set out clear risk management objectives, the improved risk management process and revisions to the risk management structure including the establishment of a risk management committee.

4 Recommendation

The Board is asked to endorse the revised risk management strategy.

Name of Director: Vicky Morris
Title: Chief Nursing Officer

Title of report	Risk Management Strategy
Name of director	Vicky Morris, Chief Nursing Officer

Worcestershire Acute Hospitals NHS Trust

Date of meeting: 5 July 2017 **Enc H2**

Report to Trust Board

Title	**Board Business**
Sponsoring Director	**Michelle McKay** **Chief Executive Officer**
Author	**Martin Wood** **Deputy Company Secretary**
Action Required	
Previously considered by	Board Away Day

Priorities (√)

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

Related Board Assurance Framework Entries	N/A
Legal Implications or Regulatory requirements	There is a requirement tofor the Trust to have designated statutory leadership roles
Glossary	TLG – Trust Leadership Roles STP- Sustainability and Transformation Plan QIRG – Quality Improvement Review Group

Key Messages

Worcestershire Acute Hospitals NHS Trust

Date of meeting: 5 July 2017 **Enc H2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 5 JULY 2017

1. Introduction

The purpose of this report is to present to the Board a number of matters relating to the conduct of business.

2 Proposed Workforce Committee

Board members have discussed at the recent away day the focus to be given to workforce issues. The discussion has centred on whether a Workforce Board Committee should be established or whether workforce issues should be undertaken by a group (with Non-Executive Director membership) reporting to the Finance and Performance Committee. Whichever option is selected consideration will need to be given to the terms of reference to ensure that there is clarity of the areas of responsibility with that Committee/Group and the existing Board Committees. Terms of reference will be prepared once the preferred option has been selected.

3 Recommendation

The Board is invited to determine the arrangements which it wishes to put in place for the consideration of workforce issues. Terms of reference can then be prepared and presented to the Board for approval.

4. Revised Board Calendar for 2017

With the appointment of new Board members, the opportunity has been taken to review the Corporate Calendar for the remainder of the current year.

The calendar has been revised on the basis of:-

1. Moving Board meetings away from Wednesday to nearer the weekend. Tuesdays have been selected.
2. The Pulse dates have been incorporated
3. Two Committee meetings have been arranged on the same day. Monday for the Finance and Performance Committee with Audit and Assurance Committee in the afternoon. (Except November due to Pulse meetings) This allows for a Board Away day on the Tuesday.

4. Quality Governance Committee remains on the Thursday morning with provision for a Workforce Committee in the afternoon, if established.
5. Clinical Governance Committee remains on the first Tuesday of the month
6. Trust Leadership Group (TLG) remains unchanged on Wednesdays. Executive Team meetings have been removed with the bulk of the business being undertaken by TLG.
7. The A and E Delivery Board, STP and QIRG meetings are included for completeness and remain unchanged.
8. A Trustees meeting has been scheduled for November post Board to approve the Accounts.

The proposed calendar has been circulated to Board members.

5. Recommendation

The Board is invited to approve the revised Corporate Calendar for the remainder of 2017.

6 Leadership Roles for Board Members

Standing Orders currently provide that the Chairman will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

The list below is considered best practice of statutory and other postholders and the known lead has ben identified:-

1) Caldicott Guardian – Associate medical Director Patient Safety
2) Senior Information Risk Owner – Chief Finance Officer
3) Health & Safety – Chief Operating Officer
4) Emergency Planning – Chief Operating Officer
5) Quality- Chief Nursing Officer
6) FOI- Qualified person- this is the CEO in the NHS organisations.
7) Raising concerns (formerly whistleblowing) – Freedom to Speak Up Guardian
8) Director of Infection Prevention & Control – Chief Nursing Officer
9) Decontamination
10) Sustainability- Director of Asset Management and ICT

11)Counter Fraud & Security- Director of Finance
12)CQC Registered Manager- Chief Nursing Officer
13)Date Protection Officer (not usually executive level)
14)Accountable Officer for Controlled Drugs-,Chief Pharmacist
15)Freedom To Speak Up Guardian – Bryan McGinity
16)Senior Independent NED
17)Equality & Diversity lead
18)End of Life
19)Organ donation
20)Learning from Deaths – Chief Medical Officer
21) Responsible Office – Chief Medical Officer
22)Medical Validation – Chief Medical Officer

7 Recommendation

The Board is invited to ensure that there is a designated lead for these roles..

