Worcestershire NHS
Acute Hospitals NHS Trust

Trust Board

There will be a meeting of the Trust Board on Wednesday 1 March 2017 at 09:30 to 11:30 in the Board Room, Alexandra Hospital, Redditch.

This will be followed by a public question and answer session from 11:45 to 12:45. Members of the public can email questions to the Company Secretary, Kimara.sharpe@nhs.net by Tuesday 28 February, 12 noon.

Caragh Merrick, Chairman

Agenda		Enclosure
1	**Welcome and apologies for absence**	
2	**Patient Story**	
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 **11 January 2017** as a true and accurate record of discussions.*	**Enc A**
6	**Action Log**	**Enc B**
7	**Chairman's Business**	**Enc C1**
8	**Chief Executive's Report**	**Enc C2**
Quality of Care		
9.1	**Quality Governance Committee report** Quality Governance Committee Chairman	**Enc D1**
9.2	**Quality Improvement Plan (includes section 29A response)** Acting Director of Performance	**Presentation**
9.3	**Board Assurance Framework** Interim Chief Nurse	**Enc D2**

Finance and use of resources		
10.1	**Finance and Performance Committee** Finance and Performance Committee Chairman	**Enc E1** **To follow**
10.2	**Financial Performance Report** Director of Finance	**Enc E2**
10.3	**Nursing and Midwifery Workforce** Interim Chief Nurse	**Enc E3**
10.4	**Medical revalidation report** Acting CMO	**Enc E4**
Operational Performance		
11.1	**Integrated Performance Report** Director of Finance	**Enc F1**
Strategic Change		
12.1	**Sustainability and Transformation Plan - Governance** Director of Planning and Development	**Enc G1**
12.2	**Trust Management Group** Acting Chief Executive	**Enc G2**
Leadership and Improvement Capability		
13.1	**Organisational Development Plan** Director of HR and OD	**Enc H1**
Stakeholders		
14.1	**Future of Acute Hospital Services in Worcestershire** Director of Planning and Development	**Enc I1**
Governance		
15.1	**Audit and Assurance Committee report** Audit and Assurance Committee Chairman	**Enc J1**
Items for information		
17	**Any Other Business** *as previously notified*	
	Date of Next Meeting The next public Trust Board meeting will be held on **Wednesday, 4 May, Alexandra Hospital Board Room**	

Worcestershire NHS
Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON

WEDNESDAY 11 JANUARY AT 09:30 hours

Present:

Chairman of the Trust:	Caragh Merrick	Chairman
Board members: (voting)	Rob Cooper	Acting Chief Executive
	John Burbeck	Non-Executive Director
	Philip Mayhew	Non-Executive Director
	Bryan McGinity	Non-Executive Director
	Jill Robinson	Interim Director of Finance and Performance
	Gareth Robinson	Interim Chief Operating Officer
	Andrew Short	Acting Chief Medical Officer
	Jan Stevens	Interim Chief Nursing Officer
	Chris Swan	Non-Executive Director
	Bill Tunnicliffe	Non-Executive Director
Board members: (non-voting)	Denise Harnin	Director of HR & Organisational Development
	Sarah Smith	Director of Planning and Development
In attendance:	Kimara Sharpe	Company Secretary (minutes)
	Paul Crawford	Patient Representative
Public Gallery:	Press	2
	Public	4
Apologies:	Stewart Messer	Chief Operating Officer
	Lisa Thomson	Director of Communications

133/16 **WELCOME**

Mrs Merrick welcomed members of the public to the meeting. She also welcomed two new non-executive directors to their first meeting, Chris Swan and Phil Mayhew.

Mrs Merrick recognised that the Trust was particularly challenged at the present time and she assured members of the public that there was a presentation later in the meeting which would cover the patient flow issues. She would welcome questions from the public at the end of the meeting.

She went onto clarify that the three deaths that had occurred at the Trust had not taken place in a corridor. She expressed sympathy for the friends and families of those who had died.

134/16 **PATIENT STORY**

Mrs Merrick introduced Judi Barrett, a midwife with responsibility for patient experience and CW who had agreed to tell her story.

CW explained that she had suffered a death of a twin in utero in 2015. She had received excellent support from the bereavement midwife and had a caesarean section to deliver the surviving twin. However when she became pregnant in 2016, she was worried about the delivery. She specifically requested a VBAC (vaginal birth after a caesarean). She felt that she was not being listened to. However at 34 weeks, she met Judi who explained about the risks and the need for her to have caesarean section. Judi described a 'gentle' caesarean section and she agreed with this.

CW then described the gentle caesarean section as a wonderful experience. She saw the baby being born and he was placed on her prior to the cord being cut. He fed immediately. She expressed her thanks to Judi for listening to her and meeting her needs.

Judi then explained that the consultants and other staff had learned from the experience and were very positive.

Mrs Merrick thanked CW for sharing her emotional story. She emphasised the necessity of treating the whole person, not just the issue. Ms Stevens thanked Judi and her colleagues for the outstanding care given.

Resolved: that
The Board

- Noted the content of the story

135/16 **ANY OTHER BUSINESS**

It was agreed to outline the developments in respect of a medical school at Worcester University.

136/16 **DECLARATIONS OF INTERESTS**

The following new declarations of interest were made:

Chris Swan (Non-Executive Director)

- Cobalt Development Ltd
- Chairman of Redditch Football Club

Philip Mayhew (Non-Executive Director)

- Associate Director – Koru Consulting Limited
- Director of Midlands School of Social Entrepreneurs
- Director of the Institute for Continuous Improvement in Public Services
- Member of Loughborough University's School of Service Operations Management Advisory Board
- Trustee of Colebridge Trust
- Governor at Solihull College and Summerfield Pupil Referral Unit

There were no other additional declarations of interest.

Resolved that
The Board

- Noted the declaration of interests for Mr Mayhew and Mr Swan.

137/16 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 2 NOVEMBER 2016**

Resolved that:-

- The Minutes of the public meeting held on 2 November 2016 be confirmed as a

correct record and be signed with the amendment of the date.

137/16/1 **MATTERS ARISING/ACTION SCHEDULE**

Mrs Sharpe confirmed that all the actions had been completed or not yet due. In relation to the organisational development strategy, Mrs Merrick recognised that this was a key document and that the Director of HR and OD was working on it.

Mr McGinity asked whether a similar unit to Evergreen had been opened at the Princess of Wales Community Hospital. Mr Robinson confirmed that whilst this had not taken place, additional beds had been opened and he would expand on this later in the meeting.

138/16 **Chairman's Report**

Mrs Merrick drew the Board's attention to the Chairman's Action which had been reviewed and agreed by the Finance and Performance Committee. She also outlined the non-executive directors' changes in responsibilities, particularly in respect of whistle blowing and Health and Safety for which Mr Burbeck was assuming responsibility.

She highlighted that Mr Burbeck had been reappointed for six months and Mr McGinity for 12 months. She was looking to recruit associate non-executive directors to ensure a smooth transition of responsibilities.

Resolved that:-
The Board

- Noted the Chairman's Action taken on 5 December
- Approved the revised committee membership and governance structure
- Approved the appointment of John Burbeck as the Whistleblowing Champion and as the health and safety NED lead
- Received the update with respect to the Board appointments

139/16 **Acting Chief Executive's Report**

Mr Cooper highlighted a number of issues within his paper. The substantive executive directors for Finance, Nursing and Medicine were being interviewed at the end of the month. He was delighted that Ms Robinson had agreed to assume responsibility for the performance function for the Trust.

He was working with colleagues on the outputs from the health economy risk summit which was held on 23 December.

He was pleased that the consultation had commenced in respect of the Future of Acute Hospital Services in Worcestershire. He also highlighted the objectives set for each of the directors for the next three to six months.

He thanked all the staff who have worked tirelessly over the crucial Christmas and New Year period and who continues to work hard in challenging circumstances.

He confirmed that the planned Chief Inspector of Hospitals visit took place at the end of November and the report was expected in the next few weeks. He thanked the staff involved in planning the visit.

He stated that he has appointed a Director of Urgent Care to focus on the current pressures.

He was pleased that 75% of staff had received their flu vaccine. He thanked Ms Stevens for organising the campaign.

Finally he thanked the staff involved in the organising of the staff awards at Chateau Impney in November. It had been a superb evening recognising outstanding service to the Trust.

Resolved that:-
The Board

- Received the assurance within the report.

140/16 **STRATEGY**

140/16/1 **Emergency Care pressures**

Mr Robinson gave a presentation outlining he significant pressures that the Trust was under. He acknowledged that the patient experience for some patients was not as the Trust would wish. He asked that the public recognise the pressures and use suitable alternatives to ensure that only the sickest patients attend the trust.

He turned to an overview of the situation. Over 15% more ambulances are currently attending the A&E departments. 75% of all attendees are still being seen within 4 hours of arrival. However there is a challenge with the number of sick patients arriving and staying on trolleys. The number one priority is to ensure patient safety during their stay.

He then turned to the actions which have taken place. A Director of Urgent Care is now in place and changes have been made to the senior leadership team within the medicine division. Bed capacity has increased on both sites and elective operations have been cancelled until at least 16 January apart from life threatening conditions, cancer and those waiting longer than 45 weeks. Partner organisations have also supported the Trust providing extra staff.

The full hospital protocol has been operational. Mr Robinson is now considering the opening of Avon 5. This is dependent on ensuring safe staffing levels.

He confirmed that the three patients who died did not die in the corridor. Investigations are underway. Ms Stevens confirmed that she regularly spoke to patients and relatives and found that nearly all were satisfied with their care.

Mr Mayhew asked the timescales for the completion of the investigation. Ms Stevens explained the process which was to investigate within 60 working days. This was a nationally set target. Once the investigation was complete, it would be considered by the serious incident and learning group, the clinical governance group and the quality governance committee if appropriate. She confirmed that the incidents had been reported externally to the CQC as well as the local CCGs.

Mrs Merrick commented that she was looking to bring more visibility of patient experience to the Trust Board in future meetings and was working with the Director of Finance and Performance and the Company Secretary on how to achieve this.

Mr McGinity raised the issue of more attendees to the A&E departments. Mrs Merrick commented that this was a feature of the health summit and work was being undertaken to understand this issue. She confirmed that acuity was more severe than previous years.

Mr Burbeck reinforced the commitment of staff to provide the best possible service for

patients. However he recognised that attitudes needed to change about the use of the A&E department.

Mrs Merrick confirmed that staff had patient safety at the forefront of their work. She was committed to developing a longer term strategy to be in place by October.

Resolved that:-
The Board:-

- Expressed sympathy to the relatives of the patients who died
- Received the presentation
- Expressed their concern with the volume of activity within the A&E departments

140/16/2 **Herefordshire and Worcestershire Sustainability and Transformation Plan**

Ms Smith presented the draft Plan to members. It had been published on 22 November. The public engagement ends in March. She stated that it was the framework for developing more detailed work.

Mr McGinity requested that the final Plan is written in Plain English. Ms Smith confirmed that there was a summary version available.

Mr Mayhew welcomed the Plan but was concerned that there was no reference to social enterprise. He would also wish active engagement with young people including the use of social media. Ms Smith agreed to feed these back.

Ms Smith confirmed to Mr Burbeck that work had started already on elements of the Plan. The governance arrangements were being reviewed by the executive lead and she would bring details of these arrangements to a future meeting.

Mrs Merrick welcomed the Plan and thanked Ms Smith for her work.

Resolved that:-
The Board:-

- Received the Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) that was published on Tuesday 22 November 2016.
- Noted that the document is intended for discussion and public engagement – it is not a final plan at this stage.
- Noted that formal approval of the final plan will be sought at the end of the public engagement and discussion process.

140/16/3 **Trust Management Group (TMG)**

Mrs Merrick welcomed the report which showed clear accountability for areas of work. She commented that this together with the performance management framework was a step forward for the Trust.

Resolved that:-
The Board

- Noted the report

141/16 **QUALITY AND PATIENT SAFETY**

141/16/1 **Quality Governance Committee**

The Chair of the Committee, Dr Bill Tunnicliffe presented the report from the Quality Governance Committee (enclosure E1). The report covered both November and December meetings.

Dr Tunnicliffe welcomed the improvement in ward to board reporting. This is as a direct result of the revised governance structures. The demonstration of the new system at the November meeting provided assurance that the Trust has the concentrated on ensuring that information is only a few clicks away for front line clinicians and the same information can be aggregated quickly to Trust level.

He expressed concern that the December Clinical Governance Group meeting had been cancelled as this had impacted on the effectiveness of the December QGC.

He was pleased with the quality of the divisional reports from women and children. However medicine and surgery needed to be improved.

The Committee continued to focus on avoidable mortality. The data show that the Trust is not achieving its goals on mortality reviews and he was hopeful of seeing a clear trajectory at the next meeting. He continued to be concerned about the patient experience in relation to fracture neck of femur and had requested more action taken.

Mr McGinity asked about the organisational development (OD) for the divisional teams. Mrs Harnin confirmed that management of performance was a key element of the OD strategy and she outlined the work undertaken at a recent workshop.

Dr Short outlined the work being undertaken with the medical leadership and confirmed that he was finalising the programme in the next week to start in the Spring.

Mrs Merrick stated that she was keen for the Board to be more sighted on leadership development and capability and this would be incorporated into the performance management framework. She recognised that there had been a challenge with the operation of the Workforce Assurance Group as it had been too operational. Mrs Harnin confirmed that the Group was now accountable to the TMG with a strategic meeting when required.

Mr Mayhew asked about the links between the OD plan and the SAFER programme. Mr Robinson stated that change management skills were needed to ensure that SAFER was implemented effectively.

Dr Tunnicliffe returned to the issue of avoidable mortality. He stated that review of deaths was essential to be able to learn. Dr Short agreed but stated that the large number of medical consultant vacancies hindered the plans for mortality reviews. He was currently working on an electronic solution but the results of this would not be seen until after March 2017.

Mrs Merrick asked Mrs Harnin to outline the Trust's approach to filling the vacancies. Mrs Harnin stated that the HR department was overseeing all the vacancies. She described the actions being taken which included review of each vacancy and reviewing whether the post could be covered in an innovative way. The Trust's offer to consultants has been changed to include where appropriate removal expenses or development incentives.

Mrs Merrick asked whether all specialisms had a vision. She understood that areas without a vision had difficulty in attracting candidates. Dr Short confirmed that specialisms working county wide had no difficulty in recruiting high calibre candidates. Those with a disparate team were not so successful. He reminded members that there were areas of national shortage such as breast imaging or radiology. Mrs Harnin confirmed that one to one support was being given to those areas which needed to develop different ways of working and develop a vision. Mrs Merrick asked that this be

a priority for the executive team.

Mr Cooper agreed to give an update in his report to each meeting.

Resolved that:-
The Board

- Received the summary of the final report into the never event
- Received assurance in respect of the management of safeguarding
- Noted the lack of assurance in respect of the time to theatre for patients who had suffered a fracture neck of femur and primary mortality reviews
- Noted the lack of assurance in respect of the medicine and surgery divisional reports
- Noted the avoidable mortality report
- Noted the report

141/16/2 **Trust Improvement Plan**

Mrs Merrick acknowledged that the paper presented was high level and work in progress. Ms Smith confirmed that the executive management team had developed a rapid improvement plan for the Trust which had been informed by the feedback from the CQC and the risk summit. Progress has been made in areas which have had a dedicated project resource such as out patients. The Specialised Services Division and the Women and Children division had made progress following the CQC visits. She was working with the executives to present more detail to the board development day in February.

Mr Mayhew requested sight of the top areas which needed to be changed but was concerned about the number of plans and the risk of them not being synchronised. Mrs Merrick confirmed that a key deliverable was to leave special measures.

Resolved that:-
The Board

- Received the summary plan of the Trust and Divisional priorities for improvement
- Noted the next steps in the delivery and monitoring of the improvements
- Sought assurance that the plans can be delivered

142/16 **FINANCE AND PERFORMANCE**

142/16/1 **Finance and Performance Committee Report**

Mr Burbeck as chair of the Finance and Performance Committee spoke to the report. He stated that the financial situation was under control. However because the Trust was not meeting the required performance targets, the full sustainability and transformation funding could not be accessed.

He thanked Ms Robinson and Mr Cooper for their work in achieving an agreement on the contract with commissioners, which covers the current financial year and all outstanding issues from the previous two years.. The current financial forecast indicates that the Trust would fall short of the expected financial target by £4.4m. Discussions are underway regarding specific technical adjustments which leaves a requirement for a reduction in expenditure of £1.2m which needs to be delivered by the end of March.

He then turned to the operational performance. Due to the necessity to cancel the planned operations, the Trust is unlikely to meet the performance targets although these are kept under close review. He noted that people with cancer continue to be treated as a priority.

Mr Burbeck went onto outline the revised plans for performance management and the holding of people to account. He welcomed the new approach.

Finally he stated that the different financial arrangements for 2017/18 would mean that the health economy would work together more effectively.

Mrs Merrick endorsed the arrangements and asked Mr Cooper to explain the working of the cap and collar contract. Mr Cooper stated that the Trust was guaranteed an income of £268m. If the Trust undertook more activity then a maximum of £273m would be paid. If activity fell below that of £266m, the Trust would still receive £266m. This arrangement allowed a focus on managing costs and activity rather than responding to data queries.

Mrs Merrick asked whether there was any opportunity to improve the RTT target. Mr Robinson stated that he would update the Board at the February meeting on the RTT target once he had developed plans with the surgical division.

Resolved that:-
The Board

- Noted that Income & Expenditure is on plan year to date (before STF payments).
- Noted that operational performance continues to be significantly behind plan and the STF improvement trajectories. Additional support and review mechanism has been introduced, but capacity planning, recruitment and bed availability remain driving factors.
- Noted that the full year planned deficit is achievable and within the control of the Trust provided the risks are mitigated.
- Noted the recommendation to approve the business cases for the Winter Plan and Endoscopy.
- Considered the approach proposed for the submission of the Financial Plan Paper 17/18-18/19.

142/16/2 **Integrated Performance Report**

Ms Robinson presented the report. She reminded members that the Quality Governance Committee and the Finance and Performance Committee scrutinise the respective performance. She confirmed that she would bring more detail in respect of performance monitoring to the February Finance and Performance Committee.

Mr Mayhew advised to link OD with performance management to ensure that performance management is an integral part of roles.

Resolved that:-
The Board

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

142/16/3 **Financial Performance Report**

Ms Robinson outlined the current financial situation. She stated that 2016/17 financial target was a deficit of £47.7m. If the Trust meets this target, it will receive 70% of the total STF monies (£12.9m). She is currently forecasting that the Trust will meet the target and so receive this extra funding. However, the remaining 30% is dependent on the Trust meeting operational targets. The Trust met the target for quarter 1 but has not done so since then. She has lodged an appeal in relation to quarter 2. If the Trust does not receive the 30% of the STF, then the Trust will not meet the overall control

total.

She then turned to the contract agreement. She was pleased with the settlement as it secures income for the trust. She was conscious that the Trust needed to have plans going into next year to maintain the financial position. There were detailed plans relating to agency spend (medical and nursing) which focussed on the rate of pay rather than the numbers engaged.

She responded to Mr McGinity and confirmed that the trust had not received confirmation of the receipt of capital funds.

Resolved that:-
The Board

- Noted the Trust's financial position

143/16 **GOVERNANCE**

143/16/1 **Audit and Assurance Committee report**

Mr McGinity reported that the Associate Director for Patient Flow had presented a comprehensive report to the Committee which related to the audit undertaken on the discharge policy. He was pleased to report that a significant number of internal audit outstanding actions had now been dealt with.

Mr McGinity then turned to the review of Trust Board expenses. The review had found that the policy was robust but that the figure quoted in the annual report had been misleading as it had included items not part of expenses.

The audit report into the emergency department timings revealed that there were minor discrepancies relating to timings but that there was no evidence that this was being manipulated by staff.

The audit on temporary staffing received limited assurance and controls had now been applied.

Finally the Committee had received an investigation report into allegations that consultants had not declared interests appropriately. This had not been proven and interests had been declared as required.

Mr McGinity expressed his concern that there was a general trend of staff not adhering to policies. He had been assured that this was being dealt with by the executive management team.

Resolved that:-
The Board

- Noted the progress with the discharge audit recommendations and the changes being instigated
- Noted the receipt of the following audits/reviews:
    - Expenses
    - Emergency department
    - Temporary staffing
    - Fixed assets
- Noted the review of the F&P committee
- Noted the receipt of the investigation report
- Noted the concern the Committee has with respect to policy implementation

144/16 **FOR INFORMATION**

144/16/1 **Nursing and Midwifery staffing report**

Resolved that:-
The Board

- Noted the report

144/16/2 **Charitable Funds Committee report**

Resolved that:-
The Board

- Noted the report and the annual report.

145/16 **ANY OTHER BUSINESS**

145/16/1 **Development of a medical school**

Ms Smith reported that she will be meeting with the University of Worcester to support them in progressing the application to become a medical school. Currently the Trust provides training for medical students from Warwick University and the University of Birmingham and would welcome such a development.

DATE OF NEXT MEETING

The next Trust Board meeting will be held on Wednesday 1 March 2017 at 09:30 in the Alexandra Hospital board room, Redditch.

The meeting closed at 11:31 hours.

Signed _____ **Date** _____

Caragh Merrick, Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT MARCH 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
11-1-17	STP	140/16/2	Lack of mention of social enterprise and use of social media	SS	Jan 2017		Feb back to appropriate personnel	
11-1-17	STP	140/16/2	Governance arrangements – bring back to a future meeting	SS	Mar 2017		On agenda	
11-1-17	Trust Improvement Plan	141/16/2	Present more detail to the Board Development Day	SS	Feb 2017		Superseded by Quality Improvement Plan – presented to QGC 16-2-17	
7-7-16	WAG	74/16/1	OD strategy to be presented to TB in September	DH	Sept 2016		Deferred. For discussion with the Chairman for way forward Planned for December BoD meeting. Deferred. Awaiting a further date for discussion	

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 1 March 2017 **Enc C1**

Report to Trust Board

Title	**Chairman's Report**
Sponsoring Director	**Caragh Merrick, Chairman**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is requested to: • Receive the update with respect to the Board appointments
Previously considered by	Not applicable

Priorities (√)

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

Related Board Assurance Framework Entries	2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services 3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care
Legal Implications or Regulatory requirements	

Key Messages

This paper details the recruitment to Board posts.

Title of report	Chairman's Update report
Name of director	Caragh Merrick

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 1 March 2017 **Enc C1**

REPORT TO TRUST BOARD – 1 MARCH 2017

1 Chief Executive

I am delighted that Richard Beeken is now the Acting Chief Executive until our substantive Chief Executive commences on 27 March.

Richard will be on secondment from NHS Improvement where he is the Director of Delivery for Midlands and East.

Rob Cooper has been offered a post as a Financial Turnaround Director closer to where he lives. I would like to thank Rob for his commitment to the Trust and in particular the work he undertook to stabilise the Trust finances.

2 Executive Director appointments

I am delighted that appointments have been made to the posts of Chief Nursing Officer (CNO), Chief Medical Officer (CMO) and Director of Finance. Vicky Morris will be commencing as CNO in March. Suneal Kapadia will be joining us as the CMO in the Spring and Jill Robinson has already commenced as Director of Finance. I am also delighted that Haq Khan has accepted the position of Acting Director of Performance.

3 Recommendations

The Board is requested to:

- Receive the update with respect to the Board appointments

Caragh Merrick
Chairman

Title of report	Chairman's Update report
Name of director	Caragh Merrick

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc C2**

Report to Trust Board

Title	**Acting Chief Executive's Report**
Sponsoring Director	**Richard Beeken, Acting Chief Executive**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is asked to • Approve the revised governance structure • Receive the Health and Wellbeing CQUIN update • Receive the assurance contained within the report
Previously considered by	Not applicable

Priorities (√)

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

Related Board Assurance Framework Entries	All BAF risks are covered.
Legal Implications or Regulatory requirements	None
Glossary	Sustainability and transformation plan (STP) Emergency Care Improvement Programme (ECIP) RTT – referral to treatment time

Key Messages

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

Date of meeting: 1 March 2017 **Enc C2**

WORCESTERSHIRE ACUTE HOSPITAL NHS TRUST

REPORT TO PUBLIC TRUST BOARD – 1 MARCH 2017

1 Situation

This report aims to brief Board members on various issues.

2 Background

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

3 Objectives for the next month

I have the following objectives for the period of time that I am Acting CEO. These are:

- Quality improvement
- Urgent Care
- Other constitutional commitments e.g. RTT.
- Ensuring that the financial targets are met

I am working closely with the divisions as they are key to delivering the outputs for these objectives.

I have reviewed and redesigned the governance framework which shows clearly the split between assurance and operational delivery. I have also revitalised the Trust Management Group (TMG) which is now meeting fortnightly. This is the 'engine house' of the Trust.

I would ask the Board to approve the interim governance structure as detailed in the appendix to this report. We recommend this is adopted for the next three months and then reviewed once the new executive management team is in place.

4 Divisional Leadership changes

The following changes have been made to the divisional leadership structure:

- David Burrell - Acting Director of Operations for the Medicine Division.
- Kate Winwood - Acting Director of Operations for the Specialised Clinical Services Division (SCSD).
- Alison Harrison has been seconded to the Corporate Nursing team on an interim part-time basis, remaining responsible for the Haematology, Oncology and Palliative Care areas of her divisional role.
- Dilly Wilkinson – Acting Deputy Director of Nursing – on secondment from George Eliot until September 2017

5 NHS Improvement Director

I should like to welcome Cathy Geddes as the NHS Improvement Director. She replaces Marie-Noelle Orzel. Cathy is an experienced Director of Nursing and has also been an acting CEO. She has led a major service redesign programme in London.

6 Operational pressures/A&E Delivery Board

I should like to thank all the staff who continue to work tirelessly. There is continued pressure through the Trust with patient flow.

The A&E Delivery Board is the overarching strategic leadership forum. The Trust is the joint chair. One of the main actions being undertaken is the implementation of SAFER. A number of issues have been identified which are being worked through. We are also deploying best practice for inpatient flow. The programme is part of the overall improvement programme. I should like to take the opportunity to thank the health system in supporting us in this work. Improvements will be noticeable in the next few weeks as the systems and processes are embedded.

7 CQC

Members will be aware that the CQC wrote to the Trust on 27 January. This letter has been the focus of our Improvement Plan progress of which is a separate agenda item. I attach the letter as appendix 2 to this Board report.

8 Fred Holland

I should like to congratulate Fred Holland, diabetes champion for the Trust, for receiving the British Citizen Award for his work in the fight against diabetes. Fred received his award in January at Westminster Palace. The British Citizen Awards (BCAs) were launched to recognise exceptional individuals who work tirelessly and selflessly to make a positive impact on society. BCAs are awarded twice annually, and recognise 'everyday' people whose achievements may otherwise by overlooked.

Fred estimated that he has raised up to £2 million for good causes over the last 58 years and is now a diabetes champion for the Trust.

9 Stroke Service - update

From the end of January the Worcestershire Health and Care Trust centralised all stroke rehabilitation beds into a 32 bedded unit at Evesham hospital. It should free up general rehabilitation beds for patients closer to home. There is a current stroke workforce task and finish group and stroke strategy group that meet on a monthly basis to deliver the county wide strategy for Stroke and will include future working with Hereford for delivery of services against the STP programme.

10 Improvements at the Alex

The brand new, dedicated eye theatre opened its doors to day case surgical patients at the end of January, following refurbishment of existing theatre facilities at the hospital.

The Garden Suite has relocated to a larger dedicated unit on the former Ward 9. This gives 16 chairs for a chemotherapy suite.

11 Hospital Hopper

The Hospital Hopper services started on 1 February. This service, running between the Worcestershire Royal and the Alexandra Hospital has proved to be popular in its first few weeks of operation.

12 Health and WellBeing CQUIN - update

Part of the 2016/17 NHS staff health & wellbeing CQUIN relates to ensuring patients and staff are always offered healthy options in restaurants, cafes and vending machines on site as part of a focus on improving the culture within organisations, specifically regarding health and wellbeing.

The trust successfully completed the first submission in July 2016 relating to data collected that included the following; the name of the franchise holder, food supplier, type of outlet, start and end dates of existing contracts, remaining length of time on existing contract, value of contract and any other relevant contract clauses.

Since submission of the data the Facilities team have been working with five external retail service providers and the Trusts own Catering Department to ensure that all twelve retail outlets and the vending operations meet the CQUIN indicators;

a. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS)[1]. The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets;
b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS);
c. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts; and
d. Ensuring that healthy options are available at any point including for those staff working night shifts.

Each retail outlet has been independently RAG rated as it goes through the transitions required to meet the CQUIN indicators and the Trusts management team are confident that all of the requirements will be met by the end of March 2017.

13 Consultants

Please see the attached starters and leavers.

14 Recommendation

The Board is asked to

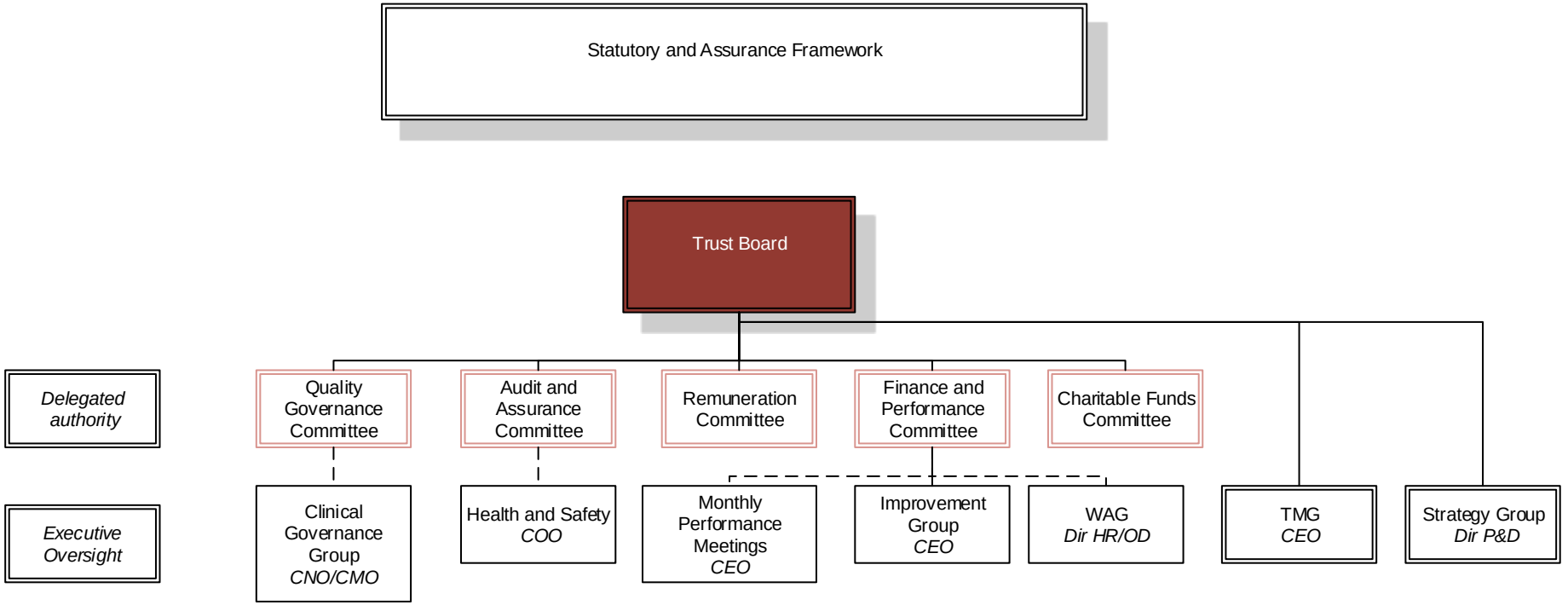
- Approve the revised governance structure
- Receive the Health and Wellbeing CQUIN update
- Receive the assurance contained within the report

Richard Beeken
Acting Chief Executive

[1] The Nutrient Profiling Model can be used to differentiate these foods while encouraging the promotion of healthier alternatives. https://www.gov.uk/government/publications/the-nutrient-profiling-model

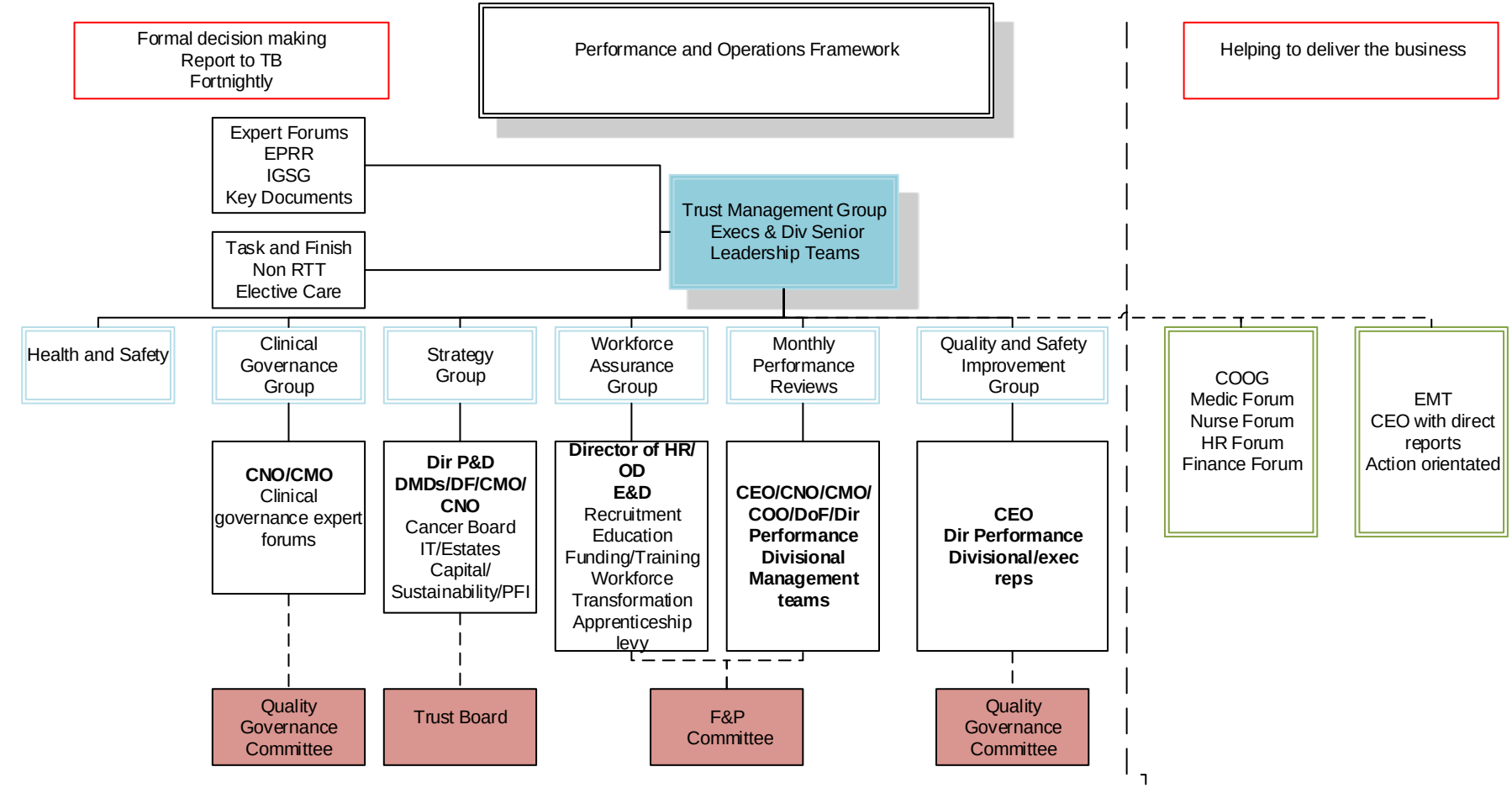
Date of meeting: **1 March 2017** **Enc C2**

Revised Interim Governance Framework



Title of report	Acting Chief Executive's Report
Name of director	Richard Beeken

Date of meeting: **1 March 2017** **Enc C2**



Title of report	Acting Chief Executive's Report
Name of director	Richard Beeken

Date of meeting: 1 March 2017 **Enc C2**

Consultant Starters
Dr Kate Cusworth, Consultant Physician in Respiratory Medicine, commenced 12th January 2017
Mr Ross Hodson, Consultant in Emergency Medicine, commenced 16th January 2017
Dr Sonal Singh, Consultant Dermatologist, commenced 16th January 2017

also

Dr Kiritea Brown, Consultant in Obstetrics & Gynaecology, officially commenced on 5th January 2016 onto maternity leave, and has returned as of 5th January 2017.

Consultant Leavers
Dr John Chambers, Consultant in Palliative Care, last day of service 13th January 2017.

Title of report	Acting Chief Executive's Report
Name of director	Richard Beeken

CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
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For the attention of the Chief Executive
BY EMAIL to: rob.cooper1@nhs.net

Mr. R Cooper
Chief Executive
Worcestershire Acute Hospitals NHS Trust
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

27 January 2017

The Care Quality Commission
The Health and Social Care Act 2008
SECTION 29A WARNING NOTICE:
Provider: Worcestershire Acute Hospitals NHS Trust

Regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Management of blood and blood derived products
- Termination of pregnancy
- Family planning

Our reference: MRR1-3107518238
Account number: RWP

Dear Mr Cooper

This notice is served under Section 29A of the Health and Social Care Act 2008.

This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by

Worcestershire Acute Hospitals NHS Trust for the regulated activities above requires significant improvement:

The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with the above Regulated Activities at the locations identified below.

Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Regulated activities

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Management of blood and blood derived products
- Termination of pregnancy
- Family planning

Alexandra Hospital
Woodrow Drive
Redditch
B98 7UB

Regulated activities

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Management of blood and blood derived products
- Termination of pregnancy
- Family planning

Kidderminster Hospital and Treatment Centre
Bewdley Rd
Kidderminster

DY11 6RJ

Regulated activities

- Treatment of disease, disorder or injury
- Surgical procedures
- Maternity and midwifery services
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Termination of pregnancy
- Family planning

The reasons for the Commission's view that the quality of health care you provide requires significant improvement are as follows:

- The systems, processes and the operation of the governance arrangements in place are not effective in terms of:
    - identifying and mitigating risks to patients as outlined below and in relation to which significant improvement is required
    - providing assurance that actions are taken to improve safety and quality of patient care

Significant improvements are required to the quality of the health care provided by the trust in relation to the regulated activities set out in this Notice at the locations above, by way of having established systems in place that operate effectively in order to address the points above.

Following the announced inspection visits as part of the comprehensive inspection of Worcestershire Acute Hospitals NHS Trust between 22 and 25 November 2016, feedback was provided by Bernadette Hanney, Head of Hospital Inspections, Peter Turkington, Chair of the inspection and Jo Naylor-Smith, Inspection Manager to the executive team of the trust on 25 November 2016 regarding the areas of key concern, which required addressing immediately, as referred to below. The concerns raised by CQC in this meeting were confirmed in writing in a letter sent to the trust by Bernadette Hanney, Head of Hospital Inspections on 1 December 2016.

Following the unannounced inspection visits, as part of the comprehensive inspection of Worcestershire Acute Hospitals NHS Trust on 7, 8 and 15 December 2016, feedback was provided by Jo Naylor-Smith, Inspection Manager to the Chief Nursing Officer and Deputy Chief Nursing Officer of the trust regarding the areas of key concern, as referred to below, which required addressing immediately. The concerns raised by CQC in this meeting were

confirmed in writing in a letter sent to the trust by Bernadette Hanney, Head of Hospital Inspections on 20 December 2016.

Due to the seriousness of our concerns Professor Sir Mike Richards wrote to NHS Improvement and NHS England on 21 December 2016 requesting they arrange a risk summit, which took place on the 22 December 2016.

The information you have provided subsequent to the inspection visits detailed above, together with the evidence gathered during the course of the inspection process, as set out in this Notice, demonstrates that there is a need for a significant improvement in the quality of the healthcare provided by the trust in relation to the regulated activities at the locations cited in this Notice, for the reasons given above.

Areas which demonstrate the lack of effective governance and the consequences of that

At the quality improvement review group meeting on the 30 September 2016 the trust presented their revised framework for governance and assurance; having recognised that improvements were required to strengthen the risk management and governance throughout the trust. During our inspection we found that the risk management and quality assurance processes were not sufficiently understood, embedded or supported by reliable performance data to ensure that the risks to safety, quality and sustainability are systemically identified and understood across all locations or divisions of the trust. Risk registers were not detailing all the risks and quality assurance processes were not identifying shortfalls and therefore remedial action is lacking. This demonstrates that the trust's governance system in relation to the management of risk is not operating effectively to ensure that senior leaders and the board have clear oversight of risks affecting the quality and safety of care of patients and the need for significant improvement remains.

The board cannot rely on the processes in place or the information they are receiving in order to take assurance that risks are identified and actions taken to reduce the risks to patients.

Examples of this are detailed below:

- The trust had determined to use National Early Warning Score (NEWS) and Paediatric Early Warning Scores (PEWS) systems in order to identify and escalate deteriorating patients; however this was not working effectively at Worcestershire Royal Hospital or the Alexandra Hospital, Redditch. The risk of a patient suffering harm as a result of their clinical deterioration not being identified and escalated appropriately was not on the relevant divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure

that senior leaders and the board have clear oversight of the risk of harm to the deteriorating patient.

During the course of our inspection we reviewed a total of 23 sets of patient records from Avon 2 ward, Avon 3 ward, haematology ward, Evergreen ward, the theatre assessment unit and the acute stroke unit in Worcestershire Royal Hospital. We found NEWS charts were not completed in their entirety in seven records. This meant that there was not clear oversight of the deterioration of those patients. In the document entitled 'CQC actions post MR risk summit letter' (not dated but provided for the risk summit held on 22 December 2016), in relation to NEWS the trust has stated "We agree that this is not acceptable". Actions detailed included future training and development and to undertake more frequent audits and spot checks. The risks to patients as a result of these failings had not previously been identified by the trust.

- Within the paediatric ward at Worcestershire Royal Hospital, we reviewed three PEWS charts. We found that PEWS scores were not completed in their entirety in all three records and two records did not document the frequency that observations were required. Within the trust's PEWS audit in November 2016 it was noted that one patient had a PEWS score of above three and this had not been escalated.
  In the document 'CQC actions post MR risk summit letter' (not dated but provided for the risk summit held on 22 December 2016), in relation to the PEWS charts not being consistently completed, the trust stated that 'this tool is not fully embedded and a programme of work is rapid implementation is underway. Our buddy trust will return at the end of January to review our implementation/actions and provide assurance that the improvements have been made and sustained.' In the document provided to us on 11 January 2017, subsequent to the insufficient assurance surrounding these concerns being provided at the risk summit of 22 December 2016, the trust submitted an audit of PEWS charts carried out on week commencing 2 January 2017 showing that of 10 sets of records reviewed, 95% had PEWS scores recorded correctly. However the records did not provide evidence that all scores that indicated a patient's condition was deteriorating were escalated appropriately and not all patients with a high pain score were appropriately escalated or reviewed. Therefore there are not effective governance processes in place to ensure clear oversight of the management of the deterioration of paediatric patients.

- During our comprehensive inspection we found that the types of risk assessment referred to below for patients were not routinely completed for patients at Worcestershire Royal Hospital and the Alexandra Hospital. The systems to assess monitor and mitigate risks relating to the health, safety and welfare of service users receiving care are not

operating effectively, including protecting service users from abuse and avoidable harm.

- We reviewed 14 sets of patients' records from the emergency department within Worcestershire Royal Hospital. We found that dementia assessments had not been completed for four out of five patients who met the trust criteria for requiring assessment. In the document provided to us on 11 January 2017 the trust stated 'Dementia & Delirium Assessments are being monitored by the Dementia Team. The current standard is that 90% of patients over 75years old admitted as an emergency are assessed within 72 hours. Compliance in November was 88.6%, which increased to 92.2% in December. Although the dementia pathway had been reviewed to reduce paperwork and duplication, and was due to be relaunched in January 2017, the risk to patients not receiving dementia assessments was not present on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients such as those who met the criteria for a dementia assessment but did not receive one.

- Whilst pressure area risk assessments had been completed in all 14 sets of records reviewed, these were not consistently reviewed and total scores were not calculated or documented for five patients. Failure to follow pressure area prevention procedures (including risk assessments) resulting in harm had been on the corporate risk register (dated 21 November 2016) since April 2015, and was highlighted as a risk in the previous CQC comprehensive inspection (July 2015). In the document provided to us on 11 January 2017 the trust stated the actions it had taken since our previous inspection, and future proposals included training, further development of the monthly audit tool and review of the care and comfort documentation. There was no evidence that that the trust was aware that the gaps in the completion of pressure assessments related to follow-up assessments and appropriate escalation, rather than the initial assessment. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients suffering pressure ulcers due to inadequate review and escalation of pressure area risk assessments.

- Out of a total of 23 sets of patient's records reviewed from Avon 2 ward, Avon 3 ward, haematology ward, Evergreen ward, theatre assessment unit and the acute stroke unit Worcestershire Royal Hospital, we found that venous thromboembolism (VTE) assessments had not been completed for 13 patients. Out of 24 patients records reviewed from wards 10, 11, 14 and 18 at the Alexandra Hospital, nine did not have a

VTE risk assessment completed. In the document provided to us on 11 January 2017 the trust stated 'Trust performance in achieving the target of 95% compliance for VTE assessments is currently inconsistent. Despite previous emphasis on achieving VTE assessment status correctly, the compliance figures are still poor'. The trust proposed to establish a VTE rapid improvement working group and review and redesign the process of VTE data collection and recording. However the risk of patient harm as a result of not carrying out VTE assessments was not being managed on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients suffering a VTE due to lack of appropriate assessment.

- There was a lack of detailed assessment and provision of one to one care of children and young people who presented with mental health issues. Although inconsistent support from the child and adolescent mental health service (CAMHs) had been on the women and children's divisional risk register since 2009, this risk referred to inappropriate placements and delayed discharge of a young person presenting with mental health issues. The risks relating to a lack of detailed assessment and the provision of one to one care did not feature on the corporate risk register, from an appropriate member of staff, both of which could place a young person at risk of harm. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of this risk.

- We reviewed eight sets of patients' records from the paediatric ward at Worcestershire Royal Hospital. Three had an adult mental health risk assessment, three had an adolescent mental health risk assessment and two had no mental health risk assessment. There were no boxes to enable staff to tick which of the criteria were met or to record comments, therefore information had to be documented in the nursing records, which had not happened in two cases. This meant it was not clear how staff had concluded how they had reached their decision as to which criteria were actually met, so the assessment failed to provide systematic assurance that high quality care was being delivered. In the document provided to us on 11 January 2017 the trust provided a copy of the updated 'Mental health triage CYP scale', which was implemented since our inspection. This updated form did have additional boxes for the date, time and signature of the assessor, however there was still not the option to add comments.

  When patients on the paediatric ward at Worcestershire Royal Hospital were assessed to require one to one care from a registered mental

nurse (RMN) this was not always provided. In the document provided to us on 11 January 2017 the trust provided information of the number of shifts where a RMN was requested and was provided. In October 2016 it was 0%, November 2016 it was 61.5% and December it was 63.6%. From December 2016, the trust said it had started to document when a young person requires RMN one to one care and if that is not possible, which member of the paediatric nursing team was providing the one to one care. This could be either a trained or non-trained member of staff; however the trust did not provide a risk assessment to demonstrate that they had considered whether the member of staff had the skills to undertake this task safely.

- During our comprehensive inspection we found that there was a lack of an effective plan to address the significant capacity issues causing crowding in the emergency departments (EDs) at Worcestershire Royal Hospital and the Alexandra hospital in the short or medium term. The necessary 'full capacity protocol' was not being implemented during times of high demand where emergency departments were classified and documented as 'overwhelmed' by staff completing the daily safety matrix. This meant that escalation procedures were not effective to ensure risks were mitigated in relation to patients' safety. This risk was graded as 'high' on the corporate risk register (21 November 2016). It had been an active risk since November 2014. Although many actions to mitigate this risk had been completed, the significant capacity issues causing crowding in the EDs remained. In the document provided to us on 4 January 2017, the trust demonstrated that the full capacity protocol had been implemented daily from 19 December 2016 to 2 January 2017. In the 'CQC Action Plan Update' which was provided on 17 January 2017 ahead of the Risk Summit on 18 January 2017 the trust outlined additional actions it had taken to manage the overcrowding issues in the EDs, including implementing a capacity command, control and co-ordination hub is to have a robust overview of trust capacity issues and to manage daily objectives and actions. The trust had also created a number of 'medical hot clinics' so patients were not reviewed in the EDs and a trust operational daily dashboard to allow the executive team to monitor the capacity across the trust. However with these improvements in place, the trust was not able to demonstrate a significant improvement in reducing the overcrowding in the ED departments and therefore improving patient safety.

- The emergency department at Worcestershire Royal Hospital did not have a room specifically for treating patients with mental health conditions, in line with Royal College of Emergency Medicine guidance. There was a room that met some areas of this guidance however it did not meet the criteria referring to safe exit in an emergency and being free from ligature points. This room was only used when the mental

health liaison team were reviewing a patient, meaning patients who presented with mental health conditions were cared for in the main department. During our inspection on 24 November 2016 we observed one paediatric patient who presented with a mental health condition being cared for within the paediatric waiting area, and another patient who presented with mental health problems being cared for in the corridor. This practice had not been risk assessed and there were no plans in place to change it. The lack of an appropriate mental health room to care for patients was not on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk to patient safety.

- Patients who needed admission where there was not a bed available on the appropriate ward for the speciality they required, were sent to any ward where a bed was available without this being risk assessed.

- The theatre assessment unit at Worcestershire Royal Hospital accepted medical outliers. This area did not have the appropriate equipment, including a resuscitation trolley and other facilities, to care for a deteriorating patient. During the announced inspection, six out of eight patients did not meet the admission criteria for patients to be cared for in the clinical decision unit (CDU) at Worcestershire Royal Hospital. This meant the environment had been risk assessed and was not considered to be safe for the acuity level of six of the patients being cared for there. Gynaecology patients were cared for on the antenatal ward, chestnut ward (a surgical maxillofacial ward) or any available bed in the hospital. This meant that women could be having a miscarriage in a bay on a mixed sex ward. Reduced gynaecology capacity was documented on the women's and children's risk register, however clear plans were not established to prevent women being cared for in unsuitable areas.

- Whilst the risk that areas that are not designed for in-patient use and extra capacity beds are used to house patients throughout the hospital had been present on the medical divisional risk register since July 2015, actions such as the implementation of the full capacity protocol being actioned to ensure the reduction of risk to patient safety (marked as completed in April 2016) were not seen to be occurring during our comprehensive inspection. In the document provided to us on 4 January 2017, the trust demonstrated that the full hospital protocol had been implemented daily from 19 December 2016 to 2 January 2017. It stated that at 10am on 3 January 2017, 22 escalation beds were being used throughout Worcestershire Royal Hospital. There was no evidence that all these areas had been risk assessed, or what escalation areas were open at the Alexandra Hospital. This means that patients are at risk of

being cared for in environments that were not suitable for their needs, or that may not have the appropriate equipment available should their condition deteriorate. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of this patient safety issue.

- There were a lack of policies and procedures in place to outline staff roles and responsibilities for the care of paediatric patients whilst in the emergency department. During our comprehensive inspection, paediatric patients within the emergency department at Worcestershire Royal Hospital were left for periods of time with no staff available in the paediatric area. We observed three occasions during a night time inspection on 23 November 2016 where the paediatric nurse left the department for 22 minutes, 20 minutes and 14 minutes. During these times there were between two and four children in the paediatric area. This meant that if a patient deteriorated in that area it would not be recognised in a timely way. This risk had not been identified by senior nursing staff in the department and was not documented on the departmental risk register. This demonstrates that there are not systems in place to monitor and mitigate risks relating to the health, safety and welfare of paediatric patients receiving care in the department including protecting them from abuse and avoidable harm.

- Within the emergency departments at Worcestershire Royal Hospital and the Alexandra Hospital patients were routinely cared for in corridors and non-clinical areas that were accessible to a variety of non-clinical trust staff, other patients and visitors. We observed patients receiving care on trolleys with no space in between them, which meant that confidential conversations could be overheard by other patients and visitors during clinical assessments. Although privacy screens were available, staff informed us that if they were used other trolleys would not be able to pass due to the narrow corridor. We observed patients who were distressed and confused who were being cared for in this bright, noisy environment. Whilst a letter had been developed to provide patients with information regarding their care in the corridor, and at the Worcestershire Royal Hospital call buzzers had been installed in the corridors for patient use, this did not mitigate the lack of consideration for their dignity and privacy.

- There were no plans in place to improve privacy and dignity of patients being cared for in the corridor in the ED's. In the document 'CQC actions post MR risk summit letter' (not dated but provided for the risk summit held on 22 December 2016) the trust stated 'we are concerned about the need to place patients in the corridor and recognise that this does not provide the privacy and dignity our patients deserve'. Actions

included reverse queuing, ‘halo staff’ and care and comfort rounds, all of which were in place during our inspection; however patients’ privacy and dignity remained compromised. Although ‘the inability of clinicians to perform a full medical review due to lack of privacy resulting in the patient potentially not receiving optimal medical assessment’ was in a description of a risk associated with the local ambulance staff providing care to patients in the corridor on the medicine directorate risk register from May 2015, there were no specific actions relating to improving patients privacy and dignity when being cared for in the corridor. This demonstrates that the trust’s governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients experiencing a lack of privacy and dignity when being cared for in the corridors in the ED’s.

- The trust was not reporting the number of occurrences of unjustified mixing in relation to sleeping accommodation to NHS England, as required from 1 December 2010. This demonstrates that the trust’s governance system in relation to the provision of patient’s privacy and dignity does not operate effectively to ensure that senior leaders and the board have clear oversight of this risk.

- In the theatre admissions area at Kidderminster Hospital and Treatment Centre, mixed sex accommodation breaches were observed. Patients that were undressed in theatre gowns and dressing gowns waiting for surgery could be seen by other patients of the opposite sex and by patients and visitors in the waiting area. Sleeping accommodation includes areas where patients are admitted and cared for even where they do not stay overnight and therefore includes all admissions and assessment units. Although there were plans to redesign the area to ensure privacy and dignity was maintained and to prevent mixed sex breaches, there was not a clear timescale of when this would commence. This had not been identified as a risk on the divisional risk register and the trust had not reported this practice as mixed sex accommodation breaches.