Martin Wood
Deputy Company Secretary

Date of meeting: 05 July 2017 **Enc H3**

Report to Trust Board

Title	**Freedom to Speak Up Guardian (FTSUG) Update**
Sponsoring Director	Michelle McKay Chief Executive Officer
Author	Di Pugh, Deputy Director of HR and OD
Action Required	**Note** the appointment of Mr B McGinty to the role of FTSUG on an interim period for up to 6 months **Approve** the proposal to externally recruit to the FTSUG role
Previously considered by	*Equality and Diversity Committee*

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity and missed opportunities.
Legal Implications or Regulatory requirements	NHS Constitution CQC requirements National Guardians Office requirements
Glossary	***FTSU*** – Freedom to Speak Up ***NGO*** – National Guardians Office ***Draw the Line*** – national Raising Concerns programme ***Speak Out Safely*** – RCN national programme

Key Messages

- The Department of Health accepted a number of recommendations made by Sir Robert Francis' report on 'Freedom to Speak Up' including one that there should be a 'Freedom to Speak Up Guardian' appointed in every NHS Trust during the financial year 2016/17.

- John Burbeck, Non-Executive Director was appointed to this role in February 2017 which built on his existing role within the Trust's Policy for 'Raising Concerns' and the Trust's 'Dignity at Work Policy' as nominated Non-Executive Director. John is supported by a Freedom to Speak Up Team which comprises of our current Equality and Diversity Leads for Staff and Patients, and Staff Support Advisers. This model is consistent with a number of other Trust's; although this varies. Given Mr Burbeck is leaving; it was agreed that it was timely to review the model in line with lessons learnt and best practice.

Title of report	Freedom to Speak Up Guardian
Name of Director	Michelle McKay

- Feedback from the CQC demonstrates that some staff are going to them direct to raise their concerns which suggests that our current processes need strengthening.

- This report outlines the results of the review and makes recommendations for enhancing and embedding the FTSU Guardian and Champion roles within the Trust.

- The paper provides assurance of the system in place for continuity following Mr Burbeck's departure.

- There are two potential options available to the Trust as set out in recommendations. The Board is asked to consider the recommendation of a preferred option of external appointment.

Appendix 1: Proposed FTSU Job Description
Appendix 2: Proposed New Model

Date of meeting: 05 July 2017 **Enc H3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 05 July 2017

1. Situation

The appointment of a National Guardian for speaking up freely and safely, and Freedom to Speak Up (FTSU) Guardians in NHS trusts were recommended by Sir Robert Francis, following his review and subsequent report into the failings in Mid-Staffordshire.

In July 2015, the Secretary of State confirmed the steps needed to be taken to develop a culture of safety, and supported Sir Robert's recommendations. Therefore, all NHS trusts and NHS foundation trusts are required by the NHS contract (2016/17) to nominate a FTSU Guardian.

National Guidance can be found from the CQC (Care Quality Commission) https://www.cqc.org.uk/sites/default/files/20160301_Guide_to_trusts_in_establishing_FTSU_guardian.pdf. The CQC have an interest in the roles nationally and will interview the FTSU Guardian as part of their assessment of the Trust in the Well Led domain.

Outcomes from the FTSU Guardian role include an assurance that:

- A culture of speaking up is instilled throughout the organisation.
- Speaking up processes are effective and continuously improved.
- All staff have the capability to speak up effectively and managers have the capability to support those who are speaking up.
- All staff are supported appropriately when they speak up or support other people who are speaking up.
- The Board is fully sighted on, and engaged in, all Freedom to Speak Up matters and issues that are raised by people who are speaking up.
- Safety and quality issues are assured

2. Background

John Burbeck, Non-Executive Director agreed to take on this role for the Trust in February 2017 on the back of an already established role as Nominated Non-Executive Director within the Trusts Raising Concerns and Dignity at Work Policies (supported by a Deputy Director of HR).

The Achievements of Freedom To Speak Up so far are:

- 3 formal complaints received into FTSU Guardian, 2 resolved with early intervention and 1 ongoing.
- 2 Guardian Team members have received national FTSU training
- Guardian Team member has joined the newly established network of Regional Freedom to Speak Up Guardians
- A meeting has taken place with the newly appointed lead of the Regional FTSU network.
- Recording Forms are now in place for FTSU including a safe online storage folder created only accessible to FTSU Guardian Team.

Title of report	Freedom to Speak Up Guardian
Name of Director	Michelle McKay

- The existing E&D leads are on board with FTSU and will take part in quarterly FTSU meetings.
- 25 staff applied to be FTSU Champions/Contact Links and are awaiting a training programme once the new model has been confirmed.
- First return submitted to National Guardian's Office (NGO) in line with quarterly reporting requirements

Although the model established is in its infancy, feedback from the CQC demonstrates that our current processes need strengthening; given that staff are going direct to them with their concerns rather than having the confidence to raise them internally. It is important to create a culture of confidence within the Trust processes and support staff to come forward to ensure organisational learning.