- There were not effective procedures in place to ensure that the names of children admitted to the emergency department at Worcestershire Royal Hospital were checked on the child protection risk register. The child protection risk registers were paper based and stored in the triage room in the department which was not always accessible as patients were assessed there. During the announced inspection we saw three occasions where staff did not check the risk register for children admitted to the department via ambulance. This had not been identified as a risk and actions had not been taken to ensure the trust had a system in place to ensure all children entering the department were

being protected from abuse and improper treatment. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients who were known to be 'at risk' but were not identified.

- We observed poor adherence to infection prevention and control practices with doctors not 'arms bare below the elbow', a lack of hand washing and incorrect use of personal protective equipment at Worcestershire Royal Hospital and the Alexandra Hospital. In the 'CQC Action Plan Update' which was provided on 17 January 2017 ahead of the Risk Summit on 18 January 2017 the trust stated that it and staff from NHS Improvement had carried out hand hygiene audits infection audits since the comprehensive inspection. Results ranged from 0% compliance on Ward 11 (WRH) on 11 January 2017 to 43% compliance in the ED at the Alexandra Hospital on 11 January 2017 to 100% compliance on Ward 12 (WRH) on 7 January 2017. The trust concluded from these audits that there was correct knowledge in place relating to 'bare below the elbows' and hand hygiene but there was a failure, trust wide to undertake best practice. The trust stated that it was developing a re-launch of a hand hygiene campaign and raising infection prevention and control focus by way of a 30, 60 & 90 day plan. This risk had not been previously identified and did not feature on the corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of there being insufficient procedures to prevent the spread of infection.

- The trust did not have effective oversight of incident reporting and management, including categorisation of risk and harm. Not all incidents that were required to be reported externally as 'serious' were correctly classified and externally reported. This means the trust does not have effective systems in place to assess, mitigate and improve the quality and safety of the services it provides because investigations are not carried out in sufficient depth to inform changes in practice to prevent reoccurrence or avoidable harm.

- We reviewed an incident from the vascular high dependency unit (VHDU) at Worcestershire Royal Hospital where a patient required immediate treatment to reverse the effects of controlled medication which was administered incorrectly. This was not classified or reported as a serious incident, in line with NHS England: serious incident framework (2015). An incident relating to missing controlled drugs from the paediatric ward at Worcestershire Royal Hospital had not been reported to external authorities. Following review of the incident report it was identified that 54 codeine tablets were unaccounted for. The only

actions noted following this were that the matron was notified and the controlled drugs book rectified with new number of tablets. Failure to meet the NHS England Serious Incident Framework for identifying managing and investigating incidents resulting in failure to learn from incidents leading to preventable harm was added to the corporate risk register (21 November 2016) in August 2015. Although many actions were documented as completed, the incidents detailed above demonstrate that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk that lessons will not be learned if incidents are not categorised correctly and externally reported appropriately.

- Medical staff were told in an email dated 16 November 2016 from the trust governance team that their incident reports relating to patients being cared for in areas they considered to be unsafe were inappropriate and were being deleted. This had not been previously identified by the trust as a risk and did not appear on the divisional or corporate risk register. In the 'CQC Action Plan Update' which was provided on 17 January 2017 ahead of the Risk Summit on 18 January 2017 the trust detailed immediate and ongoing actions that it had taken to address this problem including reiteration to staff by the chief operating officer, clinical director of the EDs and matrons that they should report incidents relating to high capacity and corridor care. However the impact of these actions had yet to be assessed. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk to patients receiving corridor care due to high capacity in the ED's as not all these incidents were being reported.

- Morbidity and mortality meetings were not consistently carried out or recorded across the trust. We observed that at perinatal morbidity and mortality meetings minutes were not taken and necessary actions and learning was not clearly recorded. The emergency department at Alexandra Hospital did not carry out or take part in morbidity and mortality meetings. This meant that any learning from these meetings was not shared and no-one was accountable for the completion of the actions agreed. This did not appear on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of not sharing learning from the care of patients who had died or suffered significant harm in these areas.

- During our comprehensive inspection we found patients were being placed at risk of avoidable harm from using equipment that had not been serviced, maintained tested or calibrated. The neonatal resuscitation trolley on the delivery suite at Worcestershire Royal Hospital did not always have essential checks carried out. We reviewed checklists from 1 September 2016 to 22 November 2016 and found that during this time the neonatal resuscitation trolley had not been checked on 10 occasions. Audit procedures for resuscitation equipment were not effective as it had not been identified that daily checks were not always being completed. Not all equipment had been completed had evidence of medical servicing and portable appliance testing within the safety date displayed. In the Meadow Birth Centre and delivery suite at Worcestershire Royal Hospital and the Midwifery Assessment Unit at the Alexandra Hospital we found a total of 11 pieces of equipment had not been tested within the date indicated. This had not been identified as a risk and did not appear on the divisional risk register. This means there are not effective governance systems in place to ensure that all equipment used for providing care or treatment to a patient was safe for such use.

- During our comprehensive inspection we found there was unsafe storage of medication with poor monitoring, escalation and insight into the effect of storing drugs above or below the recommended temperatures. This means the trust cannot be sure that all medicines stored both in fridges and at ambient temperatures in treatment rooms are safe to be administered to patients.

- On the Evergreen ward at Worcestershire Royal Hospital the temperature of the medicine refrigerator was not recorded daily. Over 24 days only 12 days temperature records were documented which were within the safe range of 2-8°C. In the Elias Jones unit at the Alexandra Hospital, the temperature of the treatment room (where drugs were stored at ambient temperatures) was not recorded daily and when the room temperature was higher than the safe level for the storage of drugs this was recorded but not escalated.

- In the Minor Injury Unit (MIU) at Kidderminster Hospital and Treatment Centre records showed fridge temperature checks had been completed daily however we found the maximum fridge temperatures recorded had exceeded the recommended maximum safe temperature eight degrees Celsius on a total of 60 days between August and November 2016. There was a risk that Tetanus vaccines, stored in the fridge, were less effective or ineffective as they had not been stored at the recommended temperature. Staff were not aware of this risk and had not escalated high temperatures to pharmacy in line with the trust's medicines policy. Staff told us that pharmacy staff regularly visited the MIU and inspected

the place of storage in line with the medicines policy however the fridge temperatures had not been highlighted. Following the escalation of this matter, the trust said on 24 November 2016 “the fridge is operating at a temperature within acceptable parameters and no medications had been affected.” After further enquiries from CQC, on 13 December 2016 and 11 January 2017 we were told ‘Those medicines affected were removed and resupplied’. We are not aware of any action taken by the trust to contact any patients who have received drugs (including vaccines) which have been stored at incorrect temperatures, to review any harm that may have been sustained. This shows that there are not effective processes in place to ensure that the trust policy on medicines management is being adhered to, and this had not been recognised as a risk. This also demonstrates that the trust’s governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients receiving medication that had been stored at incorrect temperatures.

- Doses of time critical medication were not being administered to patients at the correct time. In the emergency department at Worcestershire Royal Hospital we found two instances where patients did not receive Parkinson’s and diabetic medication, as they were being cared for prolonged periods in the corridor where medicine rounds did not occur. On ward 5 at the Alexandra Hospital a patient had missed doses of Parkinson’s medication, anticoagulants and intravenous antibiotics on two consecutive days. The trust was not aware of this risk and there were no effective governance systems in place to ensure the safety of patients by administering their medication as prescribed. In the document provided to us on 11 January 2017 the trust stated that the ‘supply of time critical medicines is a key priority and an audit of missed doses has been undertaken as part of the trust Medicines Optimisation Audit Plan, with associated recommendations presented to the Divisional Directors of Nursing’. The results of the audit were not provided however the trust presented a three month plan stating how the administration of time critical medications would be incorporated into medicines management training, would be a focus of the medicines safety newsletter and training outcomes would be monitored. The trust did not confirm if this has been added to the corporate risk register to ensure that there was sufficient senior leader and board oversight of this risk and the actions taken to mitigate it.

- The emergency department at Worcestershire Royal Hospital had 3.7 whole time equivalent (WTE) full-time consultants, with one additional locum consultant. The emergency department at Alexandra Hospital had one WTE full-time consultant, with three additional locum consultants. These levels of consultants were not sufficient to meet with the Royal

College of Emergency Medicine's (RCEM's) emergency medicine consultants' workforce recommendations to provide consultant presence in all emergency departments for 16 hours a day, seven days a week as a minimum. This meant that the trust was failing to ensure sufficient numbers of suitably qualified, competent, skilled and experienced consultants were deployed in order to meet the requirements of the emergency department's planned establishment and the RCEM's consultants' workforce recommendations. This risk was raised at our previous inspection and has been on the divisional risk register since March 2016. The trust is actively recruiting for substantive consultants replace the locums in the ED, however this risk remains.

- During our inspection we had concerns about staff and patient safety when untrained staff were left alone to care for patients. The discharge lounge at the Alexandra Hospital, on 7 December 2016 was being staffed by one bank healthcare support worker (HSW) (establishment reported as one trained nurse plus a HSW). She was working alone, unable to get a prompt response from senior management through the bleep system, and had no cover for meal or comfort breaks. In the clinical decisions unit at Worcestershire Royal Hospital, untrained staff were left alone to care for patients while trained staff took their meal breaks. Staff in both areas informed us this was a regular occurrence. In the document 'CQC actions post MR risk summit letter' (not dated but provided for the risk summit held on 22 December 2016) the trust agreed that this was not acceptable and said they were 'reviewing the staffing requirement via the nurse leadership in these areas to ensure compliance with safe staffing'. This risk had not been identified by senior nursing staff in the departments and was not documented on the divisional or corporate risk register. This demonstrates that the trust's governance system in relation to the management of risk does not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of patients being cared for by staff who did not have the appropriate training to do so.

- In the BAF risk report provided on 22 November 2016 risk 2790, rated as 'high' stated "As a result of high occupancy levels, patient care may be compromised". This has been on the risk register since 2 February 2015. The impact was detailed as: overcrowding in ED; increased quality and safety risk due to suboptimal location of patients, multiple transfers between wards/departments/sites, lack of privacy and dignity for patients, increased length of stay. Actions included; improving patient flow by increasing ambulatory care provision, redesigning the bed model, and improving the discharge processes. Expected completion was 31December 2016. These actions are either yet to be implemented or are not effective in reducing the risk as the data demonstrates there is no tangible improvement in performance. The ED's at Worcestershire

Royal Hospital and the Alexandra Hospital remain overcrowded with the overall trust four hour target of 95% of admitting, transferring for discharging patients not been met and being consistently reported as less than the England average. The overall trust performance against this target was; August 2016 83.5%, September 2016 82.2%, October 2016 80.9%, November 2016 78.9% and 19 December 2016 to 12 January 2017 at 73.2%. Occasions where a patient is waiting on a trolley for more than 12 hours after a decision has been made to admit them are increasing with 38 breaches recorded in November 2016, 86 in December 2016 and 113 in the first two weeks of January 2017. This means the trust does not have assurance that actions were improving patient care.

For the reasons set out above, the Commission is of the view that the quality of health care you provide requires significant improvement.

You are required to make the significant improvements identified above regarding the quality of healthcare by 10 March 2017.

Please note: If you fail to comply with the above requirements and thereby fail to make significant improvement to the quality of the health care you provide within the given timescale we will decide what further action to take against you. Possible action includes the Commission informing the Trust Development Authority, now known as NHS Improvement, that the Commission is satisfied that there is a serious failure by the trust to provide services that are of sufficient quality to be provided under the NHS Act 2006 and seeking to discuss and agree with the Authority that a recommendation be made to the Secretary of State for the Secretary to appoint a trust special administrator in the interests of the health service because of that serious failure.

We will notify the public that you have been served this warning notice by including a reference to it in the inspection report. We may also publish a summary more widely unless there is a good reason not to.

You can make representations where you think the notice has been served wrongly. This could be because you think the notice contains an error, is based on inaccurate facts, that it should not have been served, or is an unreasonable response. You may also make representations if you consider the notice should not be published more widely.

Any representations should be made to us in writing within 10 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number MRR1-3107518238

If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you contact us, please make sure you quote our reference number MRR1-3107518238 as it may cause delay if you are not able to give it to us.

Yours sincerely

Edward Baker
Deputy Chief Inspector of Hospitals.

cc.
Dale Bywater, NHS Improvement
Maggie Boyd, NHS Improvement
Richard Beeken, NHS Improvement
Paul Watson, NHS England
Jacqueline Barnes, NHS England
Simon Trickett, NHS Redditch and Bromsgrove CCG and Wyre Forest CCG
Carl Ellson – NHS South Worcestershire CCG

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 1 March 2017 **Enc D1**

Report to Trust Board

Title	**Quality Governance Committee – report to Trust Board**
Sponsoring Director	**Dr Bill Tunnicliffe, Associate Non-Executive Director, Chair**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is requested to: • Approve the revised terms of reference • Receive the update on stroke and VTE • Receive the report on the divisional reports • Note the update on avoidable mortality • Note the assurance received in respect of medicines optimisation • Note the report
Previously considered by	Not applicable

Priorities (√)

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

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience 3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care
Legal Implications or Regulatory requirements	This report covers some statutory issues such as CQC or accreditation visits.

Key Messages

This paper provides the Board with the key achievements, issues, and risks discussed at the Quality Governance Committee on 19 January and 16 February 2016.

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Date of Trust Board: 1 March 2017 **Enc D1**

REPORT TO TRUST BOARD – 1 MARCH 2017

1. Situation

This report provides the Board with key quality issues and risks discussed at the QGC meetings held on 19 January and 16 February 2016.

2. Background

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

3. Assessment

3.1 Clinical Governance Group

Members were pleased with the assurance that the CGG is giving, however it was acknowledged that the group is still developing. Senior clinical attendance is excellent. The CGG discussed the trust infection prevention and control report, VTE, the R&D report as well as the medicines optimisation report

A concern was raised about the amount of old equipment within the trust which is becoming obsolete. Risk assessments need to be undertaken. This issue is being taken forward as part of the executive management team and Trust Management Group.

3.2 Quality Improvement Plan (February meeting)

The QGC received the current status of the work being undertaken in response to the CQC letter received in January 2017. The Acting Director of Performance has a grip on the issues and is being supported by a core team.

Assurance was received on the actions being taken and the work needed for the response to the CQC. The new SNAP audits were described. They were commencing on the day of the QGC meeting. An intensive nursing support team is in place. Infection control have audited every ward to obtain a baseline and the results were discussed at the next infection control meeting. A baseline audit of fridge temperatures has also been undertaken. The plan governance structure was agreed. Risk registers are being updated and this will be completed by the end of February.

As a result of the discussion, it was agreed to include an HR professional as part of the core support team.

3.3 Stroke

QGC received a report from the Project Manager for Stroke care as I expressed concern about the latest national data available which showed the Trust as not achieving some significant targets. In particular the time from arrival to a hyper acute stroke unit (HASU) is not being achieved (4 hours). Patients are not being discharged for rehabilitation in a timely fashion so cannot free beds up for newly diagnosed patients who have had a stroke. I understand that the community beds have now been centralised at Evesham which should make a difference, but not in time for the final set of data for 2016/17. I was assured about the timeliness of obtaining a scan, but this could be improved and the stroke team are visiting

another local site to see how they undertake this part of the pathway.

This topic remains high on the agenda for the QGC.

3.4 VTE

The QGC remains very concerned that the quality audit in relation to this area will be qualified. This is part of the Quality Account. I have spoken with the project manager and whilst a substantive amount of work is being undertaken, the key is the appointment of a dedicated VTE practitioner. A business case is being developed.

Again, this topic remains high on the QGC agenda and we will be discussing this each month.

3.5 Divisional reports

Unfortunately the divisional reports remain a concern. Whilst each division does report to the QGC, they do not update all issues each month. They are not a reflection of the risks and issues for the Trust. At the next CGG it will be proposed that the divisional reports focus on one or two key issues for discussion at QGC.

Medicine: Performance is not improving with the resolution of complaints and 12 hour waits. Whilst there are harm reviews being undertaken, assurance was not received that everything that could be done was being done. There is no medical leadership for governance within the division.

Surgery: QGC remain concerned with the fractured neck of femur pathway. Unfortunately the project manager was unable to attend this meeting so we have requested her attendance for the next meeting.

SCS: A report on the harm occurred as a result of the inability to transfer patients to tertiary providers was presented. These issues had not been reported as serious incidents. This was being picked up outside the meeting.

Women and Children: This report was as usual a high standard and assurance was received with the activity being undertaken.

3.6 Avoidable Mortality (November and December meetings)

This area of work continues to be of concern. The HSMR is now within two standard deviations and SHMI is not an outlier, according to the latest figures.

A new electronic system for mortality reviews will be in place at the beginning of March. Trajectories to undertake reviews continue to be challenged by the QGC. New guidance from the Department of Health states that families need to be involved in the mortality review process which the Mortality Review Group is reviewing. The process for learning from secondary mortality reviews i.e. serious incidents, is robust and assurance can be gained in relation to this.

A detailed report on pneumonia deaths has been undertaken. This showed that the vast majority were at end of life. Better end of life care may have prevented the hospital admission. The report has been shared with the CCG mortality review group.

3.7 Research and Development Strategy

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

The Committee is not presenting the R&D strategy to the Board as stated in my last report. It has been determined, which I support, that the incoming CMO takes a lead in this area and develops a robust strategy for ratification in the Autumn.

3.8 Trust Infection Prevention and Control

There is a concerted focus on key areas of work, hand hygiene, bare below the elbow and use of personal protective equipment (PPE). A review of the cleanliness of the hospitals is being undertaken.

The c diff target has been exceeded, however there is now an antimicrobial pharmacist in place. There has also been an additional MRSA bacteraemia which is being investigated.

3.9 Medicines Optimisation

A comprehensive report was given by the Director of Pharmacy. Assurance was received in respect of the actions being undertaken to ensure the safety of medicines. Key are of risk is the number of penicillin allergies and a new risk on the administration of insulin. The Director of Pharmacy is reviewing these areas but one key mitigation is an electronic prescribing system which is being procured.

The number of incidents reported has decreased. There is work being undertaken to understand in what areas this has occurred. The result of this analysis will be presented in the next update.

There is a shortage of middle grade pharmacists which is impacting on the ability to provide chemotherapy at the Alexandra Hospital.

The Director of Pharmacy will be presenting a dashboard for pharmacy issues at the next report to the Committee.

3.10 Terms of Reference

The Committee agreed revised terms of reference which are appended for the Board to approve.

4 Recommendation

The Board is requested to:

- Approve the revised terms of reference
- Receive the update on stroke and VTE
- Receive the report on the divisional reports
- Note the update on avoidable mortality
- Note the assurance received in respect of medicines optimisation
- Note the report

Dr Bill Tunnicliffe
Chair – Quality Governance Committee

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Worcestershire NHS
Acute Hospitals NHS Trust

Terms of Reference

Quality Governance Committee (QGC)

Version: 2.3

Terms of Reference approved by: QGC

Date approved: January 2017

Author: **Company Secretary**

Responsible directorate: CEO

Review date: March 2017

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Quality Governance Committee

Terms of Reference

1. Introduction/Authority

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

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

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

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

2. Membership

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

In attendance:
Company Secretary
Head of Clinical Governance and Risk Management (or successor post)
CCG representative
Associate Director – Information and Performance

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

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

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

3 Arrangements for the conduct of business

3.1 Chairing the meetings

The Non-Executive Director will chair the meetings. In the absence of the Non-Executive Director, the Chair will be another Non-Executive Director.

3.2 Quorum

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

3.3 Frequency of meetings

The Committee will meet monthly.

3.4 Frequency of attendance by members

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

3.5 Declaration of interests

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

3.6 Urgent matters arising between meetings

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

3.7 Secretariat support

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

4 Authority

The Committee is authorised by the Trust Board.

5 Purpose and Functions

5.1 Purpose

- To be Worcestershire Acute Hospitals NHS Trust own internal quality regulator by;
    - Constructively challenge the organisational strategy
    - Scrutinise Trust management in meeting the agreed strategic objectives
    - Oversee high level clinical performance
    - Be satisfied that services are safe and of high quality
- To enable the Board to obtain assurance that the quality of care is achieving agreed expectations and in line with current good practice and where it is not to that standard, to provide oversight of improvement to achieve the agreed standards.
- To ensure that there are appropriate clinical governance systems with adequate controls in place throughout the Trust in order to:
    - Promote safety and excellence in patient care
    - Ensure the Trust explores opportunities and understands the amount of clinical risk it should accept, tolerate or be exposed to at any point in time (risk appetite)

- Identify, prioritise and seek assurance on the effective identification and management of risk arising from our clinical business
- Anticipate and respond to the external environment, paying attention to new (or newly appreciated) opportunities and risks. Looking at what has gone right and wrong in this and other organisations
- Ensure the effective and efficient use of resources though evidence based clinical practice
- Ensure that the organisation has an effective learning culture in place

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

5.2 Duties

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

5.2.1 In respect of general governance arrangements:

a. to ensure that all statutory elements of quality governance are adhered to within the Trust;
b. to agree trust-wide clinical governance priorities as contained within the Quality Account and give direction to the clinical governance activities of the Trust's divisions through the Trust Quality Dashboard and exception reports;
c. to approve the Trust's annual Quality Account and the quality aspects of the Annual Governance Statement before submission to the board;
d. to approve the terms of reference and membership of the Clinical Governance Group (CGG) and seek assurance that the expert forums underpinning delivery of quality are appropriate and executing their responsibilities on behalf of QGC
e. to consider matters referred to the QGC by the board or other subcommittees of the Board;
f. to consider matters referred to the QGC by the CGG
g. to receive and approve the annual clinical audit programme ensuring that it is consistent with the audit needs of the Trust;
h. to make recommendations to the Audit and Assurance Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference;
i. to receive assurance that its expert forums foster quality governance links with primary care and other stakeholders including patient forum members through receiving of periodical reports as requested

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

a. assuring the Board that the services provided by Worcestershire Acute Hospitals Trust meet the requirements of the Health and Social Care Act and the CQC's standards.
b. ensuring that internal standards are set and monitored, including (without limitation):
   - commissioning the setting of quality standards and key quality indicators and ensure that a mechanism exists for these standards to be monitored;
   - ensuring that standards outlined in national service frameworks are implemented and monitored;

- ensuring compliance with the registration criteria of the Care Quality Commission;

c. promoting an organisational climate of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the trust's policy on reporting issues of concern and monitoring the implementation of that policy;

d. assuring that the organisation has controls in place for reviewing patient safety incidents (including near-misses, complaints, and regulation 28 coroner reports (where applicable), mortality reviews)

e. gain assurance from within the Trust that it is looking out to the wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning;

f. assuring that opportunities for improvement in respect of incidents or complaints identified through the national patient survey or locally through PALS, are being taken forward by the organisation;

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

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

i. ensuring that risks to patients are minimised through the application of a comprehensive risk management system including, without limitation;

- monthly discussion of the strategic clinical risks faced by the trust:
- six monthly report on the trust's risk management strategy
  - processes to ensure the escalation of risks from directorate and divisional risk registers to the corporate risk register
  - monitoring of the Trust's risk management policy;
  - priorities and actions using the assurance framework;
- monthly quality exception reports from divisions
- recommendations from external bodies e.g. the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) or Care Quality Commission (CQC) or Royal Colleges, as well as those made internally e.g. in connection with serious incident reports and adverse incident reports, into practice and has mechanisms to monitor their delivery;
- implementation of reports or recommendations from National Agencies for Patient Safety (NPSA);
- escalation to the executive group other sub-committees and/or Trust board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the trust;

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

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

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

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

b. to receive an annual report from Finance & Performance Committee on the impact on the trust's cost improvement programmes to assure the Board that it's not having a negative impact on quality of care

c. To ensure the Quality Impact Assessments are undertaken on any significant

reorganisations (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the committee) and report any concern relating to an adverse impact on quality to the trust board;

To be assured that;

d. care is based on evidence of best practice/national guidance;
e. there is an appropriate process in place to monitor and promote compliance across the trust with clinical standards and guidelines including but not limited to NICE guidance and guidelines and radiation use and protection regulations (IR(ME)R);
f. the implementation of all new procedures and technologies are embedded according to trust policies;
g. to review the implications of confidential enquiry reports for the trust and to endorse, approve and monitor the internal action plans arising from them;
h. trends in complaints received by the trust are leading to improvement actions in response to adverse trends where appropriate;
i. the development of quality indicators throughout the trust is being undertaken in line with agreed plans;
j. the trust meets the requirements of commissioners and external regulators;
k. any identified gaps in the delivery of effective clinical care are progressed to improve these areas, in all divisions/specialties;
l. the research programme and governance framework is implemented and monitored;
m. there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission);
n. where practice is of high quality, that practice is recognised and propagated across the trust and to the wider NHS; and
o. to ensure the trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

6. Relationships and reporting

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

6.2 The following sub groups report to the Quality Governance Committee Clinical Governance Group (CGG)

The following expert forums are accountable to the CGG:

- Patient and Carer Experience
- Clinical Effectiveness Committee
- Research and Development
- Trust Infection Prevention and Control
- safeguarding
- Blood Transfusion
- Harm Reduction
- Divisional Governance
- Medical Devices
- Resuscitation and deteriorating patient
- Medicine Optimisation

- Incident Review
- Mortality Review

The Groups listed above will have task and finish groups commissioned to ensure that the expert forums can execute their agreed responsibilities on behalf of QGC.

7 Review of the Terms of Reference

These Terms of reference will be reviewed by March 2018 [DN I would still keep this date for review]

KS/TOR (corp gov TOR)

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc D2**

Report to Trust Board

Title	**Board Assurance Framework**
Sponsoring Director	**Jan Stevens** **Interim CNO**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Board is requested to • Receive the revised BAF • Note that the BAF is under development and will be finalised with the whole Board for presentation at the Board meeting later in the Spring
Previously considered by	Executive Management Team

Priorities (√)

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

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

Key Messages

Attached is a proposed new BAF with a suggested structure for population in the future.

Title of report	BAF
Name of director	Jan Stevens

Date of meeting: 1 March 2017 **Enc D2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD- 1 MARCH 2017

1. Situation

The Executive Management Team has reviewed the Board Assurance Framework (BAF) and has determined that it requires significant improvement. The Improvement Director recommended an alternative methodology and format which the Trust is proposing to utilise.

2. Background

The BAF details the strategic risks for the Trust. It should link to the corporate risk register. The BAF as previously presented was very detailed and operational. The attached is a high level strategic approach which clearly shows links to the corporate risks and to the Single Oversight Framework.

3. Assessment

The attached document shows the following:

- The proposed strategic risks with the current (February 2017) risk rating.
- A heat map, which in future will show the movement of the risk
- The risks mapped to the single oversight framework
- An outline which shows how each risk will be detailed in future and the clear links to the corporate risks

The new executive team will work to populate the BAF outline within the next two months, ready for presentation to the Board at a meeting in the Spring. The risks will also be mapped to the Trust priorities.

The executive team determined that the risks in relation to the governance processes as highlighted by the CQC and by the buddy trust, would form part of the mitigation in a number of the risks outlined.

It any board member has any detailed comments about the phrasing or proposed methodology, please contact the Company Secretary directly.