Our current FTSUG, John Burbeck, leaves the Trust in June 2017 and so this role will need to be replaced. Given this and the feedback received, it was agreed to take this time to reflect on established good practice from other Trusts.

3. Assessment

Feedback from Regional Group – June 2017

The meeting was well attended with at least 25 FTSU Guardians there. Picking up some threads (in no particular order):

1. The model seems to be working well within the Trusts that have implemented it for some time and where the role has the full backing of the Board with the postholder reporting directly to the Chief Executive Officer. There is a national template for the job description. It is widely recognised that the role is two pronged in terms of encouraging speaking out and challenging and changing culture.
2. The NGO has templates for reporting and figures are required to go to them to capture the data of those interventions which "come across the path" of the FTSUG. The CQC will interview FTSUG's and want to know if the Executive Team give resources to the role, both financial, other support and backing. Also they will want to know how the data from FTSU falls within the 10 categories which the NGO give in "Guidance for Freedom to Speak Up Guardians: Recording Issues eg. Patient safety/behaviour/ bullying etc. and how this intersects with the other data that the Trust might have via DATIX, Staff Survey and Patient Experience.
3. Most of the Trusts represented had employed or appointed Guardians internally; with the exception of 1 (The Royal Wolverhampton Hospitals NHS Trust who appointed externally (previously a social worker in LD)). The posts were funded between 2 and 4 days a week. They were either selected by the Board or were appointed on advertisement (a 50/50 split). On speaking to the Regional Chair, where days have been added on to an existing post, Guardians can find it difficult to balance the 'Guardian role' with the pressures of their existing role.

Where it works well is where a clear distinction and full dedication given to the role whether the postholder is appointed internally or externally, Wolverhampton report by appointing externally this distinction is clear and works well. All reported that a candidate needs clear passion and commitment for making a difference in the designated role, this together with dedicated time appear to be the most important factors rather than whether the role is appointed either internally or externally.

4. Confidentiality/Oversight of data and Independence of the Guardians was a key point and Trusts have to work out who the Guardian shares the data with. Mostly it was HR Director or CEO. The Guardian also prepares quarterly Board Reports.

5. The CQC have a new template for inspections which explicitly mentions the FTSUG. It is pivotal to a Trust getting a well led rating. The measure of seriousness with which the Trust supports FTSUG's is in direct proportion to the paid time given to the role.

6. It seemed to take the Guardians about 6 months (depending on time employed) to begin to get increasing numbers of referrals. From the figures received from the NGO so far there 2850 concerns of which 737 were linked to patient safety. One guardian's experience was that Yr 1 there were 9 concerns expressed and Yr 2 27, so work seems to grow incrementally with time in the post. There is no benchmark for what a Guardian should expect to receive in referrals.

7. Most FTSUG's are supported with a model of FTSU Champions especially in multi-site Trusts. The need was expressed at the Regional Meeting for a standardised Job Description for FTSU Champions (different to the FTSU Guardian). There was also a training need for them which can be supported nationally.

8. The range of concerns expressed to Guardians was diverse and may cover more than one of the NGO categories. These need to be documented in more than one category and there is a tool for doing this.

<u>National Survey completed for NGO</u>

Since the last report two members of our FTSU Guardian Team have attended national FTSU training and/or webinars to ensure that we are fully sighted on developments and in line with other Trusts. The key learning points from these events were:

- The NGO will be setting criteria around best practice for investigations including timescales – they will expect a standard turnaround time for all investigations in NHS Trusts.
- There are a number of models for FTSU across Trusts ranging from dedicated Guardians (appointed externally or nominated internally); nominated FTSU Guardian NEDs and FTSU Guardian Steering Groups.
- Many Trusts confirm (like WAHT) that they have used existing Whistleblowing, Bullying, Speak Out Safely campaigns to evolve into their FTSU model.
- The National Guardian (Henrietta Hughes) has confirmed that they want all of the other campaigns "Speak Up Safely", "Draw the Line" "Cut it Out"

Stamp it out" all to be replaced with FTSU so that there is common phraseology.

- The NGO recommends that FTSU Guardian/Champion attends induction so that staff are encouraged to speak out from the start.
- The green FTSU logo should be embedded in all our communications

FTSU Guardian/Champions should use the Freedom to speak up logo on their email signature.

The Way Forward - FTSU Guardian role

WAHT are committed to implementing recommendations of the Francis Report 2015 Freedom to Speak Up; An Independent review into creating an open and honest reporting culture in the NHS.

From the research gathered, although the Trust's current model is not unusual across Trusts, there is clear evidence to suggest that ring-fenced time to progress the national model is both an expectation of the NGO and CQC but more importantly an important factor in the cultural change programme within this Trust. With this in mind there are two potential options available to the Board, from the evidence gathered the recommendation would be for the Board to support option 2:

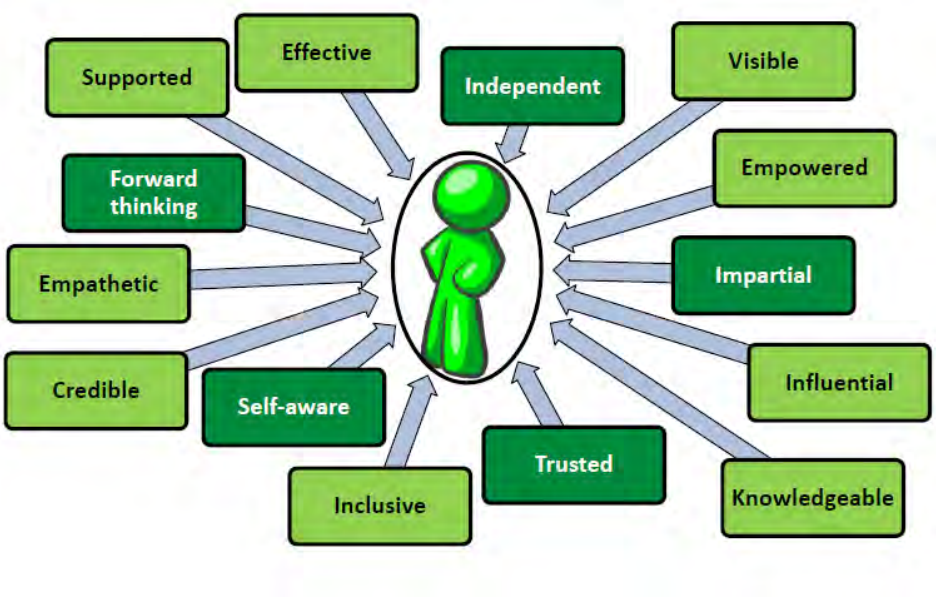
1. The Trust continues with the current model as previously presented to the Board and led by John Burbeck, Non-Executive Director. John is the current nominated FTSU Guardian with a support infrastructure as detailed within appendix 1, with David Southall attending meetings etc. on John's behalf and feeding back. Although some good progress has been made, there are limitations to this model as expected against the NGO Job Description and the CQC expectations as there is no dedicated time provided for within the structure, it's an additional duty to existing roles. The benefit to this model means no additional costs are incurred.

2. The Trust advertises and appoints a dedicated FTSUG – in line with the guidance from the NGO and CQC directly reporting into the Chief Executive with full access to the Board. There would still be a role for a designated Non-Executive Director to support the role. The potential cost for this role would be Band 7 for a recommended 3 days per week – circa £25k. This role is not currently funded but if the Board were in support of the model, we would need to consider how we allocate existing overall resources within the Corporate functions to resource this key role. A draft of the Job Description is attached in appendix 2 and the key objectives of the new FTSUG would be:

- To raise the profile of speaking up within the Trust.
- To support and help develop a culture where speaking up becomes normal practice to address concerns.
- To develop mechanisms to empower and encourage staff to speak up safely.
- To ensure that the Trust provides a safe environment for employees and others to raise concerns and speak up.

- To ensure that concerns are effectively investigated and the Trust acts on its findings.
- To ensure shared learning amongst local/regional/national Networks.

It is also important that the FTSUG is reflective of the key characteristics that the NGO has outlined, in the diagram below:



Planning for Enhancing and Embedding Freedom to Speak Up principles throughout the Trust

Key Areas that have been identified for planning and developing Freedom To Speak Up at WAHT will be developed into a detailed action plan once the FTSUG G is appointed. Key themes within the action plan will include:

- Review of the Raising Concerns (Whistleblowing) Policy and raising awareness of this policy
- Developing, in conjunction with Communications, a communication plan
- Data Analysis; to gather information about the organisation and build a picture of current themes and trends by reviewing national staff surveys, local chat back results and other routes via HR, Occupational Health, Staff side, Governance, Equality and Diversity Leads/FTSU Guardian Team and FTSU Champions/Contact Links
- Supporting cultural change throughout the organisation where staff feel supported to speak up safely.
- Recording & Monitoring of concerns and exploring an anonymous route to raise concerns via DATIX.
- Training and Awareness Raising of FTSU amongst Management and Divisions across the Trust, with specific training plan devised for managers on the handling and dealing of concerns ensuring that a culture of speaking up is created amongst staff/teams/departments.
- Sharing learning and providing feedback at local, regional and national level, Trust Board, West-Midlands Regional FTSU Network and National Guardian Office and National Annual Guardian Conference.