4 Recommendation

The Board is requested to

- Receive the revised BAF
- Note that the BAF is under development and will be finalised with the whole Board for presentation at the Board meeting later in the Spring

Jan Stevens
Interim CNO

Title of report	BAF
Name of director	Jan Stevens

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc D2**

Risk Heat Map		Current Score (likelihood x impact, arrow (tbd) indicates any movement since last report) No Movement since last report ↔							
	Outset Scores	**<=9**	**10**	**12**	**15**	**16**	**20**	**25**	**Target Score**
1. Urgent care: Failure to improve patient experience and provide safe services with overcrowding in ED and lack of patient flow.	5x5=25							**5x5=25**	**TBD**
2. CQC registration: Failure to maintain the CQC essential standards requirements	5x4=20						**5x4=20**		**TBD**
3. Safety and improvement culture: Inability to deliver sustainable improvement due to lack of capacity and capability in safety and improvement methodology.	5x4=20						**5x4=20**		**TBD**
4. Performance and National Targets: Failure to deliver national and locally agreed targets	5x4=20						**5x4=20**		**TBD**
5. Workforce Shortages: Inability to attract staff, recruit and retain employment in key medical and nursing posts.	5x4=20						**5x4=20**		**TBD**
6. Leadership capability: Failure to establish leadership teams at all levels and as teams develop they do not deliver the required leadership outcomes	4x5=20						**4x5=20**		
7. Future of Acute Hospital Services in Worcestershire: Inability to action the proposals and access capital funding	3x3=9	**3x3=9**							**TBD**
8. Capital investment: Lack of a forward strategy for capital investment, equipment maintenance and key elements of backlog maintenance	5x5=25							**5x5=25**	**TBD**
9. Deliver Financial Plan for 2016/17: Failure to deliver planned position as at 31 March 2017.	3x3=9	**3x3=9**							**TBD**

Mapped to Single Oversight Framework

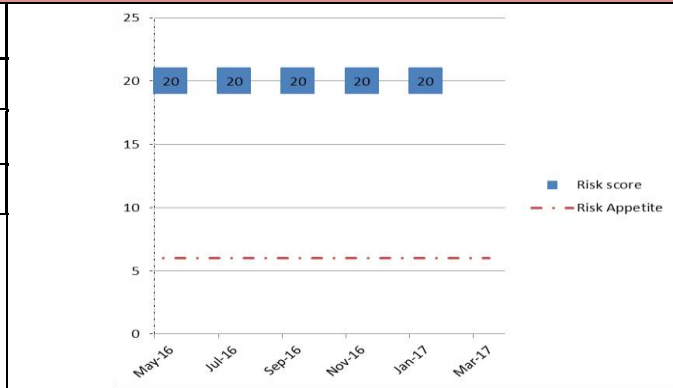
1. Leadership and Improvement Capability	**2. Operational Performance**	**3. Quality of Care**	**4. Finance and use of resources**	**5. Strategic Change**	**6. Stakeholders**
Failure to establish leadership teams at all levels and as teams develop they do not deliver the required leadership outcomes	Failure to improve patient experience and provide safe services with overcrowding in ED and lack of patient flow.	Failure to maintain the CQC essential standards requirements	Lack of a forward strategy for capital investment, equipment maintenance and key elements of backlog maintenance	Inability to action the proposals and access capital funding	
Inability to attract staff, recruit and retain employment in key medical and nursing posts.	Failure to deliver national and locally agreed targets	Inability to deliver sustainable improvement due to lack of capacity and capability in safety and improvement methodology.	Failure to deliver planned position as at 31 March 2017.		

Title of report	BAF
Name of director	Jan Stevens

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc D2**

Risk Description	**Principal Risk:**							**Risk ID**	
Risk Details									
Executive lead		**Last Reviewed**		**Target Date**				**Review Group**	
CQC Domain(s)	Safe		Caring	Responsive		Effective			Well Led
Corporate Objective(s)	1.1	1.2	2.1	2.2	3.1	3.2	4.1		4.2

Risk Rating: Likelihood x Severity			**Relevant Key Performance Indicators**		
			Metric	**Trust compliance March 2017**	**Target**
Initial Risk Score					
Current Risk Score					
Target Risk Score					
Risk Appetite					
Direction of travel					

Rationale for current score

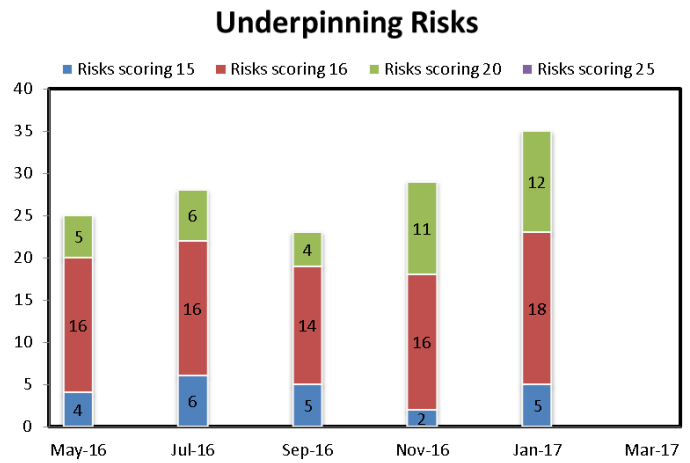
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

Title of report	BAF
Name of director	Jan Stevens

Date of meeting: 1 March 2017 **Enc D2**

Gaps in controls and assurances: what additional controls and assurances should we seek?	Mitigating Actions: what more should we do?
•	

Related High Risks (>14 and DATIX ID)



Title of report	BAF
Name of director	Jan Stevens

Worcestershire NHS
Acute Hospitals NHS Trust

1 March 2017 **Enclosure E2**

Report to (Public) Trust Board

Title	**Financial Performance – Month 10 2016/17**
Sponsoring Director	**Jill Robinson – Director of Finance**
Author	Jo Kirwan - Assistant Director of Finance Katie Osmond – Assistant Director of Finance
Action Required	The Trust Board is asked to: ➢ note the financial position ➢ note intention to reflect loss of STF income due to failure to deliver operational metrics
Previously considered by	*N/a*

Priorities (√)

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

Related Board Assurance Framework Entries	2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service. 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability. 3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances.
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 preset price to a defined measure of output of activity, it has been superseded by the national tariff.

Key Messages:

OVERVIEW

- In January the Trust reports a £4.9m deficit consistent with its forecast.
- The year to date (pre STF) deficit of £41.2m exceeds the financial control total by £1m resulting in the Trust not receiving the January finance element of the STF.
- The Trust has refreshed its forecast to reflect that the loss of STF monies due to non-compliance with the operational performance metrics of £2.9m will be supported via an increase in the value to the technical adjustment.
- The Divisions have been set control totals and are required to rapidly develop plans to ensure delivery of the required improvement in the run rate. Delivery continues to be managed through Executive Team and the monthly Divisional performance reviews. Progress to date has been slow and Divisions are presenting an update at Februarys Committee.

I&E POSITION YTD

- At the end of January the Trust is recording a YTD deficit of £33.3m, this is £4.1m worse than plan. £3m of the adverse variance is driven by the failure to deliver the operational performance related metrics of the STF (£2.3m) and the finance element of the STF (£0.7m). The remainder of the variance is attributable to CIP slippage and provision of additional bed capacity noting that adverse variances across in-patient activity and CIP have been supported via non recurrent benefits.

- The underlying deficit for January is £5.1m – an increase of £1.1m compared to December and is predominantly due to non-receipt of the finance element of the STF (£0.7m) and the provision of additional ward capacity (£0.3m).

I&E FORECAST

- The refreshed bottom built forecast which includes the contract settlement and an estimate for opening additional capacity resulted in a forecast out turn of £53.1m – exceeding the pre-STF planned deficit of £47.7m by £5.4m.

- In December the Executive Team agreed to a £1.2m expenditure reduction programme to be delivered by Divisions in Q4 with the remainder to be delivered via a technical adjustment. Although the Trust has delivered to the overall I&E forecast in January - progress against identifying the target has been slow and therefore Divisions are providing an update into Februarys Committee.

- The FY forecast for the Trust (post STF) is a deficit of £34.6m, consistent with plan. This position is reliant upon a material technical adjustment of £7m. The increased value of this technical adjustment offsets the £2.9m adverse FY variance driven by the failure to deliver the operational performance metrics of the STF.

- In short, the Trust has a plan to deliver the post STF control total of £34.6m but is reliant upon a £7m technical adjustment to do so. If this does not materialise, then the Trust will not be eligible for the Q4 STF finance element of £2.3m.

CAPITAL POSITION

- Capital funding applications have been submitted to NHSI. The funding requested within the emergency application is £2.57m and the main application is £5.053m. The Trust is awaiting a decision.

- If the loans are not approved or a decision is not forthcoming in a timely basis, the Trust will have to reprioritise other capital schemes to ensure the Trust remains within budget. The December CPG agreed a detailed plan to keep the expenditure within the CRL which is being managed on a weekly basis with monthly reviews led by the Interim Director of Finance.

KEY RISKS

- The risks requiring the greatest level of management are:

  - **Reduction in agency expenditure (R1a)** –The Q3 forecast outturn indicated that agency expenditure could exceed the ceiling by c£1.3m by the end of the year. £654k of this is due to the costs of Evergreen 2. This assumes the agency element (£0.7m) of the £1.2m Divisional expenditure reduction target is delivered. Development of plans has been slow to progress.

    Immediate actions to include:
    - Divisions to provide an update on progress into Februarys F&P Committee.
    - Divisions to finalise agency reduction plans and present into the Executive Agency Task Force – 31st January.

  - **Delivery of Divisional Control Totals** (**R10)** – Delivery of the Trust pre STF control total is reliant upon Divisions maintaining expenditure within their assigned control total. Any cost pressures that have not been incorporated into forecasts will need to be managed within the overall position.

    Immediate actions to include:
    - Divisions to provide an update on progress into Februarys F&P Committee.
    - Delivery against targets to be monitored via Divisional monthly performance meetings.

  - **Accounting treatment of technical adjustment** (**R11)** – Audit has raised issues around the timing and treatment of the adjustment.

    Immediate actions include:
  - Management are working very closely with audit to resolve and ensure the full benefit can be included in the 2016/17 financial position.

Worcestershire NHS
Acute Hospitals NHS Trust

Finance Report
Month 10

Jill Robinson

Director of Finance

1st March 2017

Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

At the end of January the Trust is recording a YTD deficit of £33.3m - this is £4.1m worse than plan. £3m of the adverse variance is driven by the failure to deliver the operational performance related metrics of the STF (£2.3m) and the finance element of the STF (£0.7m). The remainder of the variance is attributable to CIP slippage, provision of additional bed capacity and adverse variances across in-patient activity, noting that these variances have in part been supported via non recurrent benefits .

The underlying January run rate of £5.1m is £1.1m worse than December predominantly due to non receipt of the finance element of the STF (£0.7m) and the provision of additional ward capacity (£0.3m). This overall position is consistent with forecast.

Table 1 – I&E Summary

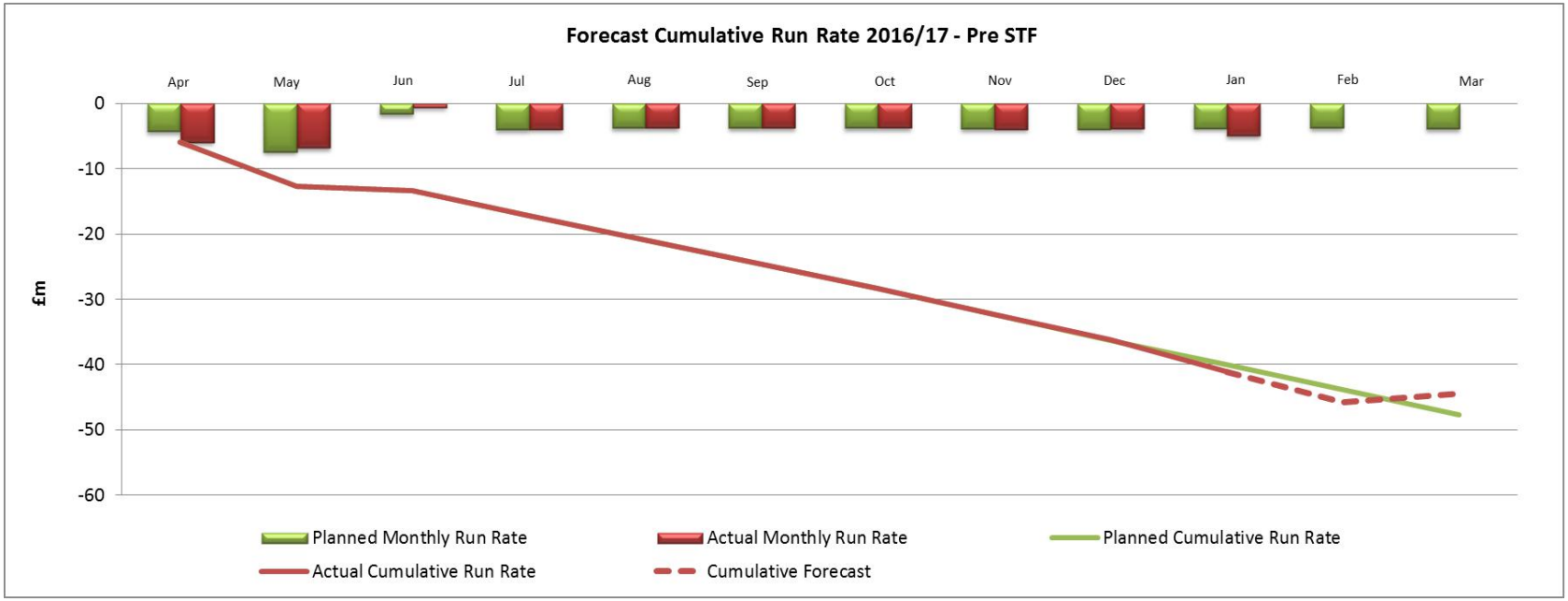
	M10 Actual £m	M10 Plan Variance £m	YTD Actual £m	YTD Plan Variance £m	Variance Analysis	Pages
Income	31.7	0.0	316.3	(2.3)	**Plan Variance (M10 – no variance)** – M10 Patient Care Income £31k adverse variance. Key variances pre settlement: Elective £0.2m, Outpatients £0.2m adverse. Non Electives £0.3m favourable.	Pages 6, 15-17
Expenditure	(36.6)	(1.1)	(357.5)	1.3	**Plan Variance (M10 £1.1m adverse)** – The underlying level of underspend has reduced due to slippage against the ramped up CIP target, increased agency expenditure and some cost pressures materialising including the provision of additional bed capacity. CIP – YTD adverse variance of £3.7m . The additional target of £3.7m explains £2.8m of the YTD adverse variance as delivery against this element of the target is anticipated via a M12 technical adjustment . Slippage against two key schemes – theatres improvement project and a further reduction in agency expenditure explain the remainder. The overall CIP programme continues to be supported non recurrently via vacancy management schemes. At M10 non clinical vacancies contribute £1.6m towards the YTD favourable variance with the majority of the remainder due to lower than planned levels of activity.	Pages 5, 11-14
Total – Pre STF	**(4.9)**	**(1.1)**	**(41.2)**	**(1.0)**		
STF	0.0	(1.1)	7.9	(3.1)	Continued non compliance against the STP operational performance metrics explains £0.3m in month and £2.3m YTD. This months non delivery of financial control total represents £0.8m in month and YTD.	
Total – Post STF	**(4.9)**	**(2.2)**	**(33.3)**	**(4.1)**		
Non Rec	**(0.2)**	**(0.2)**			M10 non recurrent items - energy provisions in excess of late invoice receipt.	
Underlying position	**(5.1)**	**(2.4)**				

Run Rate

Worcestershire NHS
Acute Hospitals NHS Trust

The Q3 refreshed forecast, which includes the CCG contract settlement and an estimate for opening additional capacity at WRH (£0.5m), results in a forecast outturn of £53.1m – exceeding the pre-STF deficit of £47.7m by £5.4m. Following the contract settlement, the bridging of this gap resided within expenditure and in December the Executive Team agreed to a £1.2m expenditure reduction programme to be delivered by Divisions in Q4. It is planned that the remainder of the challenge is to be delivered via a technical adjustment which will also support the loss of the performance element of the STF.

Although the M10 position delivered to forecast – the Divisions delivered £129k against the £244k expenditure reduction target. Delivery of the overall forecast reliant upon fortuitous benefits.



The FY forecast for the Trust (post STF) is a deficit of £34.6m, consistent with plan. This position is reliant upon a material technical adjustment of £7m. The increased value of this technical adjustment offsets the £2.9m adverse FY variance driven by the failure to deliver the operational performance metrics of the STF.

In short, the Trust has a plan to deliver the post STF control total of £34.6m but is reliant upon a £7m technical adjustment to do so. If this does not materialise, then the Trust will not be eligible for the Q4 STF finance element of £2.3m.

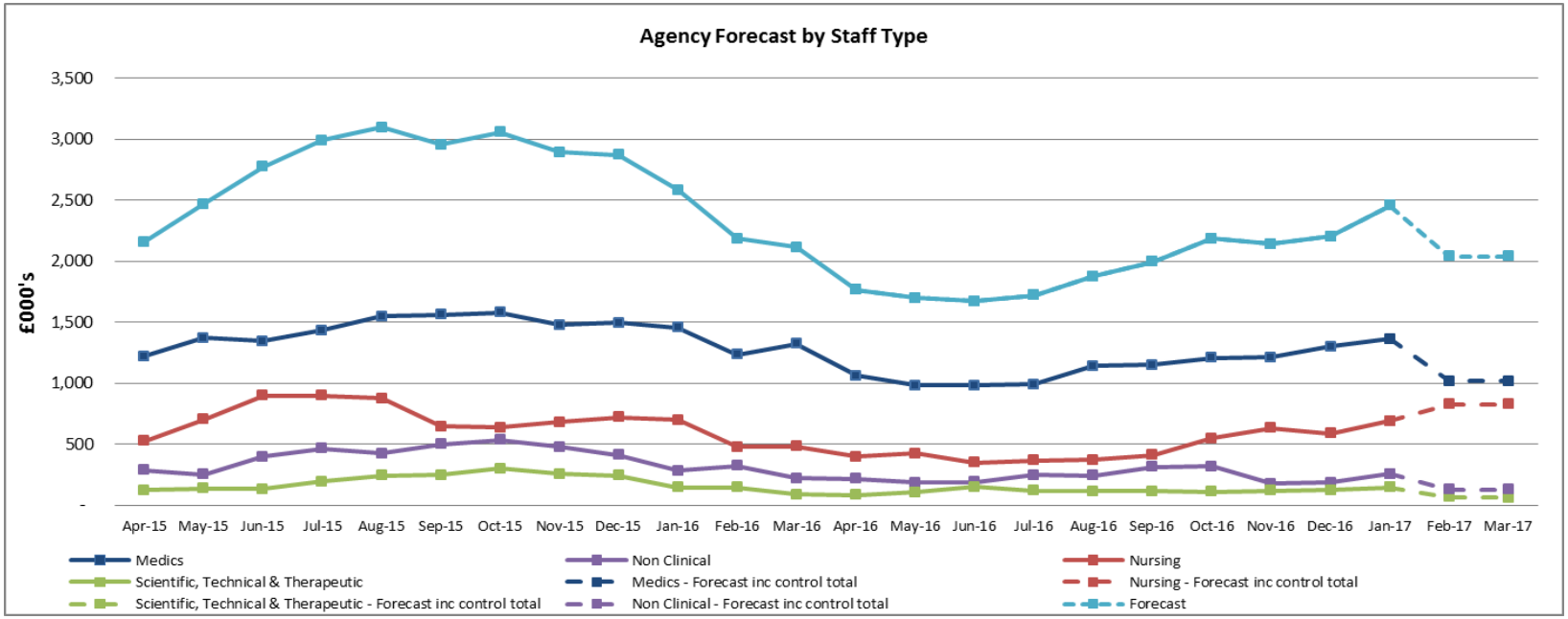
Financial Performance – Key Headlines

Worcestershire NHS
Acute Hospitals NHS Trust

Ref		Risk or Opportunity	Pages
R1a	**Pay Expenditure** – increased by £0.3m compared to the underlying December position driven by increased agency costs as a result of additional bed capacity. Total agency expenditure for the month of January is £2.5m, an increase of £0.3m compared to December actuals and represents the highest cost month in this financial year. A reduction in agency expenditure is a key component to the Trust improving its run rate moving forward and represents 60% of the Divisions expenditure reduction targets to be delivered in Q4.	Risk	Pages 5 and 11-13
	Non Pay Expenditure – (excluding non PbR drugs and devices) improved by £0.1m compared to the underlying December position - predominately due to lower than anticipated energy costs.		Pages 11-12
	Income - YTD patient care & STF income combined report an adverse variance of £6.9m against plan, this position has deteriorated in January by £1.1m. The Trust has agreed 14/15 and 15/16 year-end settlements and 2016/17 outturn with the Worcestershire CCGs. The settlement of £263.1m with Worcestershire CCGs has been reflected within the YTD financial position. Key movements in January: • STF Funding £1.1m adverse - Trust has not achieved it's financial control total (£764k) and the performance (£327k) element in January. The intention is to recover the financial control element in March 2017 following further mitigations. • Inpatient £0.1m favourable – Electives £0.24m adverse and Emergencies £254k and Day cases £89k favourable. Elective activity has been down due to bed pressures, with additional activity for day cases and emergency medicine compensating. • Outpatients £0.2m adverse – T&O £53k, Urology £41k, Respiratory £42k and Stroke Medicine £32k. • Maternity £39k favourable – births were 5% above plan in January. • Other Contract Income £1.2m favourable – includes the YTD impact of the Worcester CCGs 2016/17; partially negating the YTD impact of the fines, CQUIN & reconciliation risk for the host CCGs.		Pages 6, 15-17
R2	**Cost Pressures –** non avoidable cost pressures that have been included in the YTD position e.g. medical backfill- have been reflected within the refreshed forecast. The finance department will continue to work closely with the Divisions to identify cost pressures at the earliest opportunity and ensure that Divisions follow an appropriate approval route.	Risk	
R3	**CIP** – The CIP gap holds at £3.9m with the refreshed Q3 forecast assuming closure of the gap via a technical adjustment in M12. At month 10 this results in a £2.8m adverse variance due to phasing. Slippage against the Theatres improvement programme and a further reduction in agency scheme continues to challenge the position and are being supported via non recurrent vacancy management schemes.	Risk	
R4	**CQUINs** – Total CQUIN is worth £7.6m. Currently, £5.9m is risk rated Green, £0.4m is rated Amber and £1.3m is Red. The revised forecast assumes that £1.6m will not be secured following the YTD performance and the above RAG rating. Stronger performance in Q2 decreased the CQUIN risk from £3.3m to £2.5m. The 2016/17 final outturn settlement with the Worcester CCGs is on the premise that no further deductions are made and it includes the payment of CQUIN. This de-risks £2.057m of the CQUIN with the CCGS. The risk still remains with the Associate CCGs £0.3m and NHSE England £0.2m.	Risk	
R5	**Sustainability Transformation Fund –** the revised Q3 trajectory assumes that the Trust receives £10.2m of the £13.1m . This assumes the Trust will only achieve the Finance element of the STF and not performance targets for Q2- Q4. Finance – Green £10.2m ; Q1 performance targets were reported within the finance element (consistent with NHSI reporting).The current trajectory shows the Trust will not achieve: RTT- Red £1.2m, A&E 4 hour target – Red £1.2m, 62 day cancer waits – Red £0.5m.An appeal has been submitted for Q2 & Q3 performance element to NHSE & NHSI. The current position excludes the impact of the appeal. The Trust is still waiting to hear from NHSE & NHSI regarding the outcomes of both appeals.	Risk	
O2	**Fines** - The forecast assumes the following level of fines: • Cancer 2 week wait – Red £1.0m • Cancer 31 day – Red £0.1m • The fines element for the Worcester CCGs is encompassed within the 2016/17 settlement figure.	Opportunity	
R9	**Capital** – The full year forecast as at month 10 16/17 shows a breakeven position against the Trusts CRL, however the ED Expansion and the ASR OBC costs are all higher than previously forecast. This has resulted in further P&W schemes being deferred. The Trust is still awaiting confirmation of final outcome of the loan application. The forecast position excludes any loans being approved.	**Risk**	Pages 8-9

Agency Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust



- At the end of January the Trust has spent £19.7m on agency staffing and is £0.25m under its agency ceiling.
- Without further action, the Q3 forecast outturn indicated that the Trust could exceed the ceiling by c.£1.3m by the end of the year. £654k of the current forecast is attributable to increasing medical capacity at AGH and WRH and includes both the flip of surgical wards to medical and the provision of an additional ward at WRH.
- The Trust is committed to reducing its current agency run rate and has issued Divisions with agency reduction targets totalling £0.7m to be delivered in Q4 across all agency staffing groups.
- Target areas include: increasing direct engagement fill rates for medical agency to 95% across all Divisions, applying a maximum upper limit of +20% cap rate for medical agency from 1 March and reducing admin agency by a further 30%.
- The Trust has also revised nurse bank rates to increase bank numbers to support provision of additional capacity and reduce reliance on agency.
- Delivery against these targets continue to be monitored via the weekly Executive led agency task force and the monthly Divisional performance reviews.
- As at 14th February and reported into ET – Divisions had identified £130k of agency reduction against the £683k target – Divisions are attending Februarys Finance and Performance Committee to provide assurance on delivery.
- A further non clinical temporary staff review has commenced with the Executive Team and will conclude early March.