Current position following Mr Burbeck's departure:

As Mr John Burbeck leaves the Trust at the end of June, the Board is asked to support a handover from Mr Burbeck to Mr Bryan McGinty, Non-Executive Director for an interim period of up to 6 months should the decision of the Board be to recruit a dedicated FTSUG. Mr McGinty will continue with the model currently in place previously led by Mr Burbeck and previously presented to the Board with the support of the underpinning team.

4 Recommendation

The Board is asked to:

- Note the appointment of Mr B McGinty to the role of FTSUG on an interim period for up to 6 months
- Approve the proposal to externally recruit to the FTSUG role

Worcestershire Acute Hospitals NHS Trust

Date of meeting: 5 July 2017 **Enc H4**

Report to Trust Board

Title	**FIT AND PROPER PERSONS TEST**
Sponsoring Director	**Michelle McKay** **Chief executive**
Author	**Martin Wood** **Deputy Company Secretary**
Action Required	The Trust Board is asked to **NOTE** compliance with the requirements of the Fit and Proper Persons Test and that arrangements are in place to ensure future compliance
Previously considered by	N/A

Priorities (√)

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

Related Board Assurance Framework Entries	N/A
Legal Implications or Regulatory requirements	The Fit and Proper Person Regulations came into force on 1 April 2015 in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Glossary	CQC - Care Quality Commission

Key Messages

The CQC have raised concerns that the evidence to support compliance with these regulations is incomplete. A thorough examination has been undertaken to identify the outstanding information and ensure that it has been obtained. It is confirmed that all Board members comply with the regulations.

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Worcestershire Acute Hospitals NHS Trust

Date of meeting: 5 July 2017 **Enc H4**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JUNE 2017 (By e-mail)

FIT AND PROPER PERSONS TEST

1. Purpose

This paper seeks to provide assurance that all members of the Trust Board meet the requirements set out in the Fit and Proper Persons Test, which came into force on 1 April 2015.

2. Background

These regulations require NHS organisations to demonstrate that Directors are and continue to be fit and proper persons. The regulations apply to those performing the functions of, or equivalent or similar to the functions of a director which are those voting Board members. The test has been integrated into CQC's registration requirements, and falls within the purview of their regulatory and inspection approach. The Chair is required to confirm the fitness of all Directors who have been assessed in line with the regulations and declare to the CQC that all those within the scope of the regulations are fit and proper for the role. The regulations apply to voting and non-voting Board members.

As part of their inspection the CQC have raised concerns that the evidence to support compliance with these regulations is incomplete. A thorough examination has been undertaken to identify the outstanding information and ensure that it has been obtained. It is confirmed that all Board members comply with the regulations.

3. Moving Forward

A process has been established with Human resources and the Deputy Trust Secretary to ensure that there is compliance with the regulations.

Human Resources will ensure that for new Directors the NHS Pre-employment Standards have been adhered to. This includes the following:

- Identity Checks
- Right to Work in the UK checks
- Reference and Employment History Checks (two references, one

of which must be from the most recent employer, a full employment history including explanation of any gaps)

- Disclosures and Barring Service Check (where the individual is involved with regulated activity as out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008)
- Occupational Health clearance
- Qualification and Professional Registration Checks

Checks will also be undertaken against the insolvency, bankruptcy and disqualified directors register now and on an annual basis.

Governance

The Fit and Proper Persons Test is part of the CQC essential standards, which are a core component of the Trust's governance framework and with which the Trust must comply. An annual declaration of compliance with the regulations will therefore be made at a Public Trust Board meeting to evidence that the Trust has appropriate governance mechanisms in place in this regard.

4 Recommendation

The Trust Board is asked to **NOTE** compliance with the requirements of the Fit and Proper Persons Test and that arrangements are in place to ensure future compliance.

Martin Wood
Deputy Company Secretary

Worcestershire Acute Hospitals NHS Trust

Date of meeting: 5 July 2017 **Enc H5**

Report to	**Trust Board**
Title	**Annual Report**
Sponsoring Director	**Michelle McKay** **Chief Executive Officer**
Author	**Martin Wood** **Deputy Company secretary**
Action Required	Approve the recommendation to delegate authority to the Chief Executive Officer, in consultation with the Chair, to approve the final version of the Annual Report prior to presentation at the Annual General Meeting.
Previously considered by	Audit and Assurance Committee

Priorities (√)

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

Related Board Assurance Framework Entries	N/A
Legal Implications or Regulatory requirements	It is a statutory requirement for the Trust to produce an Annual Report.
Glossary	-

Key Messages

Worcestershire Acute Hospitals NHS Trust

Date of meeting: 5 July 2017 **Enc H5**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 5 JULY 2017

1. Situation

The purpose of this report is to invite the Board to delegate authority to the Chief Executive Officer, in consultation, with the Chair, to approve the final version of the Annual Report prior to presentation to the Annual General Meeting to be held in September 2017.

2 Background

The Trust has to produce an Annual Report every year. Best practice is for the Trust to complete the Annual Report at the same point as the Annual Governance Statement and accounts and this was undertaken at the Audit and Assurance Committee in May 2017. The Group Accounting Manual published by the Department of Health has guidance on how the annual report should be constructed. The Trust has followed this format.

The Annual Report is consistent with the External Auditors' audit opinion and cannot be changed. Any further changes would be largely presentational for the Annual general Meeting.

3 Recommendation

The Board is recommended to delegate authority to the Chief Executive Officer, in consultation with the Chair, to approve the final version of the Annual Report prior to presentation at the Annual General Meeting.

Martin Wood
Deputy Company Secretary

Title of report	Annual Report
Name of director	Michelle McKay Chief Executive Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 05 July 2017 **Enc H6**

Report to Trust Board (in public)

Title	Medical Revalidation Quarterly Report and Update – 05 July 2017
Sponsoring Director	Dr Suneil Kapadia, Responsible Officer
Author	Vivian Brobbey-Sarpong, Temporary Staffing and Projects Lead – Human Resources
Action Required	The Board is asked to note the current status and support the required actions for medical appraisal and revalidation to achieve Trust and national targets.
Previously considered by	Not applicable.

Strategic Priorities (√)

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

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

Key Messages

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

Date of meeting: 05 July 2017 **Enc H6**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 05 July 2017

1. Situation

This report describes the progress and management of medical appraisal and revalidation since the report presented to the Board in February 2017.

2. Background

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

3. Assessment

3.1 Medical appraisal and revalidation performance

As at 19th June 2017, there were 374 doctors with a prescribed connection to the Worcestershire Acute NHS Trust. 304 doctors have been revalidated as at 19th June February 2017 which is in line with the GMC revalidation trajectory timeline of entering doctors into their first revalidation cycle. Zero doctors are currently deferred and one doctor put on hold.

The appraisal rate for all medical staff is 88.56%, above the Trust board target and a slight increase since the last report with the rate of 82.07%. 40 planned appraisals have not taken place as at 31st May 2017.10 appraisees had no appraisers allocated. This figure is high. **See paragraph 3.5 for corrective actions.** All Division have recorded significant increase in appraisal rates above 85% Trust Tolerance rate with the exception of Surgery which has recorded low rates. Reasons for non-completion have been requested from all divisions.

Division	Appraisal rate at 31st May 2017	Direction of travel since 31 January 2017	Number of missed appraisals at 31st May 2017
Medicine	85.03%	↑ from 76.56%%	10
Surgery	81.71	↓ from 81.82%	15
SCSD	93.24%	↑ from 83.56	11
Women & Children	90.91%	↑from 85.71%	4

The SAS doctors' appraisal rate has increased considerably from 69.84% to 73:92% and below the Trust tolerance of 84%. This is still of concern. All other grades have recorded increase in rates with the exception of Surgery Division. **See paragraph 3.5 for corrective actions.**

3.2 NHS England Regional RO Network

The NHS England Regional Revalidation Conference was attended on 28th March 2017 by Mr Melwyn Pereira, Clinical Lead for Appraisal and Revalidation and Dawn-Marie Wright, Revalidation Support Officer. The conference provided

useful resources to support the Trust to prepare for the second cycle of revalidation following Sir Keith Pearson's Report 'Taking Revalidation Forward' in January 2017.

3.3 **NHS England Annual Organisation Audit (AOA)**

The Annual Organisation Report was submitted on 12th May 2017. Please see appendix 1 for more details. The number of unapproved incomplete or missed appraisals has increased from 50 to 74. **See paragraph 3.5 for corrective actions.**

3.4 **Update on Recommendations from NHS England - Independent Review Visit – Audit Report**

The visit was undertaken following assessment of the organisation's Annual Organisational Audit (AOA) report for 2015 which outlined the organisation's overall position with regard to appraisal and revalidation and because an interim Responsible Officer had been appointed.