Income by Point of Delivery

Worcestershire NHS
Acute Hospitals NHS Trust

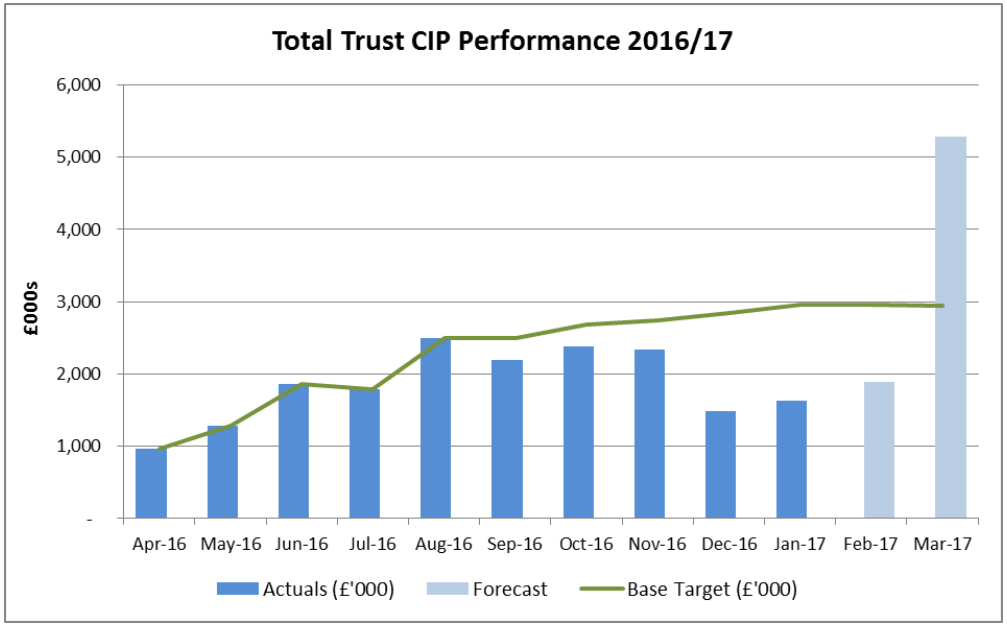
	In Month				YTD				Full Year				
	Plan £'000	Actual £'000	Var £'000	% £'000	Plan £'000	Actual £'000	Var £'000	% £'000	Initial Plan £'000	Current Plan £'000	Forecast £'000	Var £'000	% £'000
Elective	1,984	1,745	(240)	(12%)	23,068	20,834	(2,235)	(10%)	27,293	27,293	24,841	(2,452)	(9%)
Daycase	3,035	3,124	89	3%	29,114	28,403	(711)	(2%)	35,063	35,063	34,103	(960)	(3%)
Non Elective - Emerg	7,247	7,578	331	5%	74,313	72,228	(2,085)	(3%)	88,795	88,795	85,872	(2,923)	(3%)
Non Elective - Other	129	52	(77)	(60%)	1,349	1,228	(121)	(9%)	1,610	1,610	1,546	(64)	(4%)
Total Inpatients	**12,396**	**12,498**	**102**	**1%**	**127,844**	**122,692**	**(5,152)**	**(4%)**	**152,760**	**152,760**	**146,361**	**(6,399)**	**(4%)**
Outpatients New	1,726	1,651	(75)	(4%)	16,606	15,995	(612)	(4%)	19,953	19,953	19,242	(710)	(4%)
Outpatients F Up	1,689	1,615	(74)	(4%)	16,067	15,473	(593)	(4%)	19,312	19,312	18,630	(682)	(4%)
Outpatients Procedure	749	721	(28)	(4%)	7,110	7,099	(11)	(%)	8,525	8,525	8,547	22	%
Total Outpatients	**4,164**	**3,986**	**(178)**	**(4%)**	**39,783**	**38,567**	**(1,216)**	**(3%)**	**47,790**	**47,790**	**46,419**	**(1,370)**	**(3%)**
ED Attendances	1,338	1,300	(38)	(3%)	13,872	13,849	(23)	(%)	16,645	16,645	16,732	87	1%
Community MIU	173	157	(16)	(9%)	1,796	1,882	86	5%	2,155	2,155	2,300	145	7%
Total ED/MIU	**1,511**	**1,457**	**(53)**	**(4%)**	**15,668**	**15,731**	**63**	**%**	**18,800**	**18,800**	**19,032**	**232**	**1%**
Maternity - Delivery	1,064	1,107	43	4%	11,265	10,409	(857)	(8%)	13,267	13,267	12,154	(1,113)	(8%)
Maternity Ante Natal	729	745	17	2%	7,276	7,080	(196)	(3%)	8,625	8,625	8,346	(279)	(3%)
Maternity Post Natal	134	116	(18)	(13%)	1,353	1,199	(154)	(11%)	1,598	1,598	1,419	(179)	(11%)
Total Maternity	**1,932**	**1,971**	**39**	**2%**	**19,950**	**18,710**	**(1,240)**	**(6%)**	**23,555**	**23,555**	**21,946**	**(1,609)**	**(7%)**
Paed - Daycase/Elective	23	17	(6)	(26%)	210	216	6	3%	250	250	267	17	7%
Paed - Non Elective	470	492	22	5%	4,568	4,562	(6)	(%)	5,527	5,527	5,480	(47)	(1%)
Paed - Outpatient	235	219	(16)	(7%)	2,190	2,182	(8)	(%)	2,645	2,645	2,658	13	%
Paed - BPT, Drugs, CQUIN	130	150	20	15%	1,254	1,287	34	3%	1,501	1,460	1,479	19	1%
Paed - Neonatal Cot Days	354	391	36	10%	3,542	3,363	(179)	(5%)	4,250	4,250	3,963	(288)	(7%)
Total Paediatrics	**1,213**	**1,268**	**56**	**5%**	**11,763**	**11,610**	**(153)**	**(1%)**	**14,174**	**14,133**	**13,847**	**(286)**	**(2%)**
Chemotherapy Delivery	**316**	**354**	**38**	**12%**	**3,162**	**3,352**	**190**	**6%**	**3,828**	**3,828**	**4,002**	**174**	**5%**
Drugs PBR Excluded	2,285	2,285	0	%	20,998	20,998	0	%	25,700	25,212	25,212	0	%
Critical Care ITU/HDU	854	940	86	10%	8,535	8,015	(520)	(6%)	10,242	10,242	9,434	(808)	(8%)
Other Contract Income	4,996	4,746	(250)	(5%)	49,612	51,097	1,485	3%	60,663	59,592	63,028	3,436	6%
Total Other Contract Income	**8,135**	**7,971**	**(163)**	**(2%)**	**79,144**	**80,109**	**965**	**1%**	**96,605**	**95,045**	**97,673**	**2,627**	**3%**
Non Elective - Emerg Threshold	0	0	0		0	0	0		0	0	0	0	
Financial Sanctions	0	(17)	(17)		0	(755)	(755)		0	0	(985)	(985)	
Contractual Risk	(135)	(200)	(65)		(1,353)	(1,913)	(560)		(1,624)	(1,624)	(3,132)	(1,508)	
Contractual Deductions/Penalties	**(135)**	**(217)**	**(81)**	**60%**	**(1,353)**	**(2,668)**	**(1,315)**	**97%**	**(1,624)**	**(1,624)**	**(4,116)**	**(2,492)**	**153%**
Commissioner QIPP	(417)	0	417		(4,167)	0	4,167		(5,000)	(5,000)	0	5,000	
Non Contract Income	393	187	(206)	(52%)	5,019	4,912	(107)	(2%)	7,970	6,106	6,237	131	2%
Phasing Adj	(13)	(13)	0	%	(107)	(107)	0	%	0	(0)	(0)	0	
Pre STF Total	**29,494**	**29,463**	**(31)**	**(%)**	**296,706**	**292,908**	**(3,798)**	**(1%)**	**358,859**	**355,395**	**351,402**	**(3,993)**	**(1%)**
STF	1,092	0	(1,092)	(100%)	10,917	7,860	(3,057)	(28%)	0	13,100	10,153	(2,947)	(22%)
	30,586	**29,463**	**(1,123)**	**(4%)**	**307,623**	**300,768**	**(6,855)**	**(2%)**	**358,859**	**368,495**	**361,555**	**(6,940)**	**(2%)**

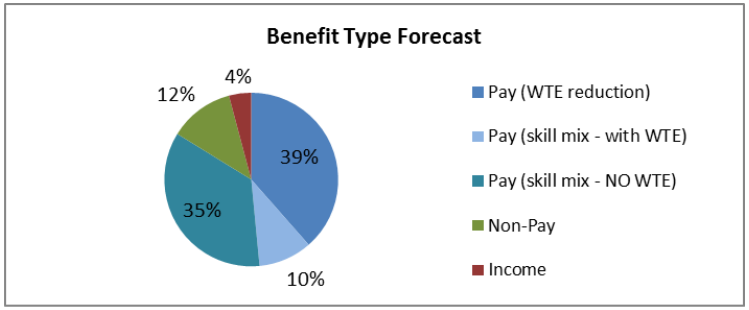
Key Activity/Income Messages

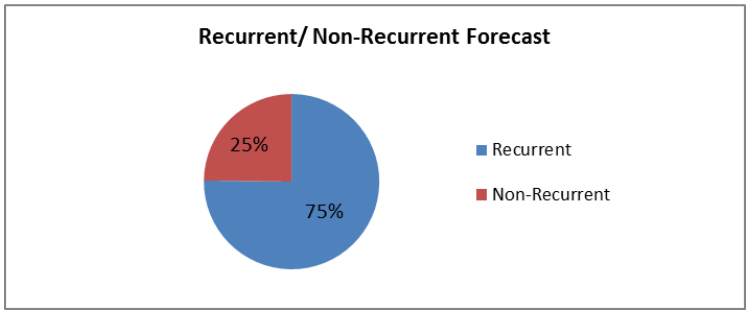
- In January Pre STF position was £31k and £1,123k Post STF below plan, the YTD position is £3,798k Pre STF and £6,855k Post STF below plan. The position reflects the Worcester CCGs outturn settlement for 2016/17.
- Inpatients position has improved in January, both Emergencies and Day cases were above plan but Electives were below planned levels. Outpatients activity has deteriorated in January and continues to underperform, YTD £1,216k adverse.
- The position assumes the Trust will still achieve the financial control in 2016/17, qualifying for the full £10.2m STF funding available for the financial element. RTT, A&E and the Cancer 62 day waits standards continue to be non-compliant. Current performance and trajectories indicate the Trust will not achieve these targets in 2016/17 . Q1 performance element of STF was payable regardless of actual achievement of the trajectory.
- The Trust has submitted an appeal for Q2 performance related STF to NHSE & NHSI and is waiting for the outcome. The Trust has submitted the Q3 appeal in January 2017.

CIP – Target £28m

Worcestershire NHS
Acute Hospitals NHS Trust







Month	Base Target (£'000)	Actuals / Forecast (£'000)	Actual v Target (£'000)	Forecast v Target (£'000)
Apr-16	967	967	0	
May-16	1,284	1,284	0	
Jun-16	1,860	1,860	0	
Jul-16	1,795	1,795	0	
Aug-16	2,502	2,502	0	
Sep-16	2,502	2,197	-305	
Oct-16	2,683	2,375	-308	
Nov-16	2,740	2,334	-406	
Dec-16	2,849	1,484	-1,365	
Jan-17	2,952	1,626	-1,326	
Feb-17	2,959	1,890		-1,069
Mar-17	2,950	5,284		2,334
	28,043	25,598	-3,710	1,265

At the end of January the Trust is reporting a £3.7m adverse variance against the CIP target predominately due to the unidentified target and slippage against two key schemes: theatres improvement programme and a further reduction in agency costs. Prior to January ytd adjustments have inflated some in month actuals. The full year forecast assumes that the Trust will fall short against the CIP target by £2.4m.

As the table on the left highlights, the monthly targets increased from August with the inclusion of the £3.7m of additional CIP and continues to increase due to phasing of key schemes such as the Theatre Improvement Programme.

The chart demonstrates that although CIP delivery performed well against the target for the first 6 months, the Trust has found it challenging to deliver against the increased profile of the target due to slippage against key schemes such as the theatres improvement programme and a further reduction in agency expenditure both of which have been impacted by the measures required to address patient flow in recent weeks”

The March increase is due to a pending technical adjustment that supports delivery of the additional £3.7m CIP target.

Capital Programme 16/17 – M10 Position

Worcestershire NHS
Acute Hospitals NHS Trust

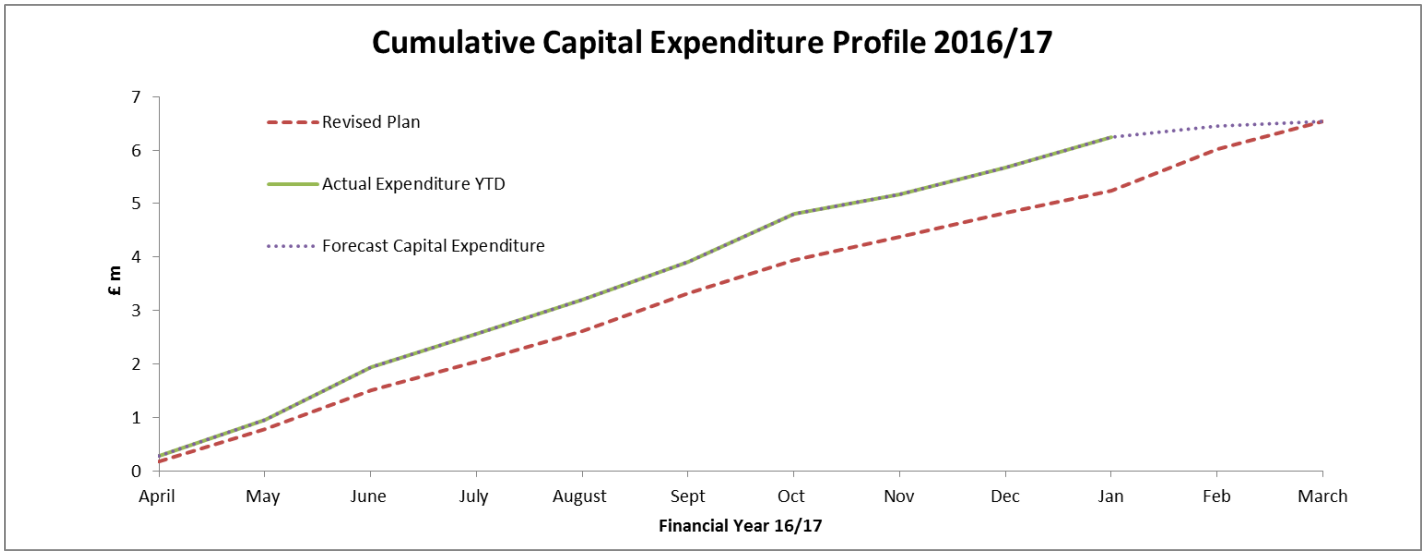
The full year forecast as at month 10 16/17 shows a breakeven position against the Trusts CRL, however the ED Expansion and the ASR OBC costs are all higher than previously forecast. This has resulted in further P&W schemes being deferred. The Trust is still awaiting confirmation of final outcome of the loan application. The forecast position excludes any loans being approved.

	£000's	In Month			YTD			Full year - Prior to any loans			
Workstream	Highlevel Summary	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Risk Details
Developments	ED Expansion - Overspend offset	(20)	(176)	(156)	(400)	(556)	(156)	(400)	(556)	(156)	The mid year review removed £400k from P&W, ICT and Equipment plans to compensate for the ED estimated overspend.
	ED Expansion	0	0	0	(1,386)	(1,386)	0	(1,386)	(1,386)	0	At month 10 the overspend on ASR and ED is forecast higher, resulting in P&W FYF being reduced to compensate.
	ASR OBC	0	(3)	(3)	0	(331)	(331)	0	(380)	(380)	Risk is that statutory schemes and essential maintenance is being deferred into 17/18.
Development Total		(20)	(178)	(158)	(1,786)	(2,273)	(487)	(1,786)	(2,322)	(536)	
Property and Works	Routine Works/Backlog Maintenance	9	(58)	(67)	(526)	(603)	(77)	(935)	(635)	300	The FYF was adjusted after a mid year review to compensate for the £400k ED overspend. The Month 10 forecast has resulted in a further reduction to compensate for the estimated overspend on the ED project £156k and the ASR project £380k, totally £536k.
	Regulatory Standards/Requirements	(74)	(40)	34	(319)	(349)	(30)	(465)	(359)	106	
	Staffing/Project Costs	0	(7)	(7)	(9)	(7)	2	(17)	(17)	0	
	Additional Schemes	(54)	(50)	4	(77)	(88)	(11)	(220)	(90)	130	
Property and Works Total		(119)	(156)	(37)	(931)	(1,048)	(117)	(1,637)	(1,101)	536	
Equipment	Equipment	(68)	(67)	1	(265)	(260)	5	(400)	(400)	0	
Equipment Total		(68)	(67)	1	(265)	(260)	5	(400)	(400)	0	
ICT	Systems & Infrastructure	(92)	(22)	70	(399)	(450)	(51)	(354)	(489)	(135)	Data Centre £1.8m FYF. Risk is staffing costs are not reduced in Feb and March.The forecast includes the £300k donation.
	EPR	(10)	(43)	(33)	(202)	(537)	(335)	(270)	(537)	(267)	
	Data Centre	(82)	(82)	(0)	(1,479)	(1,479)	(0)	(1,800)	(1,800)	0	
	Hardware and Peripherals	(22)	(23)	(1)	(119)	(119)	(0)	(119)	(119)	(0)	
	Additional Schemes	(15)	(5)	10	(68)	(78)	(10)	(180)	(78)	102	
ICT Total		(221)	(176)	45	(2,267)	(2,663)	(396)	(2,723)	(3,023)	(300)	
Total Expenditure		(428)	(577)	(149)	(5,249)	(6,243)	(994)	(6,546)	(6,846)	(300)	
Donations/Disposals	ICT	0	0	0	0	0	0	0	300	300	Donation
Grand Total		(428)	(577)	(149)	(5,249)	(6,243)	(994)	(6,546)	(6,546)	0	

Capital Programme 16/17 – M10 Position

Worcestershire NHS
Acute Hospitals NHS Trust

The full year forecast as at month 10 16/17 shows a breakeven position against the Trusts CRL by a planned reduction in capital expenditure for the last two months of the financial year.



Year to Date

The YTD £994k overspend relates to;

- The ED expansion is forecast to overspend by £556k an increase of £156k compared to previous forecast. In the absence of loans this will need to be funded by reducing P&W allocations further.
- ASR OBC expenditure of £331k relates to professional services and project manager costs.
- ICT has overspent its allocation by £396k. The majority of the costs are project management staff.

Full year Forecast

- Further work is being undertaken with P&W leads to ensure the ED forecast is accurate.
- ASR OBC FYF of £380k related to external professional services and project management costs which will have to be funded from a reduction in P&W schemes.
- ICT continues to overspend against forecast, however plans are now being worked through to mitigate this.
- A donation of £300k has been received which is included in the FYF and has been allocated to ICT.

Worcestershire NHS
Acute Hospitals NHS Trust

Appendices

Trustwide Position

Worcestershire NHS
Acute Hospitals NHS Trust

Table 1

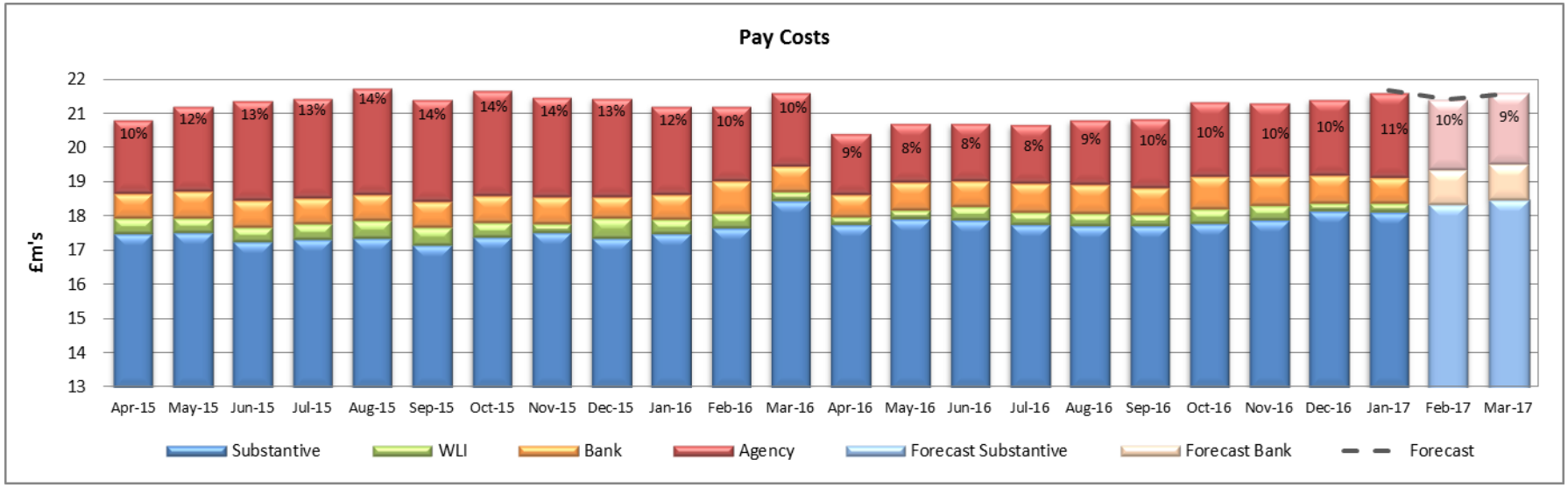
January 17 (Month 10)

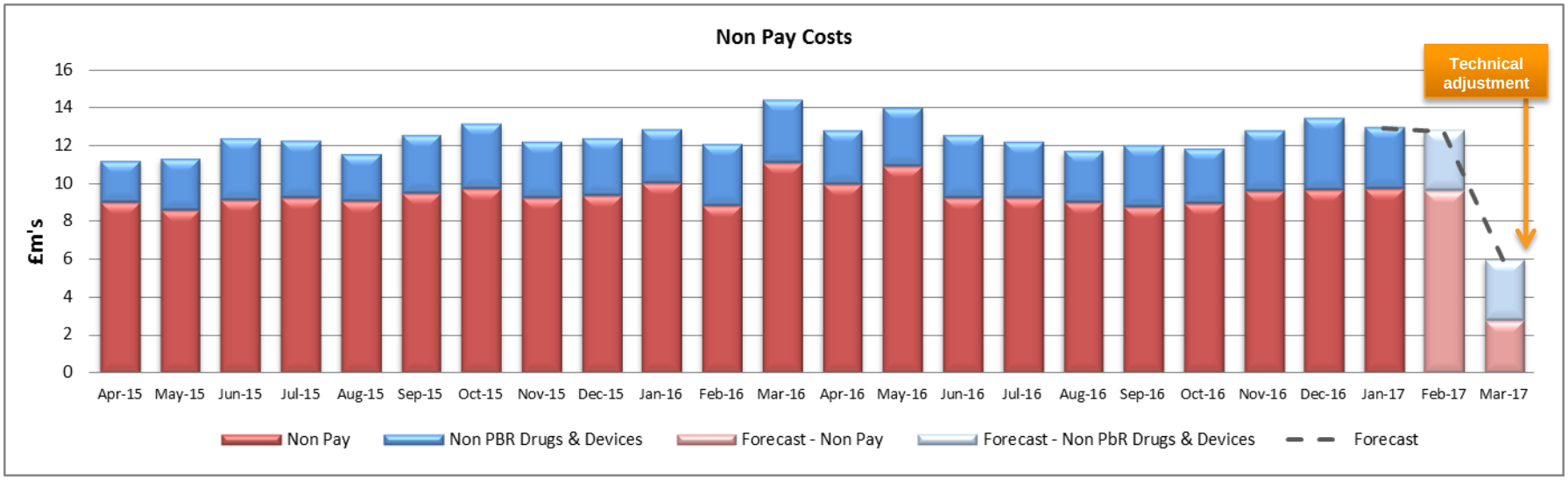
Income & Expenditure	Current Month			Year to Date			Full Year		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Revenue & Income									
Patient Care Revenue	26,255	26,224	(31)	265,221	261,422	(3,798)	317,599	313,606	(3,993)
Other Operating Income	2,160	2,244	84	21,904	23,359	1,456	26,541	27,537	996
Non PBR Drugs & Devices	3,239	3,239	(0)	31,486	31,486	0	37,796	37,796	0
STF	1,092	0	(1,092)	10,917	7,860	(3,057)	13,100	10,153	(2,947)
Total Operating Revenue	**32,746**	**31,707**	**(1,039)**	**329,527**	**324,127**	**(5,399)**	**395,036**	**389,091**	**(5,945)**
Operating Expenses									
Pay	(21,171)	(21,602)	(431)	(211,800)	(209,890)	1,910	(252,016)	(252,976)	(960)
Non Pay	(8,962)	(9,716)	(754)	(94,259)	(94,894)	(634)	(114,811)	(107,322)	7,489
Non PBR Drugs & Devices	(3,239)	(3,239)	0	(31,486)	(31,486)	0	(37,796)	(37,796)	(0)
Total Operating Expenses	**(33,372)**	**(34,557)**	**(1,185)**	**(337,545)**	**(336,269)**	**1,276**	**(404,623)**	**(398,094)**	**6,529**
EBITDA *	**(626)**	**(2,850)**	**(2,224)**	**(8,018)**	**(12,142)**	**(4,124)**	**(9,587)**	**(9,003)**	**584**
EBITDA %	-1.9%	-9.0%		-2.4%	-3.7%		-2.4%	-2.3%	
Depreciation	(816)	(816)	0	(8,668)	(8,668)	0	(10,044)	(10,545)	(501)
Net Interest, Dividends & Gain/(Loss) on asset disposal	(1,252)	(1,251)	1	(12,539)	(12,538)	1	(15,024)	(15,107)	(82)
Reported Total Surplus / (Deficit)	**(2,694)**	**(4,917)**	**(2,223)**	**(29,225)**	**(33,348)**	**(4,123)**	**(34,655)**	**(34,655)**	**0**
Less Impact of Donated Asset Accounting	6	6	0	60	60	0	72	72	0
Surplus / (Deficit) against Control Total	**(2,688)**	**(4,911)**	**(2,223)**	**(29,165)**	**(33,288)**	**(4,123)**	**(34,583)**	**(34,583)**	**0**
Surplus / (Deficit) %	-8.2%	-15.5%		-8.9%	-10.3%		-8.8%	-8.9%	

Pay & Non Pay Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust

Percentages shows proportion of agency spend against total spend.

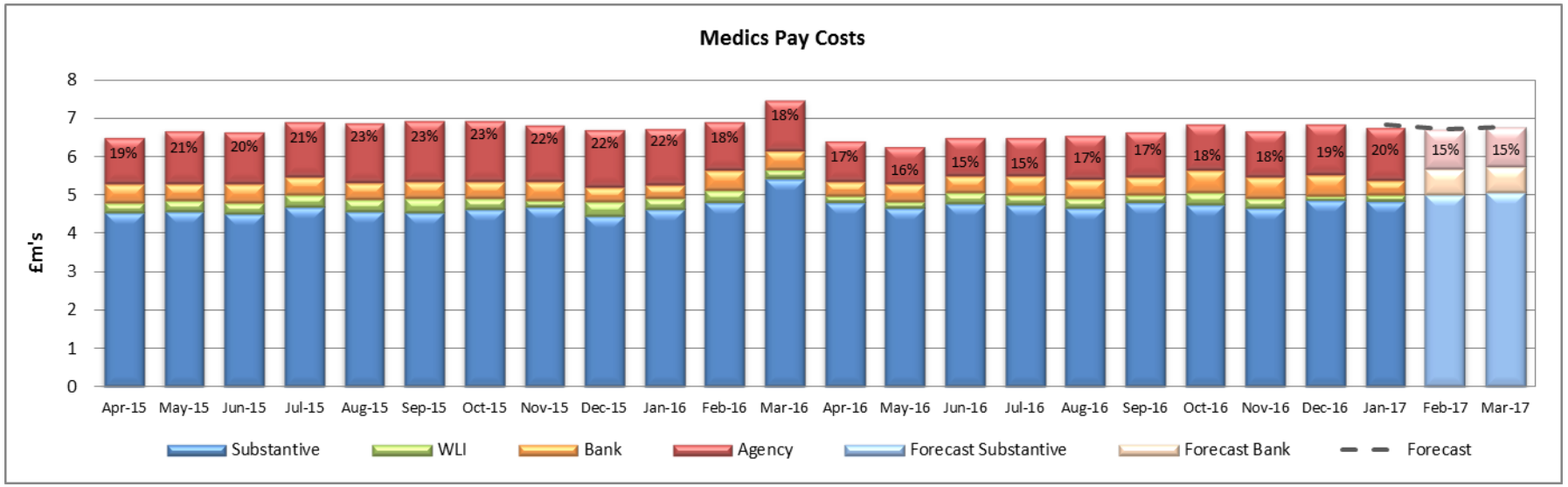


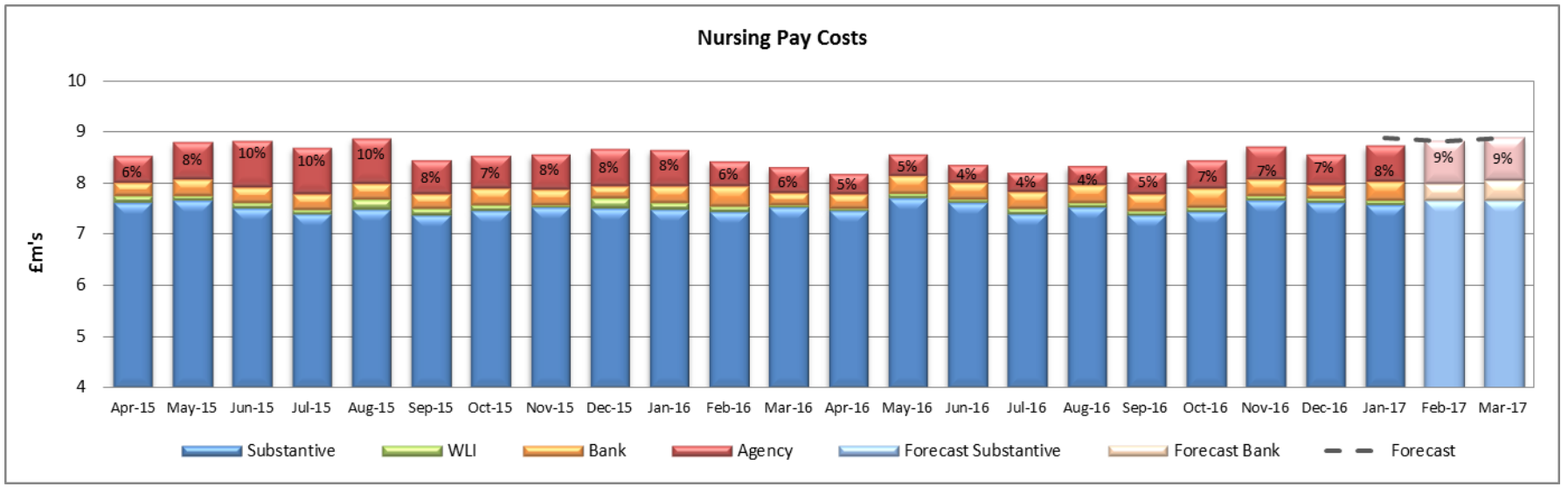


Medics & Nursing Pay Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust

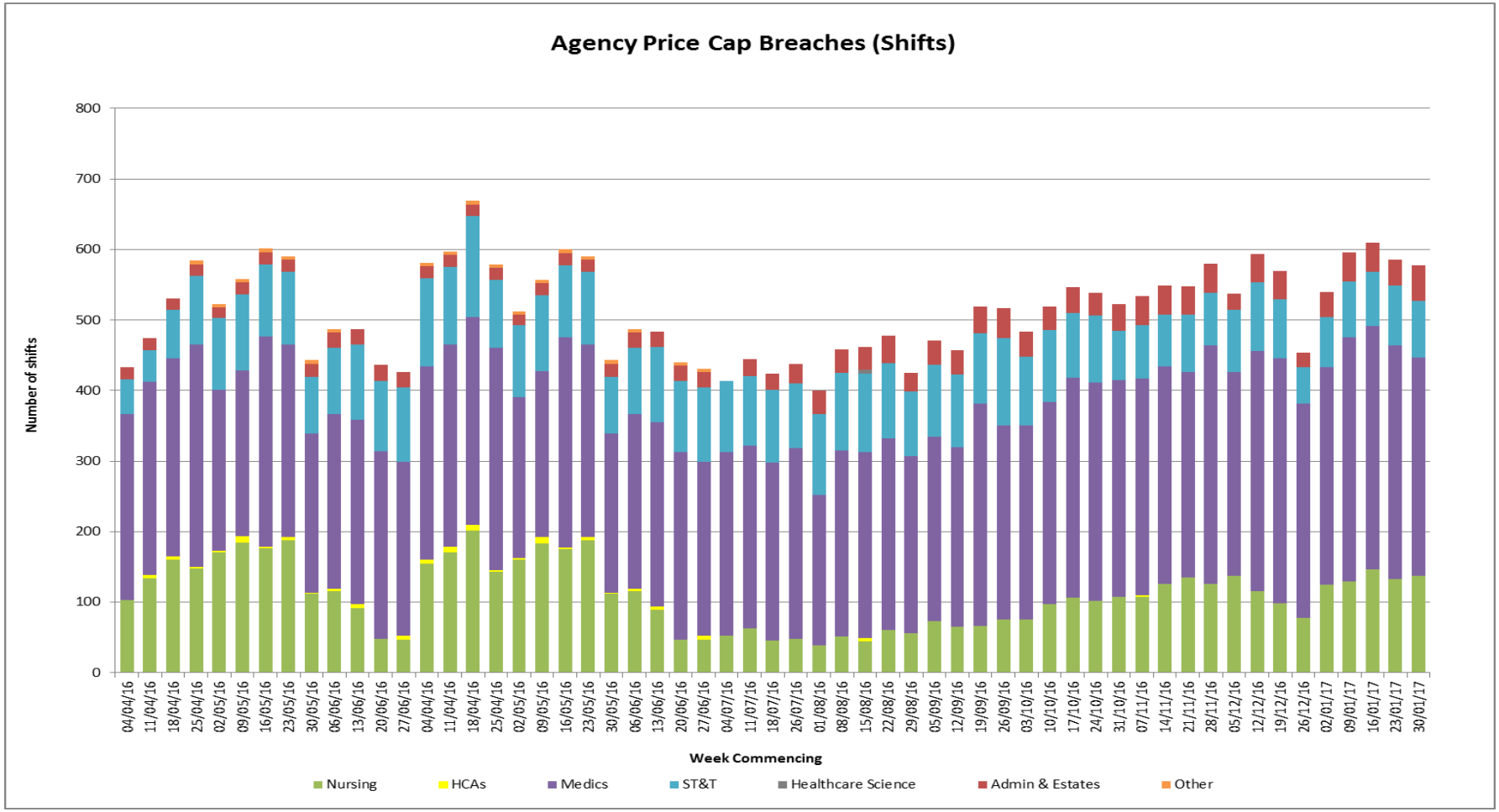
Percentages shows proportion of agency spend against total spend.





Agency Cap Breaches

Worcestershire NHS
Acute Hospitals NHS Trust



NHS Improvement agency performance is measured against price caps, framework breaches and wage caps. The chart above includes price cap performance only.

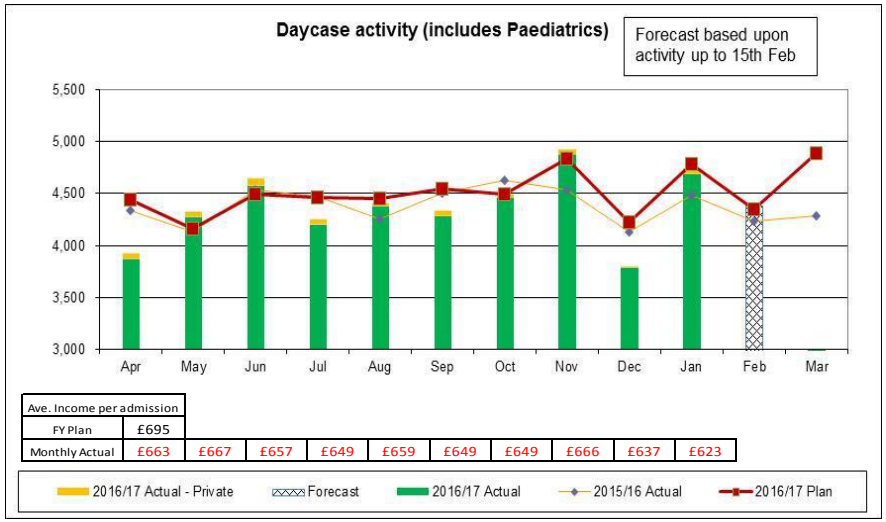
Activity

Worcestershire NHS
Acute Hospitals NHS Trust

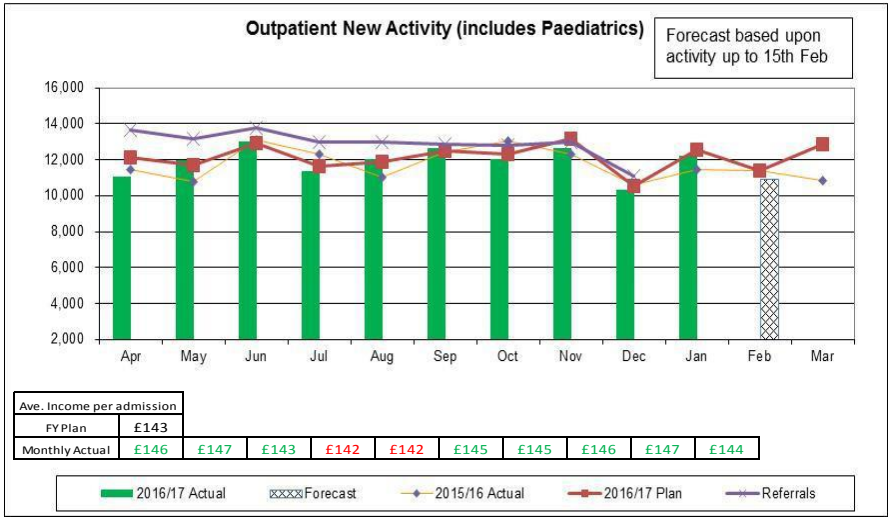
	In Month				YTD				Full Year				
	Plan	Actual	Var	%	Plan	Actual	Var	%	Initial Plan	Current Plan	Forecast	Var	%
Elective	710	572	(138)	(19%)	8,165	7,151	(1,014)	(12%)	9,679	9,679	8,596	(1,083)	(11%)
Daycase	4,752	4,664	(88)	(2%)	44,596	43,426	(1,170)	(3%)	64,901	53,771	52,691	(1,080)	(2%)
Non Elective - Emerg	3,474	3,444	(30)	(1%)	35,457	34,567	(890)	(3%)	42,403	42,403	41,388	(1,016)	(2%)
Non Elective - Other	46	22	(24)	(52%)	483	492	9	2%	575	575	621	46	8%
Total Inpatients	**8,983**	**8,702**	**(281)**	**(3%)**	**88,701**	**85,636**	**(3,065)**	**(3%)**	**117,559**	**106,429**	**103,296**	**(3,133)**	**(3%)**
Outpatients New	11,936	11,639	(297)	(2%)	115,623	112,871	(2,752)	(2%)	138,738	138,738	135,624	(3,114)	(2%)
Outpatients F Up	21,221	20,478	(743)	(4%)	202,696	199,160	(3,536)	(2%)	243,400	243,400	240,645	(2,756)	(1%)
Outpatients Procedure	4,290	4,079	(211)	(5%)	40,667	40,151	(516)	(1%)	48,800	48,800	48,395	(405)	(1%)
Total Outpatients	**37,447**	**36,196**	**(1,251)**	**(3%)**	**358,986**	**352,182**	**(6,804)**	**(2%)**	**430,939**	**430,939**	**424,663**	**(6,275)**	**(1%)**
ED Attendances	12,277	11,401	(876)	(7%)	127,314	125,491	(1,823)	(1%)	152,768	152,768	152,120	(648)	(%)
Community MIU	2,936	2,681	(255)	(9%)	30,451	31,919	1,468	5%	36,539	36,539	38,984	2,445	7%
Total ED/MIU	**15,214**	**14,082**	**(1,132)**	**(7%)**	**157,765**	**157,410**	**(355)**	**(%)**	**189,307**	**189,307**	**191,104**	**1,797**	**1%**
Maternity - Delivery	470	491	21	5%	4,963	4,643	(320)	(6%)	5,845	5,845	5,415	(430)	(7%)
Maternity - Non Delivery	191	178	(13)	(7%)	1,948	1,741	(207)	(11%)	2,312	2,312	2,069	(243)	(11%)
Maternity - Outpatient	3,780	3,982	202	5%	36,492	38,065	1,573	4%	44,112	44,112	45,051	939	2%
Maternity Ante Natal	506	516	10	2%	5,053	4,897	(156)	(3%)	5,989	5,989	5,772	(217)	(4%)
Maternity Post Natal	487	413	(74)	(15%)	4,913	4,307	(606)	(12%)	5,802	5,802	5,105	(697)	(12%)
Total Maternity	**5,433**	**5,580**	**147**	**3%**	**53,369**	**53,653**	**284**	**1%**	**64,061**	**64,061**	**63,411**	**(649)**	**(1%)**
Paed - Daycase/Elective	37	28	(9)	(25%)	327	340	13	4%	415	415	419	4	1%
Paed - Non Elective	614	584	(30)	(5%)	5,966	5,707	(259)	(4%)	7,220	7,220	6,906	(314)	(4%)
Paed - Outpatient	1,425	1,462	37	3%	13,313	13,785	472	4%	16,080	16,080	16,682	602	4%
Paed - BPT, Drugs, CQUIN	18	0	(18)	(100%)	184	0	(184)	(100%)	270	221	0	(221)	(100%)
Paed - Neonatal Cot Days	736	718	(18)	(3%)	7,365	6,411	(954)	(13%)	8,816	8,838	7,590	(1,247)	(14%)
Total Paediatrics	**2,831**	**2,792**	**(39)**	**(1%)**	**27,156**	**26,243**	**(913)**	**(3%)**	**32,801**	**32,774**	**31,597**	**(1,177)**	**(4%)**
Chemotherapy Delivery	**1,092**	**1,014**	**(78)**	**(7%)**	**9,380**	**9,827**	**447**	**5%**	**11,130**	**11,130**	**11,882**	**752**	**7%**
Drugs PBR Excluded	0	0											
Critical Care ITU/HDU	806	888	82	10%	8,061	7,800	(260)	(3%)	9,673	9,673	9,216	(457)	(5%)
Other Contract Income	0	0											
Total Other Contract Income	**806**	**888**	**82**	**10%**	**8,061**	**7,800**	**(260)**	**(3%)**	**9,673**	**9,673**	**9,216**	**(457)**	**(5%)**
Non Contract Income													
Phasing Adj													

Elective, Day Cases & Outpatients New

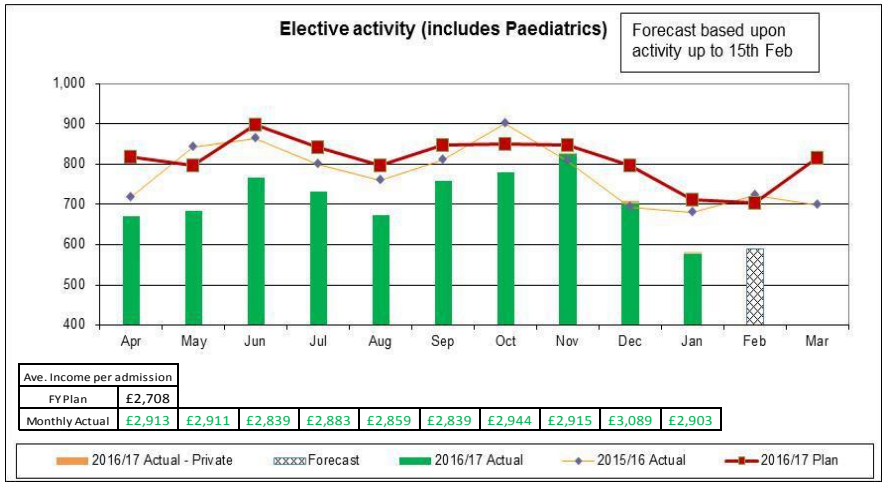
Worcestershire NHS
Acute Hospitals NHS Trust



Ave. Income per admission										
FY Plan	£695									
Monthly Actual	£663	£667	£657	£649	£659	£649	£649	£666	£637	£623



Ave. Income per admission										
FY Plan	£143									
Monthly Actual	£146	£147	£143	£142	£142	£145	£145	£146	£147	£144



Ave. Income per admission										
FY Plan	£2,708									
Monthly Actual	£2,913	£2,911	£2,839	£2,883	£2,859	£2,839	£2,944	£2,915	£3,089	£2,903

Activity performed within Trust and sent Private				
	Daycase		Elective IP	
	Trust	Private	Trust	Private
Apr	3,876	50	670	0
May	4,275	50	682	0
Jun	4,576	71	768	0
Jul	4,209	48	737	0
Aug	4,384	31	670	0
Sep	4,284	52	759	0
Oct	4,460	35	779	0
Nov	4,881	54	823	3
Dec	3,786	18	703	5
Jan	4,689	58	578	2
Feb	0	0	0	0
Mar	0	0	0	0
YTD	43420	467	7169	10

Outsourcing Plan

The Trust has agreed to outsource activity in a few specific areas where there are exceptional capacity pressures. This is on the basis that rates are at or below tariff.

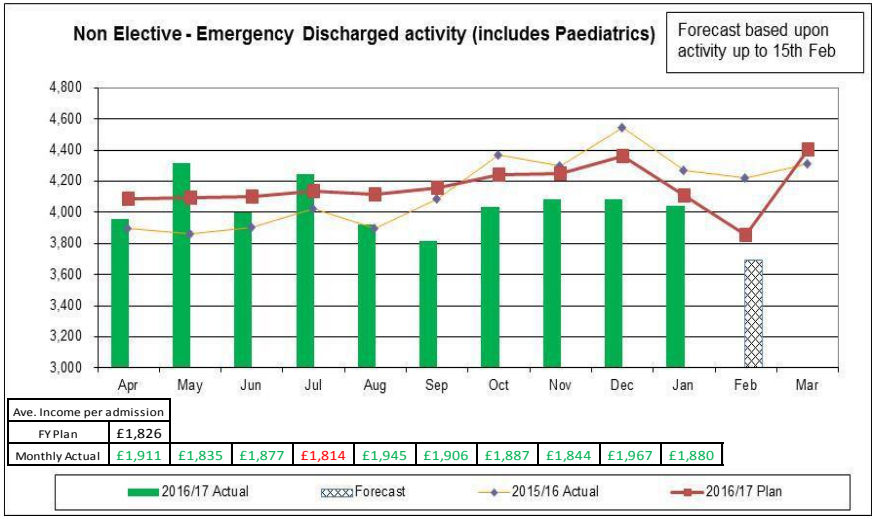
Agreed areas are:

- Dermatology (via third party subcontractor)
- Endoscopy
- Radical Prostatectomies
- T&O – maximum of 27 cases pm as agreed with CCGs
- General Surgery – maximum of 20 cases pm
- In December Gastro and General Surgery underutilised their endoscopy capacity.

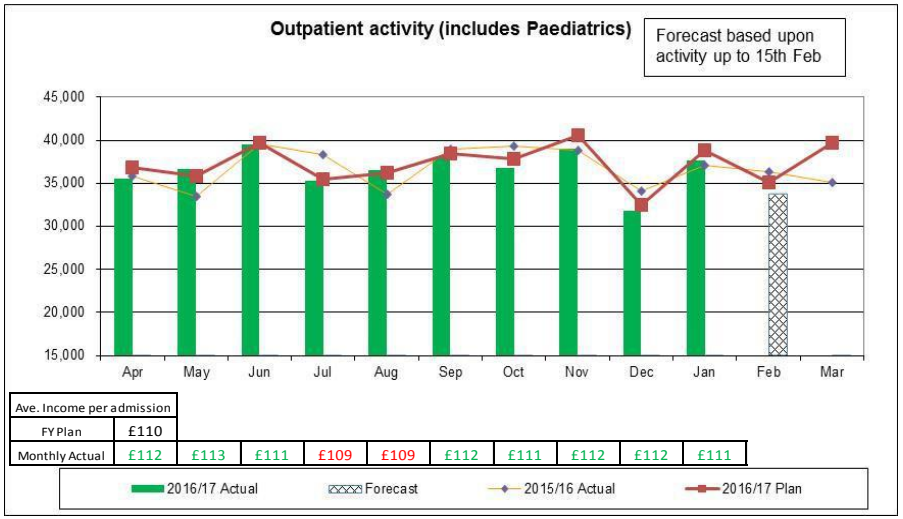
To date we have not utilised all of the potential outsourced capacity.

Outpatients, Non Elective and A&E

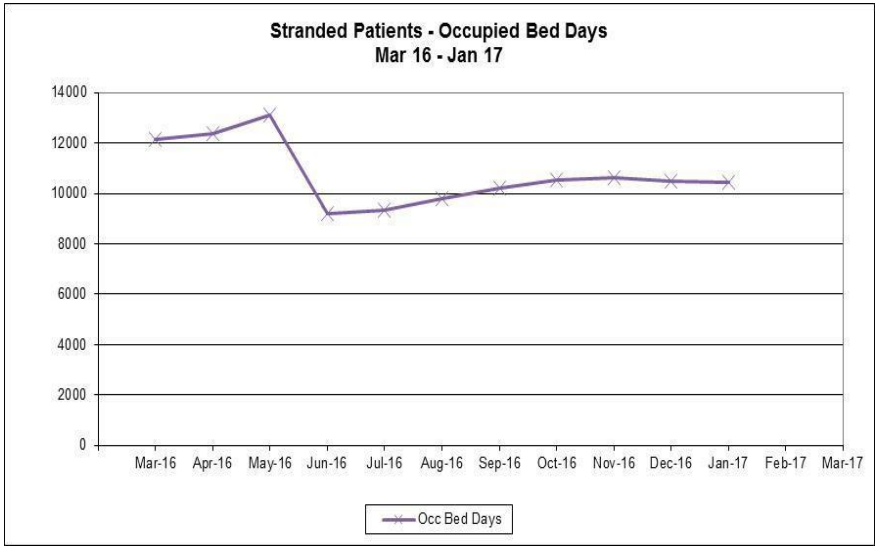
Worcestershire NHS
Acute Hospitals NHS Trust

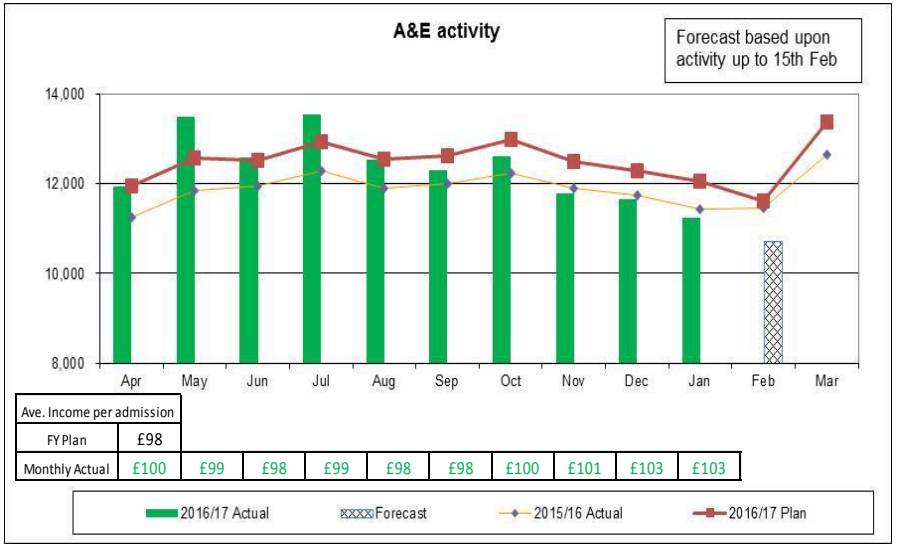


Ave. Income per admission										
FY Plan	£1,826									
Monthly Actual	£1,911	£1,835	£1,877	£1,814	£1,945	£1,906	£1,887	£1,844	£1,967	£1,880



Ave. Income per admission										
FY Plan	£110									
Monthly Actual	£112	£113	£111	£109	£109	£112	£111	£112	£112	£111





Ave. Income per admission										
FY Plan	£98									
Monthly Actual	£100	£99	£98	£99	£98	£98	£100	£101	£103	£103

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

Balance Sheet

Worcestershire NHS
Acute Hospitals NHS Trust

				Full Year			
Balance as at 31 December 2016	Balance as at 31 January 2017	Movement in Month	Balance Sheet	Annual Plan	Forecast 31st March 2017	Variance from Plan	Balance at 31st March 2016
£000s	£000s	£000s	**ASSETS, NON CURRENT**	£000s	£000s	£000s	£000s
249,669	249,578	(91)	Property, Plant and Equipment and intangible assets, Net	270,605	252,796	(17,809)	250,590
3,325	3,647	321	Other Assets, Non-Current	3,238	2,852	(386)	1,669
252,994	**253,224**	**230**	**Assets, Non-Current, Total**	**273,843**	**255,648**	**(18,195)**	**252,259**
			ASSETS, CURRENT				
5,876	6,685	810	Inventories	5,800	5,895	95	7,081
16,928	16,867	(61)	Debtors	15,121	16,555	1,434	25,823
8,066	5,676	(2,389)	Cash and Cash Equivalents	1,900	1,900	(0)	1,474
30,870	**29,229**	**(1,641)**	**Assets, Current, Total**	**22,821**	**24,350**	**1,529**	**34,378**
283,864	**282,453**	**(1,411)**	**ASSETS, TOTAL**	**296,664**	**279,999**	**(16,665)**	**286,637**
			LIABILITIES, CURRENT				
1,936	**1,936**	0	PFI leases, Current	1,936	**1,941**	5	1,936
40,859	**40,746**	(113)	Creditors < 1 Year	38,367	**32,753**	(5,614)	48,270
42,795	**42,682**	**(113)**	**Liabilities, Current, Total**	**40,303**	**34,694**	**(5,609)**	**50,206**
(11,926)	**(13,454)**	**(1,528)**	**Net Current Assets/(Liabilities)**	**(17,482)**	**(10,344)**	**7,138**	**(15,828)**
			LIABILITIES, NON CURRENT				
130,277	134,058	3,781	Creditors > 1 Year	153,031	137,747	(15,284)	95,757
70,603	70,442	(161)	PFI leases, Non-Current	70,058	70,114	56	72,055
0	0	0	Other Liabilities, Non-Current	0	0	0	0
200,880	**204,499**	**3,620**	**Liabilities, Non-Current, Total**	**223,089**	**207,861**	**(15,228)**	**167,812**
40,188	**35,271**	**(4,917)**	**TOTAL ASSETS EMPLOYED**	**33,272**	**37,443**	**4,171**	**68,619**
£000s	£000s		**FINANCED BY :- PUBLIC EQUITY**	£000s	£000s	£000s	£000s
184,564	184,564	0	Public Dividend Capital	184,564	188,042	3,478	184,564
54,320	54,320	0	Revaluation reserve	54,320	54,320	0	54,320
(861)	(861)	0	Other reserves	(861)	(861)	0	(861)
(197,835)	(202,752)	(4,917)	I&E Reserve	(204,751)	(204,058)	693	(169,404)
40,188	**35,271**	**(4,917)**	**TOTAL PUBLIC EQUITY**	**33,272**	**37,443**	**4,171**	**68,619**

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc E3**

Report to Trust Board

Title	**Nursing and Midwifery Workforce Report**
Sponsoring Director	**Jan Stevens, Chief Nursing Officer**
Author	**Sarah Needham, Lead for Education and Workforce**
Action Required	The Trust Board is requested to note the following: • Building a flexible and permanent nursing workforce against a backdrop of national nursing shortages remains a challenge. • The Trust is strengthening its approach to recruitment and retention. • Controls are in place to manage the risks associated with nursing vacancies.
Previously considered by	

Priorities (√)

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

Related Board Assurance Framework Entries	2678 - If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels
Legal Implications or Regulatory requirements	Required to undertake monthly staffing levels reviews Required to undertake 6 monthly acuity and dependency reviews of ward/ unit areas.
Glossary	WTE – whole time equivalent DDN – Divisional Directors of Nursing

Date of meeting: 1 March 2017 **Enc E3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 1 March 2017

1. Situation

This paper provides an update on the Nursing and Midwifery Workforce Action group, including the key risks and mitigation plans in the following areas:

- Adult inpatient ward nursing workforce acuity/dependency review
- Trust position on nursing recruitment.
- Compliance information on safer staffing levels at ward and site level.