Summary of recommendations and associated action has been provided in appendix 2

3.4 **Risks**

The process of central allocation of appraisers/appraisees will pose retention risk to the number of appraisers that can be recruited to administer the appraisal process. Appraisers anticipating increase workload due to equitable distribution may resign from their role. There is a potential impact on small specialty areas resisting undertaking cross specialty appraisals due to lack of confidence resulting from in adequate training and resources.

3.5 **Corrective Actions**

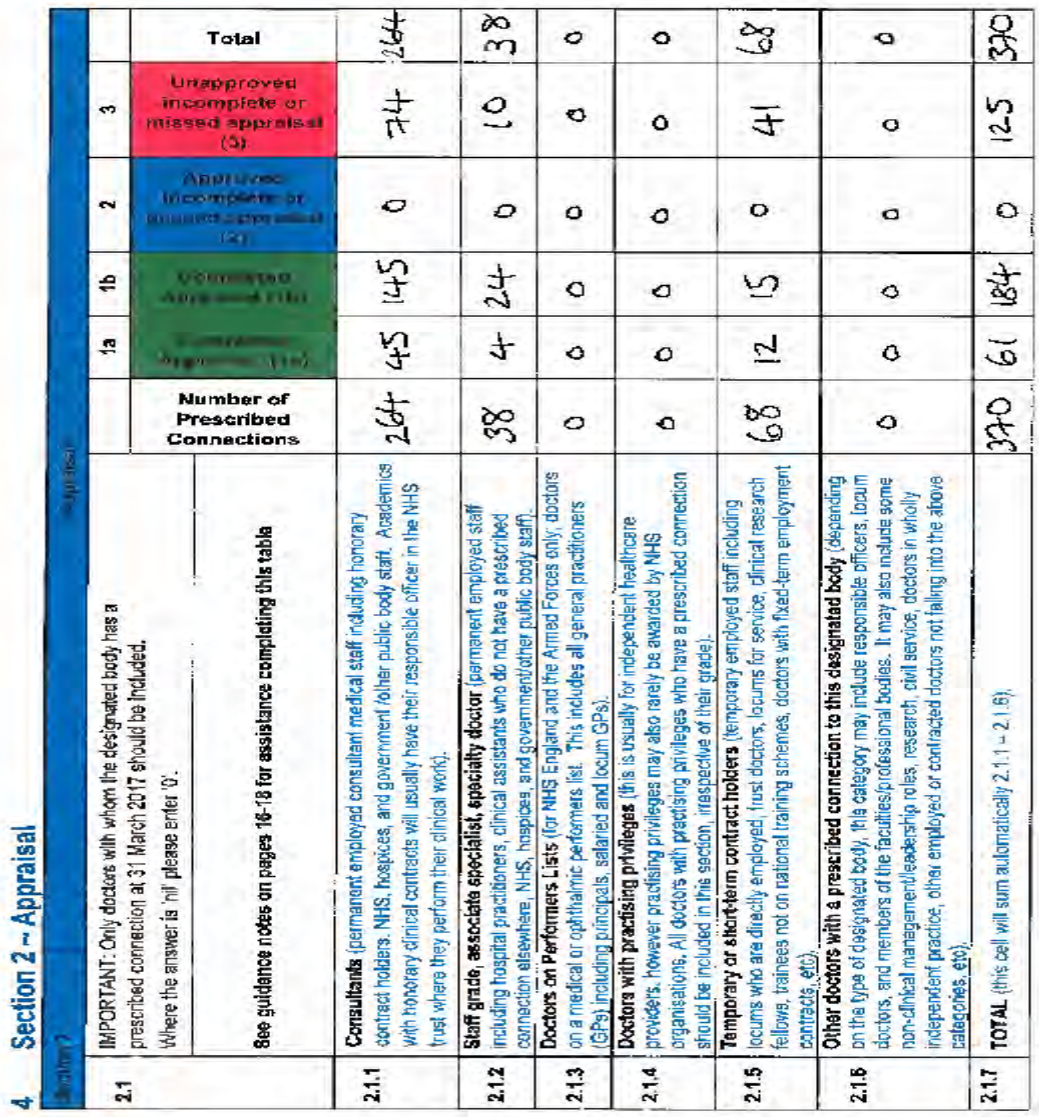
- Corrective actions following the Independent visit recommendations have been outlined in appendix 2.
- All doctors who have missed their appraisals have been allocated appraisers with deadline to arrange their appraisals. The central allocation of appraisees to appraiser will ensure equitable distribution. Monthly reports are issued to all divisions to take action on missed appraisal. Responses and actions are followed up periodical. The Trust Medical Appraisal and revalidation Policy has been reviewed to include consequences for non-engagement.