2. Background

In November 2013 The National Quality Board published '*A guide to support providers and commissioners in making the right decisions about nursing, midwifery and care staffing capacity and capability'.* Subsequently in July 2014 NICE published recommendations on safe staffing for adult-inpatient wards.

Reviewing the nursing workforce requires a multifactorial approach to determine the most appropriate skill mix. The review utilised the Safer Nursing Care Tool (SNCT) which is an evidenced based national tool. The tool triangulates data in the following domains:

- Professional judgement
- NICHE guidelines
- Quality Metrics -Nurse sensitive indicators i.e. falls, pressure ulcers, infections, complaints etc.

The nursing workforce review in October 2016 has primarily focused on all adult inpatient wards and excludes maternity, children's wards and Emergency / Outpatient departments and Intensive Care units.

3. Assessment

We are strengthening existing work streams to assure improved focus, pace and grip. This includes:

- Proactive recruitment continues across the Trust, initiatives include;
  - Return to practice awareness in partnership with Worcester University
  - Quarterly job fairs at the Trust
  - Internal transfer process for all internal staff
  - Proactive recruitment of Student nurses and offering their final placements in the areas where they have been appointed at job.
  - New mentorship model pilot programme to increase our nursing student capacity.
  - New task and finish group focusing on improving our strategic approach to nurse recruitment.

Implementation of new roles;

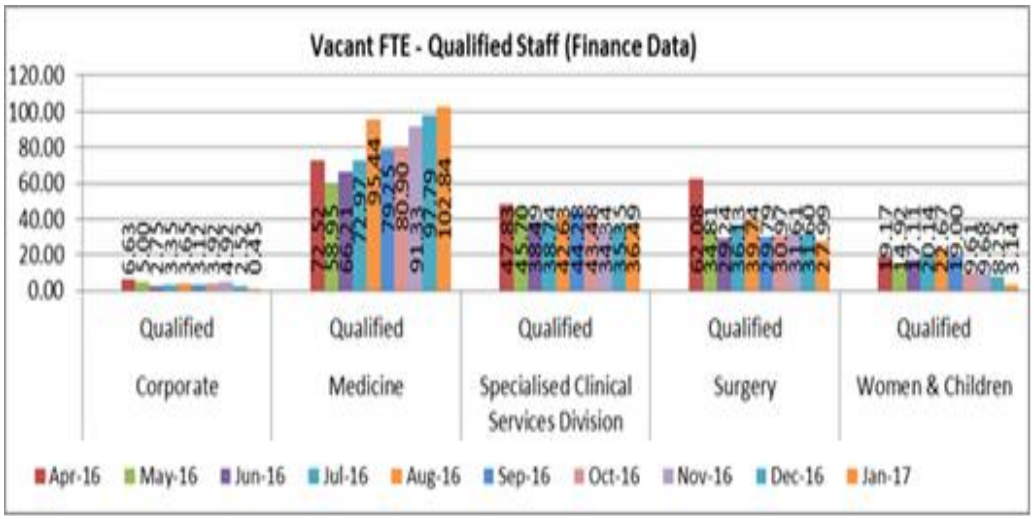
- Ward Administrator

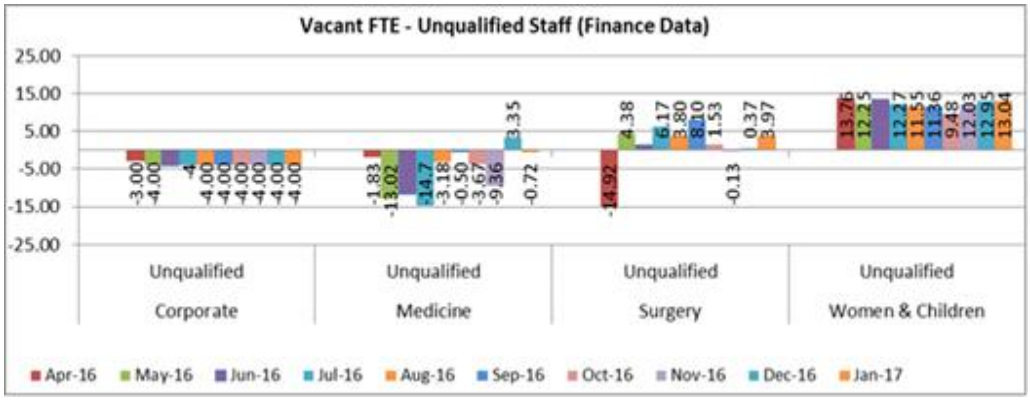
- Ward house keeper
- Midwifery Consultant
- Development and commencement of staff on Band 4 Nursing Associate training
- Advanced Nurse Practitioner training for Endoscopy
- Development of a bridging programme in partnership with Worcester University for our staff seconded to complete a foundation degree in health and social care. This will enable them to practice as a 'Clinical Associate- band 4' in October 2017. They will then complete a formal bridging programme designed by HEE in 2 years' time when it is released.

The Nursing workforce review has taken place utilising the Shelford group tool, quality metrics and professional judgement between October and December 2016.

- Acuity and dependency assessment has been completed on all adult inpatient wards
- Triangulation on acuity with professional judgement and quality metrics has been completed.
- Meetings between Divisional Directors of Nursing (DDN) and finance completed.
- Analysis and presentation of results to CNO to take place in February 2017 with DDN's and Finance for confirm and challenge session.
- Ward workforce establishment to be signed off by the Board in March 2017.

4 Recruitment





5 **Overall Summary**

The current total number of qualified nurse vacancies in the Trust is 170.46 WTE compared to December 2016 board report which reported 200.45 WTE.

The total number of unqualified staff vacancies is 17.01 compared to 48.48 WTE reported in December 2016.

The improvements in our figures are due to a number of divisional recruitment events along with Trustwide events which took place in;

Date	Recruitment event	New Recruit Numbers
16th January 2017	HCA values based recruitment	12 HCA recruited
21st January 2017	Quarterly Trust Recruitment Event	14 HCA's, 13 trained

Hot spot areas for vacancies are:

- MAU, Alex
- Beech B, WRH
- Ward 12, Alex

To manage the risk posed by nurse vacancies the following controls are in place:

- Agency/bank use overseen by Divisional Directors of Nursing (DDN)
- Active recruitment
- New roles being introduced.
- Monitoring fill rates.
- Daily review of staffing by Matrons and Divisional Directors of Nursing
- Moving staff to support staffing gaps.

We are further strengthening controls by:

- Regular scrutiny of use of e-roster at ward level.
- Strengthening accountability and responsibility through new performance metrics. A new electronic tool to provide instant assurance

re staffing levels is to be launched at the end of February 2017.
- Increasing NHSP pay rates to top of band for 2,5,6. This has increased fill rates in the first 3 weeks since the launch by 10%.
- Incentive initiatives launched to increase the fill rates until the end of February.
- Rebranding of Trust Bank has taken place. It is now called; Worcestershire Acute Hospitals Nurse bank launched in partnership with NHS Professionals

6 Safer staffing fill rates

The Board is required to receive information on fill rates per ward and information is also provided per site for the Trust (see appendix 1).

- Areas below the 80% (national expected fill rate) are highlighted in red.
- Impact on the quality and safety of these areas is scrutinised by the DDNs and Matrons.
- If fill rates are reported as over 100% this is because unqualified staff are utilised to support and backfill trained staff vacancies.
- Reviews of staffing takes place three times per day and staff are mobilised from areas with higher staffing levels into areas which require support. A new electronic system to monitor staffing levels in real time on the wards will go live at the end of February 2017

7 Recommendation

The Trust Board is requested to note the following:

- Building a flexible and permanent nursing workforce against a backdrop of national nursing shortages remains a challenge.
- The Trust is strengthening its approach to recruitment and retention.
- Controls are in place to manage the risks associated with nursing vacancies.
- Consideration to lengthen the Incentive initiatives which is due to end this Month for a further 2 months.

Jan Stevens
Interim Chief Nurse

Ward name	Day		Night	
	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
Acute Stroke Unit	94.8%	107.2%	101.4%	114.3%
Avon 2- Gastro	103.9%	92.1%	116.1%	127.1%
Avon 3- Infectious Diseases	94.0%	100.5%	113.5%	145.7%
Avon 4	101.7%	117.2%	98.3%	126.9%
Laurel 1 Cardiology-CCU	97.3%	91.7%	99.2%	106.2%
Laurel 2 Resp	97.7%	86.0%	98.1%	102.5%
Medical Assessment Unit WRH	109.5%	95.6%	88.7%	87.1%
Medical High Care and Short Stay	97.4%	105.3%	100.6%	100.0%
Silver Assessment Unit	107.1%	98.1%	80.3%	86.3%
GP Unit WF - ward (TCS)	85.6%	87.8%	99.8%	99.5%
MAU ALX	87.3%	103.5%	103.0%	99.2%
Ward 12 Medicine	110.5%	110.4%	106.6%	94.5%
Ward 2 Specialist Med	84.8%	91.0%	120.7%	103.2%
Ward 5 - Medicine AHD	120.6%	130.8%	104.8%	100.4%
Ward 6	94.7%	95.8%	94.3%	100.9%
CCU- Alex	87.4%	-	100.0%	-
Ward 9	106.7%	98.7%	101.6%	101.4%
Ward 10	107.6%	98.9%	101.4%	100.1%
Ward 11	92.6%	124.2%	128.5%	75.9%
Ward 16	98.9%	116.3%	101.1%	77.4%
Ward 17	104.7%	147.6%	109.4%	93.5%
Ward 18	95.3%	108.7%	77.8%	118.1%
SCDU & SHDU	109.2%	79.9%	100.0%	90.7%
Beech A	106.6%	112.4%	102.5%	102.7%
Beech B	93.2%	119.1%	100.9%	74.6%
Chestnut	87.6%	104.4%	101.3%	101.0%
Trauma & Orthopaedics	97.0%	103.9%	99.4%	104.0%
Severn Unit & HDU	113.7%	67.3%	100.8%	88.2%
WRH Delivery Suite & Theatre	83.4%	107.1%	92.8%	82.3%
WRH Maternity Triage	106.9%	100.0%	100.0%	100.0%
WRH Meadow Birth Centre	100.0%	100.0%	100.0%	100.0%
WRH Postnatal Ward	89.7%	95.0%	89.5%	67.7%
WRH Riverbank	84.1%	91.0%	92.2%	87.1%
Alex Ward 1	100.2%	77.4%	106.4%	90.1%
WRH Gynaecology - Chestnut Ward	90.3%	93.5%	93.5%	93.5%
Alexandra Neonatal	-	-	-	-
WRH Neonatal	96.4%	87.1%	96.0%	90.3%
WRH TCU Nursery Nurses	67.7%	103.2%	54.8%	96.8%
WRH TCU Midwives	100.0%	-	100.0%	-
WRH Antenatal Ward	94.2%	899.2%	87.1%	96.8%
ITU ALEX	100.0%	100.0%	100.0%	-
ITU WRH	100.0%	100.0%	100.0%	-
WARD 1 KTC	100.0%	100.0%	100.0%	-
Laurel 3, WRH	100.0%	100.0%	98.4%	122.8%

Title of report	Nursing and Midwifery Workforce Report
Name of director	Jan Stevens

Date of meeting: 1 March 2017 **Enc E3**

Appendix 1

Ward 11-75.9 % fill rate for HCA but 128.57 % fill rate for trained.

Ward 16 – 77.4% fill rate for HCA but 101.1% fill rate for trained.

Ward 18 – 77.8% fill rate for qualified but 118.1 % for HCA.

Beech B 74.6 % for HCA but 100.9% trained.

Postnatal was 67.7% HCA however, low numbers utilised in this area which reduces the %.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc E4**

Report to Trust Board

Title	Medical Revalidation Quarterly Report and Update – February 2017
Sponsoring Director	Dr Andrew Short, Interim Chief Medical Officer and 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 (√)

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

Related Board Assurance Framework Entries	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels.
Legal Implications or Regulatory requirements	Statutory requirement to appoint a Responsible Officer. Statutory requirement for 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: 1 March 2017 **Enc E4**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 1 MARCH 2017

1. Situation

This report describes the progress and management of medical appraisal and revalidation since the report presented to the Board in February 2016.

2. Background

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

3. Assessment

3.1 Medical appraisal and revalidation performance

As at 31st January 2017, there were 368 doctors with a prescribed connection to the Worcestershire Acute NHS Trust. 298 doctors have been revalidated as at 3rd 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. Two doctors have been referred to the GMC for non-engagement.

The appraisal rate for all medical staff is 82.07%, below the Trust board target although slight increase since the last report. 53 planned appraisals have not taken place as at 31 January 2017. This figure is still high. The Women and Children's recorded a significant improvement in performance. All other divisions have recorded figures below the 85% Trust Board target in January. Medicine Division has recorded the most significant decrease in appraisal rates. Reasons for non-completion has been requested from all divisions.

Division	Appraisal rate at 31/01/17	Direction of travel since 31/01/17	Number of missed appraisals at 31/01/17
Medicine	76.56%	↓7.84% from 83.08%	12
Surgery	81.82%	↓64% from 82.35%	14
SCSD	82.50%	↓1.27% from 83.56%	22
Women & Children	91.43%	↑19.8% from 76.32%	5

The consultant appraisal rate has increased to 84.96% which is close to the Trust board tolerance of 85%. The SAS rate of appraisal has recorded a significant decrease 69.84% from 80%. See paragraph 3.5 for corrective actions.

3.2 **NHS England Regional RO Network**

The next Regional RO network meeting has been scheduled for 28th March 2017.

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

The NHS England quarterly appraisal status report (Q3 - 1 October 16 to 31 December 2016) was returned on the 11th February. Q1 and Q2 reports previously returned reported similar non-compliance.

3.4 **Outcome Report from NHS England - Independent Review Visit**

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.

Audit data highlighted that the Trust had a high proportion of unapproved missed appraisals (112/32.7%) together with the low rate of completed appraisals within year. Additionally of the 67.3% (249) completed appraisals only half of these (32.2%) (119) were completed within the agreed timeframe. The AOA return also stated that no explanation was recorded for missed/incomplete appraisals.

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 are captured a detailed action plan which is available on request..
- All missed appraisals will form part of the priority list to be allocated centrally with cross specialty appraisals considered.

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.

Andrew Short
Acting CMO

Worcestershire NHS
Acute Hospitals NHS Trust

1 March 2017 **Enclosure F1**

Report to Public Trust Board

Title	Integrated Performance Report (Month 10)
Sponsoring Director	Jill Robinson, Director of Finance
Author	Rebecca Brown, Assistant Director of Information and Performance
Action Required	The Board is asked to: 1. Review the Integrated Performance Report for Month 10. 2. Seek assurance as to whether: a) The risks of under-performance in each area have been suitably mitigated, and; b) plans are in place to improve performance.
Previously considered by	*n/a*

Priorities (√)

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

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 3291 Deficit is worse than planned and threatens the Trust's long term financial sustainability 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience
Legal Implications or Regulatory requirements	Section 92 of the Care Act 2014 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

Title of report	Integrated Performance Report – Month 10 2016/17
Name of director	Jill Robinson

Key Messages:

The Trust continues to face ongoing performance challenges against the majority of the operational targets and standards that relate to both good patient access and the STF.

Performance against the 4 hour emergency access standard (EAS) remains challenging, and flow related pressure continued in January. Increased operational controls are in place to create flow and to release designated assessment area spaces to ensure that patients that are admitted in a timely way to the right bed first time.

Performance in respect of the 18 week referral to treatment target remains a concern, and there was planned under performance in the Cancer 62 day standard in January.

The Trust is dealing with a Section 29A warning notice from the CQC which states that the trust's governance system in relation to the management of risk is not operating effectively to give clear Board level oversight of quality and safety risks.

Title of report	Integrated Performance Report – Month 10 2016/17
Name of director	Jill Robinson

Worcestershire NHS
Acute Hospitals NHS Trust

1 March 2017 **Enclosure F1**

REPORT TO FINANCE AND PERFORMANCE COMMITTEE

1. Situation and Background

This paper presents an overview of performance for January 2017 (Month 10). 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.

Divisional Performance Reviews take place on a monthly basis and are currently being strengthened to improve management of risk and assurance and escalation to the relevant Committee.

For comprehensive data on January performance, please refer to the Trust dashboard.

2. Assessment

2.1 Urgent Care and flow

2.1.1 EAS performance has not met the national target for more than 2 years and when compared to our peer Trusts, has been ranked no higher than 20th out of 28 for 2016/17. The December Trust performance was the lowest for more than 2 years. Figures have fluctuated towards slight improvement in January, with mid-month February figures maintaining this level of performance.

2.1.2 *Table showing 4 hour wait performance January 2016 – January 2017*

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
4 Hour Waits (%) - Trust inc. MIU	84.30%	82.40%	82.30%	84.40%	82.20%	84.70%	85.70%	83.70%	82.80%	80.90%	78.90%	74.10%	76.80%

2.1.3 The STF trajectories for the EAS have not been met for any month of the year, including January. The Trust forecasts that we will not meet the EAS STF trajectory for the remainder of the financial year.

2.1.4 The Time to initial assessment, 95th percentile tolerance is set at 15 minutes or below. The 95th percentile for time to initial assessment for **all** patients was 35 minutes in January. The performance for patients arriving by ambulance was 45 minutes (A&E only). This performance has remained consistently concerning over the past year. The Finance and Performance Committee should be mindful that the Trust is still reporting weekly figures to the CQC on TTIA, following the March 2015 CQC Improvement Notice.

2.1.5 There were 167 12 hour (trolley) breaches in January, and although there have been breaches in February to date, it is likely that there will be far fewer in February. This is of great concern to the Trust and A&E Delivery Board. Initial Case Reviews and Harm Reviews are taking place on all trolley breaches in accordance with internal procedures.

Title of report	Integrated Performance Report – Month 10 2016/17
Name of director	Jill Robinson

2.1.6 Extended ambulance handover times continue to be an issue for the Trust. There were 141 ambulance handovers of over 60 minutes in January 2017, compared to January 2016 when there were 29 handovers of over 60 minutes.

2.1.7 Bed occupancy (funded at midnight) remains high at 100% and 95% on the Worcestershire Royal and Alexandra Hospital sites respectively.

2.1.8 Oversight of urgent care and flow issues is gained at multiagency level in the A&E Delivery Board, and supported by the A&E Delivery Board Operational Group. Partners include the Acute Trust, Health and Care Trust, West Midlands Ambulance Service and the County Council. A multiagency plan is in place to improve urgent care performance and flow, in line with national requirements. The Trust is working on the following workstreams which form part of the A&E Delivery Board Plan:

- Urgent Care Connect
- Front door streaming / Triage
- Review of MAU
- Review of SCDU
- Review of EPAU and GAU (capacity and SOP)

2.1.9 There are also internal programmes of work that have been identified to support flow throughout the organisation. Whilst this work is either embedding or being delivered, patient safety is ensured through undertaking harm reviews on three groups of patients: longest waiters in the department, patients that have been in the department over 12 hours from their decision to admit time and for patients that wait more that 30mins for their initial assessment.

The identified internal priorities include:

- Streaming at Front Door
- Trolleys /Chairs MAU for assessment to expand AEC
- Hot Clinics
- Acute frailty and OPAL
- Red / Green SAFER Bundle
- GP Consultant advice line
- Stroke Pathway
- Prepare and recovery from surge

2.1.10 Preliminary recovery trajectories for 17/18 have been submitted as part of the Operational Plan. These are currently being rigorously tested against the proposed improvement actions. A strong link to the outcome of corrective actions is being sought in order to assure that any trajectories put in place are deliverable.

2.2 Referral to Treatment

2.2.1 Since February 2016 the Trust has seen a month on month decline in performance. The finalised performance for January 2017 has not been finalised at the time of writing, but is anticipated to hold or slightly reverse this negative trend.

2.2.2 *Table showing incomplete RTT performance January 2016 – January 2017 (indicative)*

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
RTT - Incomplete 92% in 18 Weeks	92.04%	91.50%	89.20%	88.90%	88.80%	88.26%	87.80%	87.36%	86.79%	86.60%	85.03%	83.58%	83.56%

Note: January 2017 figure is not yet finalised

2.2.3 There has been a steady month on month increase in the over 18 week backlog from February 2016 onwards. The Trust is starting to experience a build-up of patients with waiting time over 52 weeks. It is anticipated that the Trust will be reporting eleven 52+ week waiters at the end of January 2017. Eight of these have been visible to the directorate teams and tracked through the PTL reports; three have been identified during the month end validation (two incorrect clock stops and one case of duplicate pathways). Root cause analysis is underway on all 52 week waiters in line with internal procedures.

2.2.4 The current STF recovery trajectory expects achievement of the RTT standard by the end of Quarter 4; however, it is now likely that we will not recover this trajectory in 2016/17. Updated forecasts were to achieve 82% at the end of March. Due the elective cancellations in December, which have continued into January, this forecast is also at risk. Trajectories for 2017/18 are being worked up, and will take account of the face that the implementation of actions to improve flow will have a positive impact on RTT improvement from April 2016 onwards.

2.2.5 RTT performance is managed through weekly operational meetings (at directorate level) and through Monthly Performance Meetings at Divisional level. Performance meetings are currently being reviewed for efficacy and rigour, under the Performance Improvement Implementation Plan.

2.2.6 Specialty level clinical service plans are in development with the completion date of 28th of February 2017. These will inform the recovery trajectories for 2017/18. In the short term the following actions have been put in place:

- Zero tolerance to 52+ week breaches and micromanagement of potential 52 week waiters. Deputy Chief Operating Officer is meeting with the relevant directorate managers weekly to scrutinise potential waiters on a patient by patient basis.
- A number of options to accelerate recovery in Rheumatology, Thoracic Medicine and Trauma and Orthopaedics have been submitted to the Executive Team and Trust Management Group.
- A plan is being developed to restart category 2 elective surgery on WRH site.

2.3 Diagnostics

2.3.1 Diagnostics performance (6 week standard) has been above the national tolerance for 2016/17 to date and continues to underperform. This is having an adverse impact on the RTT and cancer standards.

2.3.2 *Table showing Diagnostics 6 week wait percentage January 2016 – January 2017 (indicative)*

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
6 Week Wait Diagnostics (Proportion of waiting list)	1.05%	0.71%	3.52%	5.20%	5.90%	2.70%	2.03%	3.16%	2.36%	3.36%	2.75%	4.56%	3.97%

2.3.3 *Table showing Diagnostics 6 week wait number of patients January 2016 – January 2017 (indicative)*

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
6 Week Wait Diagnostics (Breached Patients)	92	65	337	505	613	255	174	257	201	276	229	367	345

Note: January 2017 figures are not yet finalised

2.3.4 The current underperformance against this standard is primarily driven by a capacity shortfall for endoscopic procedures - both the total waiting list and the proportion of patients waiting over 6 weeks have increased to an all-time high.

2.3.5 The anticipated January position is a slight improvement on December position overall mainly through driving internal efficiencies in Endoscopy and maximising the utilisation of existing sessions. There has been a slight deterioration in other diagnostic modalities mainly due to an increased inpatient demand on CT and the need to flex some outpatient activity to inpatient activity to support patient flow in Emergency Department. Any activity that could have been outsourced was sent out to external providers in line with departmental procedure.

2.3.6 Whilst there are further efficiency gains to be made linked to job planning and maximised utilisation of existing lists, there is insufficient base line capacity to deliver this standard in the short and medium term; equally there is no sufficient capacity in the independent sector to support delivery of this standard. A radical outsourcing plan has to be implemented to deal with the significant backlog numbers and to mitigate associated clinical risk whilst a long term service plan is in development. An outsourcing proposal was discussed in the January SCSD performance review, submitted to the Executive Team and was approved in principle subject to ratification by the Trust Management Team on 15th of February.

2.3.7 Based on current number of predicted month end breaches for Endoscopy and Radiology breaches the forecast for February 2017 is 3.04%

2.4 Cancer

2.4.1 In the last 12 months the performance for the 62 day cancer target of 85% has been met twice - in December 2015 and January 2016.

2.4.2 There has been additional reduction of long waiters in Urology and Colorectal Surgery resulting in planned underperformance against this standard in January 2017 with a return to 73-75% from February 2017 onwards. Out of the 140 patients that have currently waited over 62 days, 46 have a definitive diagnosis of cancer whilst 94 are suspected cancers where the diagnostic test or the results from diagnostics are still outstanding.

2.4.3 *Table showing Cancer 62 day wait performance January 2016 – January 2017 (indicative)*

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	86.30%	84.40%	75.30%	75.60%	79.30%	68.10%	67.20%	65.90%	73.10%	74.10%	75.40%	73.60%	51.90%

Note: January 2017 figures are not yet finalised

2.4.4 There has been a dip in performance against 2ww (all cancers) and 2ww breast symptomatic in January 2017 related to reduced capacity over Christmas period and increased incidences of patient choice. It is anticipated that the performance will improve in February 2017.

2.4.5 *Table showing Cancer 2 week wait performance for all cancers and breast symptomatic January 2016 – January 2017 (indicative)*

	2WW							
	All Cancer Two Week Wait (Suspected cancer)				Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)			
	Total	Breaches	Monthly	YTD	Total	Breaches	Monthly	YTD
Apr-16	1537	932	39.36%		171	112	34.50%	
May-16	1596	580	63.66%	51.74%	168	121	27.98%	31.27%
Jun-16	1622	500	69.17%	57.69%	192	85	55.73%	40.11%
Jul-16	1348	330	75.52%	61.63%	110	28	74.55%	46.02%
Aug-16	1470	501	65.92%	62.46%	227	109	51.98%	47.58%
Sep-16	1657	480	71.03%	64.00%	138	33	76.09%	51.49%
Oct-16	1448	199	86.26%	67.02%	137	9	93.43%	56.52%
Nov-16	1646	288	82.50%	69.08%	169	10	94.08%	61.36%
Dec-16	1368	132	90.35%	71.21%	135	6	95.56%	64.55%
Jan-17	1402	186	86.73%	72.65%	180	24	86.67%	66.99%
Feb-17	642	111	82.71%	73.06%	81	9	88.89%	68.03%
Mar-17								
Total	**15736**	**4239**	**73.06%**		**1708**	**546**	**68.03%**	

2.4.6 The Trust is working with the CCGs to roll out updated 2ww referral forms which will address some of the issues related to patient choice and reduce instances where the patient is not aware if the urgency of the referral.

Title of report	Integrated Performance Report – Month 10 2016/17
Name of director	Jill Robinson

2.5 Stroke

2.5.1 Prior to the commencement of 2016/17 the Trust was using local logic to report stroke data. Local procedures were reviewed in line with national guidance, and the reviewed nationally compliant logic has been used for 2016/17. The three core stroke metrics have been consistently under target for 2016/17. There continue to be issues with the timeliness and validation of the data.

2.5.2 Updated stroke data for December and January is not currently available. Data is currently being validated at patient level to ensure robust data quality in all metrics. This was discussed in the January Medicine divisional performance review. The Finance and Performance Committee will receive an update at the March meeting.