4 Recommendation

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

Date of meeting: 05 July 2017 **Enc H6**

Appendix 1
NHS England Annual Organisation Report AOA) submitted on 12th May 2017



4 Section 2 – Appraisal

			1a	1b	2	3	
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is 'nil' please enter '0'. See guidance notes on pages 16-18 for assistance completing this table	Number of Prescribed Connections	[illegible]	[illegible]	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders. NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	264	45	145	0	74	264
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere. NHS, hospices, and government/other public body staff).	38	4	24	0	10	38
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers. however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	68	12	15	0	41	68
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 - 2.1.6)	370	61	184	0	125	370

Title of report	Medical Revalidation Quarterly Report and Update – 05 July 2017
Name of director	Dr Suneil Kapadia

Appendix 2

Independent Verification Visit Report 19/08/2016

Summary of recommendations and associated actions

Recommendations from NHS England Midlands and East Report		**Actions**
1	A review and revision of the Senior Medical Staff Appraisal Policy is recommended in line with the comments to reflect the inclusion of all doctors and clarity around appraisal timing in relation to all connected doctors including new starters.	The Trust Medical Appraisal and Revalidation has been reviewed and approved by MMC. The policy reflects this recommendation
2	The setting up of a properly constituted management group to review performance issues to include RO, senior doctor and senior HR representative.	MARAG has been set up and first meeting was held on 24/02/2017
3	The recruitment of a clinical appraiser lead to provide leadership in respect of the appraisal process.	Clinical Appraisal and Revalidation Lead has been appointed
4	A review and centralisation of the appraisal process to be undertaken to provide a consistent process across all sites.	Appraisal process has now been centralised following approval by MMC
5	A consistent appraisal process to be applied across the Trust to offer an equitable situation to all doctors, relating in particular to allocation.	Central Allocation of appraiser process has been approved following MMC meeting
6	The reintroduction of appraiser support networks to enable discussion and calibration to take place on a regular basis across site boundaries, with a requirement that attendance at a specified minimum is mandatory for appraisers.	**Implemented** Appraiser networks on both WRH and Alex site took place in July 2016 with next meetings scheduled in December 2016. RO: Frequency of meetings to be reviewed and updated in policy (if applicable). Appraiser feedback on quality assurance review and appraisee feedback to be given on an annual basis. QA review of appraisal outputs in accordance with QAMA
7	The appraisal policy could be clarified and strengthened concerning the consequences of non-engagement.	The Trust Medical Appraisal and Revalidation Policy has been amended on Appendix letter 3

8	The introduction of the revalidation process into the appraisal policy to strengthen the link between them.	**Implemented** Narrative added in May 16 policy update.
9	Consider the involvement of others in reviewing documentation prior to recommendations made possibly the introduction of a retired non-executive director and patient involvement.	Proposal subject to further investigation by the Chief Medical Officer. Outcome of investigation will inform when this will be implemented
10	Review of all appraisal documentation within 5 year revalidation cycle prior to recommendation	Preliminary audit completed
11	Implementation of a tracking process to provide assurance that appraisers are undertaking update training on a tri-annual basis and are attending forums regularly.	***Implemented*** Record of training/network attendance maintained for all appraisers RO: process for non-attendees needs further consideration.
12	An audit of the locum agencies contracted to provide staff to the Trust could be undertaken with the aim of providing the organisation with the assurance that relevant pre-employment checks are carried out by the agency prior to their placement within the Trust.	***Implemented*** Audit completed annually as part of annual RO Trust board report. Assurance provided by HCL.
13	A formal, recorded induction process which reflects the needs and expectations around appraisal which is acknowledged and signed off by the new joiner.	**Partially implemented** New employees are issued with welcome/induction pack including appraisal policy, system for appraisal and useful links and internal/external resources, user guides for appraisal system and offers of 1:1 meetings and webinar support. *Induction checklist to be completed by new starters and submitted during Appraisal and Revalidation Training scheduled as part of the New starter induction programme*

Key:

RO: feedback and decision required from RO

Green: Recommendation fully addressed/implemented

Amber: Recommendation partially addressed/implemented

Additional feedback

- Administrative support resources required to release RO from undertaking administrative responsibilities, additional support to co-ordinate appraisal activity centrally to improve appraisal monitoring and completion.
- A scheme of delegation to be implemented to make clear who has delegated responsibility to process recommendations in GMC Connect on behalf of the RO. The Clinical Appraisal and Revalidation Lead and Human Resource Lead

for Appraisal and Revalidation have delegated responsibilities to process recommendations in GMC connect. There are plans to appoint a Deputy RO and senior appraisal leads to provided support in reviewing appraisal documents before recommendation.