2.6 Quality and Safety

2.6.1 The Trust received a Section 29A warning notice from the CQC on 27th January 2017, requiring the Trust to show *'significant improvements… regarding the quality of healthcare by 10 March 2017'*. The notice provides examples which demonstrate that *'The board cannot rely on the processes in place or the information they are receiving in order to take assurance that risks are identified and actions taken to reduce the risks to patients'.* A team has been put in place to manage both the immediate response and link to the wider Trust Improvement Plan around the concerns raised.

2.6.2 The Trust has an HSMR for the 12 months to November 2016 of 106.5 which leaves the Trust no longer a statistical outlier. The SHIMI value for the rolling 12 months to October 2016 is 109.0 which makes the Trust statistically higher (worse) than expected. Completion rates of Primary Mortality Reviews continues to be of concern, especially in light of additional winter pressures on clinical time which impacts availability to complete the reviews. The Trust has embarked on a series of improvement programmes to address these issues and ensure continued surveillance. Actions to improve this are being defined and managed by the Mortality Review Group and reported through to Quality Governance Committee.

2.6.3 CDiff performance is measured through the year by compliance with a full year threshold. The threshold for the 12 months in 16/17 was 32 cases in total, and cumulative performance reached 32 in December, with a further 3 cases in January. The Chief Nurse reported to QGC in February that of the cases where a review has been completed, there have been only 5 red (reportable) lapses in case identified (against the annual trajectory). Key themes in these lapses continue to be around non-compliance in antimicrobial prescribing and non-completion of the D&V risk assessment tool. These areas are being addressed but he Corporate Infection Prevention team with wards.

2.6.4 We have been reviewing all our areas to ensure compliance with EMSA (Eliminating Mixed Sex Accommodation). The Chief Nurse invited the national Department of Health lead to advise the Trust, and it has become apparent that the current arrangements do not always provide separate facilities. The Trust is taking action, but in December declared 15 mixed sex accommodation breaches. January figures were reported as 0.

2.6.5 Performance in time to theatres for fractured NOF remains an issue, with performance not reaching target for the past year. This issue is being addressed by a specific sub-group of the Caring Safely Programme, and forecasts based on the planned actions for quarter 4 and 2017/18 are awaited. Actions were agreed in the January Surgery divisional performance review that harm reviews would be included in the next fractured NOF corrective action statement, and that an improvement trajectory and underpinning action plan would be completed.

It is recommended that QGC review 17/18 trajectories for fractured NOF, and provide assurance that the action plan in this area supports the delivery of the trajectory. This is due to happen in the March 2017 meeting.

2.6.6 The Board should note that all Quality and Safety issues are reported through for assurance to Quality Governance Committee.

3. Recommendation

3.1 It is again recommended that the Director of Finance reviews the long term forecasts for the key indicators as an integral part of 17/18 planning. It is acknowledged that continued patient flow pressures have held this work up in January.

The Board is asked to:

1. Review the Integrated Performance Report for January 2017.
2. Seek assurance as to whether:
   a) The risks of under performance in each area have been suitably mitigated, and
   b) plans are in place to improve performance.

Title of report	Integrated Performance Report – Month 10 2016/17
Name of director	Jill Robinson

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: January 2017

Patient Safety

Area	Indicator Type		Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Current YTD	Prev Year	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Incidents and Never Events	Local	QPS3.3	Incidents - SI's open > 60 days (Awaiting closure - WAHT)	8	9	4	7	6	4	1	4	4	1	2	4	1	-	-	0	-	>0	CMO	
	National	QPS4.1	Never Events	0	0	0	0	0	0	0	1	0	0	0	0	1	2	2	0	-	>0	CMO	
	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	6	2	0	3	1	1	1	1	2	2	1	3	1	16	26	<=1	-	>=2	CNO	
	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	0	0	2	1	0	2	1	2	3	2	0	7	2	20	12	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	1	0	-	>=1	CNO	
Mortality*	National	QPS9.1	Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge - rolling 12 months	112	110	109	110	110	110	111	110	108	109				-	-	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months*	104	107	106	107	107	109	110	109	108	109	107			-	-	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.21	% Primary Mortality Reviews completed			66%	61%	46%	54%	56%	58%	57%	58%	49%	44%				>=60		<60	DPS	
	National	QPS.9.22	% Secondary Mortality Reviews completed			0%	0%	0%	0%	0%	0%	17%	10%	10%	0%				>=20		<20	DPS	
Safety Thermometer	National	QPS10.1	Safety Thermometer - Harm Free Care Score	94.28%	94.82%	93.77%	90.97%	93.33%	92.86%	94.47%	93.10%	91.78%	91.51%	89.91%	91.79%	94.63%	-	-	>=95%	90% - 94%	<90%	CMO	
VTE	National	QPS11.1	VTE Risk Assessment	93.20%	93.86%	93.58%	95.64%	96.19%	95.43%	95.64%	93.80%	93.89%	92.84%	93.46%	93.40%	93.48%	94.37%	95.00%	>=95%	94% - 94.9%	<94%	CMO	
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	2	3	2	2	4	2	3	0	6	4	5	6	3	35	29	15/16 Threshold <= 33 16/17 Threshold < = 32			CNO	
	National	QPS12.4	MRSA Bacteremia - Hospital Attributable (Monthly)	0	1	0	0	0	0	0	0	0	0	1	1	0	2	1	0	-	>0	CNO	
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective	95.31%	98.61%	95.40%	94.50%	95.00%	95.40%	95.80%	95.90%	92.70%	97.10%	96.60%	93.80%	97.00%	95.40%	-	>=95	-	<95%	CNO	

Patient Experience

Area	Indicator Type		Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Current YTD	Prev Year	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Complaints & Compliments **	Local	QEX1.1	Complaints - Numbers (In Month)	63	57	64	59	58	65	57	70	57	60	68	60	58	612	629	-	-	-	CNO	
	Local	QEX1.3	Complaints - Number per 10,000 Bed Days (YTD)	20.02	20.32	20.74	25.23	24.70	27.41	26.82	31.31	25.86	25.62	25.98	25.70	25.42	25.42	20.74	-	-	-	CNO	
	Local	QEX1.14	Complaints - % of Category 2 complaints responded within complainant deadline (WAHT) - NEW	81.0%	61.0%	55.0%	63.0%	73.0%	68.0%	67.0%	65.0%	51.0%	46.0%	61.0%	70.0%	69.0%	62.0%	67.0%	>=90	80-90%	<79%	CNO	
Friends & Family****	National	QEX2.1	Friends & Family - A&E (Score)	72.4	61.6	63.2	70.2	57.4	63.8	74.7	82.1	64.1	66.8	69.1	77.5	69.0	69.0	70.8	>=71	67-<71	<67	CNO	
	National	QEX2.61	Friends & Family - Acute Wards (Score)	77.0	74.6	77.1	78.8	80.1	79.7	79.2	82.1	78.0	80.0	80.9	78.0	83.0	80.0	-	>=71	67-<71	<67	CNO	
	National	QEX2.7	Friends & Family - Maternity (Score)	86.7	78.2	76.1	84.2	87.6	87.6	83.2	86.0	85.8	79.0	83.0	81.4	87.1	84.0	84.2	>=71	67-<71	<67	CNO	
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	0	0	0	0	0	0	0	0	0	0	0	15	0	15	2	0	-	>0	CNO	

* Mortality data is extracted from HED this has a delay as it waits for validated HES/SUS data so is reported in arrears

** QEX metrics. From April 2016 these are reported as Complaints closed in month. 15/16 was reported as Complaints open in month. From April 2016 the definition for responding to complaints changed from 25 days to agreed with complianant.

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

Reporting Period: January 2017

Effectiveness of Care

Area	Indicator Type	Indicator		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Current YTD	Prev Year	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Hip Fracture***	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	59.0%	76.0%	63.1%	55.1%	65.9%	69.6%	47.7%	47.9%	53.4%	66.1%	61.4%	61.2%	63.7%	58.1%	66.0%	>=85%	-	<85%	CMO	
	Local	QEF3.1i	Hip Fracture - Time to Theatre <=36 hours (%) - WRH	55.0%	66.0%	48.0%	52.0%	68.0%	64.0%	40.0%	46.0%	40.0%	67.0%	50.0%	68.0%	59.0%	55.0%	65.8%	>=85%	-	>=85%	CMO	
	Local	QEF 3.1ii	Hip Fracture - Time to Theatre <=36 hours (%) - ALX	67.0%	84.0%	88.0%	60.0%	61.0%	86.0%	60.0%	52.0%	69.0%	66.0%	78.0%	48.0%	71.0%	63.0%	61.2%	>=85%	-	>=85%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Treatment Pts	68.0%	80.0%	75.9%	63.0%	79.0%	81.0%	65.0%	77.0%	63.0%	80.0%	67.0%	69.5%	78.7%	69.6%	75.9%	>=85%	-	<85%	CMO	
Risk Register Activity																								
Risks	Local	QR1.31	% Forward Plan completed is defined as 'audit completed and action plan produced')													13.0%			25%	10%-24%	<10%	CNO	
	Local	QR1.4	% of National Audits with an action plan													40.0%			>80%	50%-79%	<50%	CNO	
	Local	QR1.5	% of National Audits with on overdue actions													14.0%			<5%	5% - 20%	>20%	CNO	
	Local	QR1.6	% of Local Audits with an action plan													100.0%			>80%	50% - 79%	<50%	CNO	
	Local	QR1.7	% of Local Audits with no overdue action																<5%	5% - 20%	>20%	CNO	
	Local	QR1.8	% of NICE assessments outstanding at >8 weeks following publication (due at 12 weeks)																<20%	20% - 60%	>60%	CNO	
	Local	QR1.9	% Of nice assessments completed within 12 weeks following publication																>95%	20% - 94%	<20%	CNO	
	Local	QR1.10	% of non or partially compliant NICE guidance with an exception and/or risk report																>80%	30% - 79%	<30%	CNO	

*** The target for Fractured NoFs has changed to 85% from 90% - effective April 1st, 2016. The 2015/16 performance is RAG rated against 90%.

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Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: January 2017

Area	Indicator Type		Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Waits	National	PW1.1.3	6 Week Wait Diagnostics (Proportion of waiting list)	1.05%	0.71%	3.52%	5.20%	5.90%	2.70%	2.03%	3.16%	2.36%	3.36%	2.75%	4.56%	3.98%	3.66%	1.28%	National	<1%	-	>1%	COO	
	National	CW3.0	RTT - Incomplete 92% in 18 Weeks	92.04%	91.50%	89.20%	88.90%	88.80%	88.26%	87.80%	87.36%	86.79%	86.60%	85.00%	83.58%	83.90%	83.90%	89.20%	National	>=92%	-	<92%	COO	
Theatres	Local	PT2.1	Booking Efficiency - ALX	71.00%	77.00%	75.00%	74.00%	69.00%	75.00%	67.00%	74.00%	72.00%	71.00%	72.00%	75.00%	71.00%		-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT2.2	Booking Efficiency - WRH	82.00%	77.00%	85.00%	86.00%	80.00%	83.00%	87.00%	81.00%	81.00%	87.00%	87.00%	75.00%	83.00%		-	Local				COO	
	Local	PT2.3	Booking Efficiency - KGH	68.00%	71.00%	71.00%	74.00%	74.00%	78.00%	70.00%	73.00%	66.00%	68.00%	69.00%	70.00%	71.00%		-	Local				COO	
	Local	PT1.1	Utilisation - ALX	70.00%	72.00%	70.00%	72.00%	66.00%	72.00%	66.00%	73.00%	69.00%	42.00%	69.00%	71.00%	29.00%		-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT1.2	Utilisation - WRH	72.00%	70.00%	72.00%	74.00%	68.00%	72.00%	76.00%	75.00%	75.00%	78.00%	78.00%	71.00%	75.00%		-	Local				COO	
	Local	PT1.3	Utilisation - KGH	65.00%	68.00%	68.00%	67.00%	70.00%	71.00%	66.00%	70.00%	64.00%	65.00%	66.00%	67.00%	69.00%		-	Local				COO	
A & E	National	CAE1.1	4 Hour Waits (%) - Trust	81.37%	78.70%	78.77%	80.60%	78.28%	81.70%	82.20%	79.90%	78.40%	76.30%	73.99%	68.50%	71.70%	77.50%	85.30%	National	>=95%	-	<95%	COO	
	National	CAE1.1a	4 Hour Waits (%) - Trust inc. MIU - from September 14	84.30%	82.40%	82.30%	84.40%	82.20%	84.70%	85.70%	83.70%	82.80%	80.90%	78.90%	75.30%	76.80%	81.70%	87.90%	National	>=95%	-	<95%	COO	
	Local	CAE2.1	12 hour trolley breaches	0	0	0	0	0	5	1	13	4	4	37	88	167	319		Local	0		0	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile	35	49	54	40	33	22	24	32	23	37	36	47	45	34	-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment for All Patients (Mins) - 95th Percentile	32	42	46	34	35	28	30	40	35	31	34	34	35	32	-	National	<=15mins	-	>15mins	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	41.74%	38.40%	37.74%	54.00%	56.10%	57.30%	59.10%	60.70%	57.40%	54.70%	53.90%	39.20%	39.70%	53.20%	43.43%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	86.02%	85.58%	81.65%	91.70%	90.20%	91.70%	93.00%	90.30%	90.80%	87.69%	87.70%	78.70%	79.50%	88.10%	88.62%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes - WMAS data	29	26	68	31	51	34	26	70	43	97	81	157	141	731	381	Local	0		>0	COO	
Cancer *	National	CCAN1.0	31 Days: Wait For First Treatment: All Cancers	98.50%	97.50%	96.10%	95.90%	96.90%	96.60%	99.20%	97.80%	97.30%	98.30%	94.60%	97.60%	93.70%	96.90%	97.50%	National	>=96%	-	<96%	COO	
	National	CCAN5.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	86.30%	84.40%	75.30%	75.60%	79.30%	68.10%	67.20%	65.90%	73.10%	73.90%	75.30%	73.60%	51.90%	70.60%	81.20%	National	>=85%	-	<85%	COO	
	National	CCAN8.0	2WW: All Cancer Two Week Wait (Suspected cancer)	84.10%	89.00%	77.30%	39.40%	63.70%	69.20%	75.50%	65.92%	71.00%	86.30%	82.50%	90.40%	86.70%	72.70%	85.70%	National	>=93%	-	<93%	COO	
	National	CCAN9.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	82.90%	91.20%	79.40%	34.50%	28.00%	55.70%	74.50%	51.98%	76.09%	93.40%	94.10%	95.60%	86.70%	67.00%	80.00%	National	>=93%	-	<93%	COO	
	National	CCAN10.1	Cancer Long Waiters (104 Day +) includes suspected and diagnosed - treated in month - NEW			5	10	12	18	12	12	11	12	14	11	20.5			-	-	-	-	COO	
Stroke**	Local	CST1.0	80% of Patients spend 90% of time on a Stroke Ward (Local Definition - until March 2016)	72.55%	81.10%	89.80%	-	-										82.21%	Local	>=80%	-	<80%	COO	
	Local	CST1.1	80% of Patients spend 90% of time on a Stroke Ward (National Definition - from April 2016)									27.30%	61.00%	70.59%					Local	>=80%	-	<80%	COO	
	Local	CST2.0	Direct Admission (via A&E) to a Stroke Ward (Local Definition - until March 2016)	69.23%	77.30%	66.10%	-	-										74.40%	Local	>=70%	-	<70%	COO	
	Local	CST2.1	Direct Admission (via A&E) to a Stroke Ward (National Definition - from April 2016)									9.10%	19.30%	17.24%					Local	>=90%	-	<90%	COO	
	Local	CST3.0	TIA (Local Definition - until March 2016)	62.07%	64.70%	60.00%	-	-										64.23%	Local	>=60%	-	<60%	COO	
	Local	CST3.1	TIA (National Definition - from April 2016)				62.50%	50.00%	31.80%	5.60%	6.40%	4.60%	4.50%	8.00%					Local	>=60%	-	<60%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH ***	108%	102%	102%	100%	101%	99%	100%	100%	100%	100%	99%	99%	100%	100%	102%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX ***	104%	104%	96%	86%	87%	84%	87%	86%	93%	96%	96%	91%	95%	90%	94%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN2.3	Beds Occupied by NEL Stranded Patients (>7 days) - last week of month										47.00%	52.50%	45.60%	45.60%			Local	<=45	-	>45		
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute***	26	33	27	36	33	33	22	26	39	34	45	25	23	316	457	-	-	-	-	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute***	807	1090	725	739	788	1063	704	514	1,145	1,005	1,225	1,068	706	8,957	14561	-	-	-	-	COO	
	Local	PIN4.2	Bed Days Lost Due To Acute Bed No Longer Required (Days)	3,966	3,320	3,468	3,038	3,252	3,106	2,409	2,459	2,899	3,387	3,402	2,933	3,068	29,953	40,369	-	-	-	-	COO	
Elective	National	PEL3.0	28 Day Breaches as a % of Cancellations	19.7%	14.6%	36.1%	38.3%	15.3%	20.0%	17.7%	22.9%	10.1%	7.1%	40.2%	28.4%	39.00%	25.54%	20.1%	TBC	<=5%	6 - 15%	>15%	COO	
	National	PEL3.1	Number of patients - 28 Day Breaches (cancelled operations)	14	14	26	23	13	15	11	11	7	7	39	25	39	190	-	TBC	-	-	-	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	1	0	0	0	1	4	1	1	0	0	1	1	0	9	4	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	5.0	4.6	4.7	4.7	4.4	4.8	4.3	4.7	4.8	4.6	4.6	5.0	4.93	4.7	4.8	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	6.9	6.5	6.5	6.5	6.1	6.6	5.9	6.4	6.9	6.6	6.8	7.1	6.98	6.6	6.6	-	-	-	-	COO	

Please note RTT submission had not been completed when this report was produced.
**April 15 figures onwards for indicators CAE1.1, CAE1.1a, CAE1.2, CAE1.3, CAE1.4, CAE2.0, CAE3.1, CAE3.2, CAE4.0 are calculated using a slightly different methodology to previously reported numbers.*
Cancer _this involves small numbers that can impact the variance of the percentages substantially.
*** Stroke data is being validated due to a discrepancy between OASIS validated data and what has been reported on SSNAP which is the national system. Validation is occurring at patient level for Dec and Jan.*
****Bed occupancy data source is Bed State Report.*

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

Worcestershire Acute Hospitals NHS Trust (WAHT)is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register. This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Worcestershire Acute Hospitals NHS Trust

Workforce Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: January 2017

Area	Indicator Type	Indicator		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Current YTD	Prev Year	Tolerance Type	2016/17 Tolerances			SRO
																				On Target	Of Concern	Action Required	
Vacancies & Recruitment	Local	WVR1.0	Number of Vacancies - Total	408	379	383	522	440	406	461	524	499	486	497	512	502		383	Local	<=200	201-229	>=230	DCE
Turnover	Local	WT1.0	Staff Turnover WTE %	12.8%	12.7%	13.0%	13.0%	12.9%	12.8%	12.7%	12.6%	12.5%	12.6%	13.0%	12.8%	12.8%		12.97%	Local	<>10-12%	<>12-14%	>14%	DoHR
	Local	WT1.3	Nursing Staff Turnover - Qualified	14.0%	13.7%	14.2%	14.3%	14.4%	13.9%	14.4%	14.1%	13.8%	13.9%	13.6%	13.5%	13.2%		14.2%	Local	<>10-12%	<>12-14%	>14%	DoHR
	Local	WT1.4	Nursing Staff Turnover - Unqualified	13.6%	13.7%	13.8%	14.0%	14.3%	14.6%	13.9%	13.5%	13.0%	12.6%	14.1%	14.5%	15.1%		13.8%	Local	<>10-12%	<>12-14%	>14%	DoHR
Sickness & Absence	Local	WSA1.0	Sickness Absence Rate Monthly (Total %)	4.70%	4.34%	4.06%	3.90%	4.10%	3.73%	4.12%	3.98%	3.90%	4.52%	4.81%	4.91%	5.16%		4.06%	Local	<= 3.50%	>=3.51% & <=3.99%	>= 4.00%	DoHR
Temporary Staffing	Local	WTS1.0	Agency Staff - Medics (WTE) Indicative	159.4	154.8	158.7	126.6	128.1	126.4	130.3	145.9	144.2	156.6	154.1	163.3	152.9		158.7	Local	<=85	85.1-100	>100	DCE
Induction	Contractual	WIN1.3	% of eligible staff attended Induction	100.0%	73.4%	87.0%	100.0%	93.6%			93.0%			96.6%	82.1%		93.0%	88.2%	Contractual	>= 90%	80 - 89%	< 80%	DoHR
Statutory and Mandatory Training**	Contractual	WSMT10.2	% Of Eligible Staff completed Training	85.1%	84.7%	84.5%	85.5%	88.2%	85.9%	84.5%	85.2%	85.0%	87.4%	86.9%	87.9%	88.2%	86.5%	85.1%	Contractual	>= 90%	60.1-89.9%	<=60%	DoHR
Appraisals	Contractual	WAPP1.2	% Of Eligible non-medical Staff Completed Appraisal	78.3%	76.2%	79.9%	81.1%	84.9%	79.4%	78.9%	82.1%	83.4%	84.6%	86.8%	85.3%	83.8%	83.0%	77.9%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP2.2	% Of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	81.4%	83.0%	82.4%	80.2%	83.6%	82.9%	82.6%	81.4%	81.1%	82.3%	83.4%	83.1%	82.1%	82.3%	83.6%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP3.2	% Of Eligible Consultants Who Have Had An Appraisal	83.5%	85.2%	84.6%	83.7%	85.7%	85.8%	86.4%	85.9%	86.0%	85.7%	85.7%	85.8%	83.7%	85.5%	86.2%	Contractual	>= 85%	71 - 84%	< 71%	DoHR

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

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

****WSMT metrics - Please note that Hand Hygiene which was included in 2015/16 has been excluded for 2016/17*

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

Worcestershire Acute Hospitals NHS Trust (WAHT)is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register. This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Worcestershire Acute Hospitals NHS Trust

Worcestershire NHS
Acute Hospitals NHS Trust

Maternity Metrics Overview

Reporting Period: January 2017

Area	Indicator Type	Indicator		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Current YTD	Prev Year
Scheduled Bookings	National	MSB1.1	Women Booked Before 12 + 6 Weeks	88.5%	88.6%	91.3%	85.5%	89.5%	90.1%	88.8%	87.5%	91.5%	87.7%	91.3%	86.7%	88.6%	88.7%	89.2%
	Contractual	MSB1.2	Total Bookings	479	493	503	523	504	507	489	503	473	460	473	446	490	4868	6114
Deliveries	Contractual	MDEL1.0	Deliveries	447	462	496	441	458	460	497	437	478	479	420	456	478	4604	5782
Births	Contractual	MBIR1.0	Total Births	454	470	502	449	465	468	506	445	485	490	424	460	491	4683	5876
Normal Vag. Deliveries	Contractual	MNVD1.0	Maintain Normal Vaginal Delivery Rate	57.3%	60.6%	63.3%	56.0%	60.5%	60.4%	62.0%	66.8%	62.1%	63.9%	64.0%	60.3%	61.3%	62%	59.3%
C- Section	Contractual	MCS1.0	Total Caesareans	29.8%	28.6%	27.6%	32.7%	27.3%	28.3%	28.2%	25.2%	25.3%	25.5%	22.9%	26.1%	26.4%	27.4%	29.6%
	Contractual	MCS1.1	Elective Caesareans	11.6%	13.0%	11.7%	13.8%	12.0%	12.6%	12.1%	11.9%	10.7%	12.1%	11.2%	12.5%	13.8%	12.2%	12.2%
	Contractual	MCS1.2	Emergency Caesareans	18.1%	15.6%	15.9%	18.8%	15.3%	15.7%	16.1%	13.3%	14.6%	13.4%	11.7%	13.6%	12.6%	15.3%	17.4%
Outcome Indicators	National	MOI1.0	Breast Feeding Initiation Rates	70.1%	71.1%	70.6%	72.0%	68.5%	72.8%	67.7%	69.5%	71.5%	66.9%	71.0%	75.2%	67.4%	69.8%	71.4%
	Contractual	MOI3.0	Midwife Led Care %	18.3%	22.5%	22.4%	19.5%	24.7%	22.0%	23.5%	27.7%	27.2%	21.1%	21.0%	22.1%	22.4%	23.5%	21.3%

NB: Please note that tolerances are adjusted between financial years

Tolerance Type	2016/17 Tolerances			SRO	Data Quality Kite mark
	On Target	Of Concern	Action Required		
National	>=90%	-	<90%	CNO	
Local	>=6290 bookings in the year			CNO	
Local	>=5890 deliveries in the year			CNO	
Contractual	<=480	481 - 531	>532	CNO	
Contractual	>63%	63% - 60%	<60%	CNO	
Contractual	<27%	27% - 28%	>28%	CNO	
Contractual	<=11.2%	11.3 - 13.2%	>13.2%	CNO	
Contractual	<=15.2%		>15.2%	CNO	
National	> 74%	70% - 74%	< 70%	CNO	
Contractual	Establish Baseline for 17/18			CNO	

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 NHS
Acute Hospitals NHS Trust

Date of Trust Board: 01 March 2017 **Enc G1**

Report to Trust Board

Title	**Herefordshire and Worcestershire Sustainability and Transformation Plan – Governance Structure**
Sponsoring Director	**Sarah Smith, Director of Planning and Development**
Author	**Sarah Smith, Director of Planning and Development**
Action Required	The Board is requested to: • Note the governance structure supporting the current phase of STP development and delivery

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

STP – Sustainability and Transformation Plan
SRO – Senior Responsible Officer
FYFV – Five Year Forward View

Key Messages

The draft Herefordshire and Worcestershire Sustainability and Transformation Plan was published in November 2016.

A public engagement exercise is currently underway alongside a financial refresh - after which the plan will be finalised.

Meanwhile the agreed work streams are mobilising and this paper provides an overview of the governance structures supporting this stage of STP development / delivery.

NHS England will publish the updated NHS FYFV delivery plan in March 2017, which is expected to contain further guidance around STP governance.

Date of Trust Board: 01 March 2017 **Enc G1**

REPORT TO TRUST BOARD – 01 MARCH 2017

1. Situation

An overview of the governance structures supporting the current phase of the Herefordshire and Worcestershire STP is presented to the Trust Board.

2. Background

Following joint planning guidance issued in December 2015, the draft 5 – year Herefordshire and Worcestershire Sustainability and Transformation Plan was published in November 2016.

A public engagement exercise is currently underway alongside a financial refresh - after which the plan will be finalised.

3. Assessment

The Trust Board have requested further information around the governance structures supporting this phase of STP development / delivery and an overview is provided as appendix one. It should be noted that these are new and still embedding. For example the Delivery Board has held its first meeting at the beginning of February.

The Accountable Officer for the STP remains Sarah Dugan and the Independent Chair Mark Yates.

The high level STP work programme is included as appendix two. There are executive level SROs identified from the participating organisations for each of the work streams. The STP Delivery Board comprises the Directors of Strategy and the central PMO.

3.2 Next steps

NHS England will publish the updated NHS FYFV delivery plan in March 2017, which is expected to contain further guidance around STP governance.

4 Recommendation

The Board is requested to:
Note the governance structure supporting the current phase of STP development and delivery

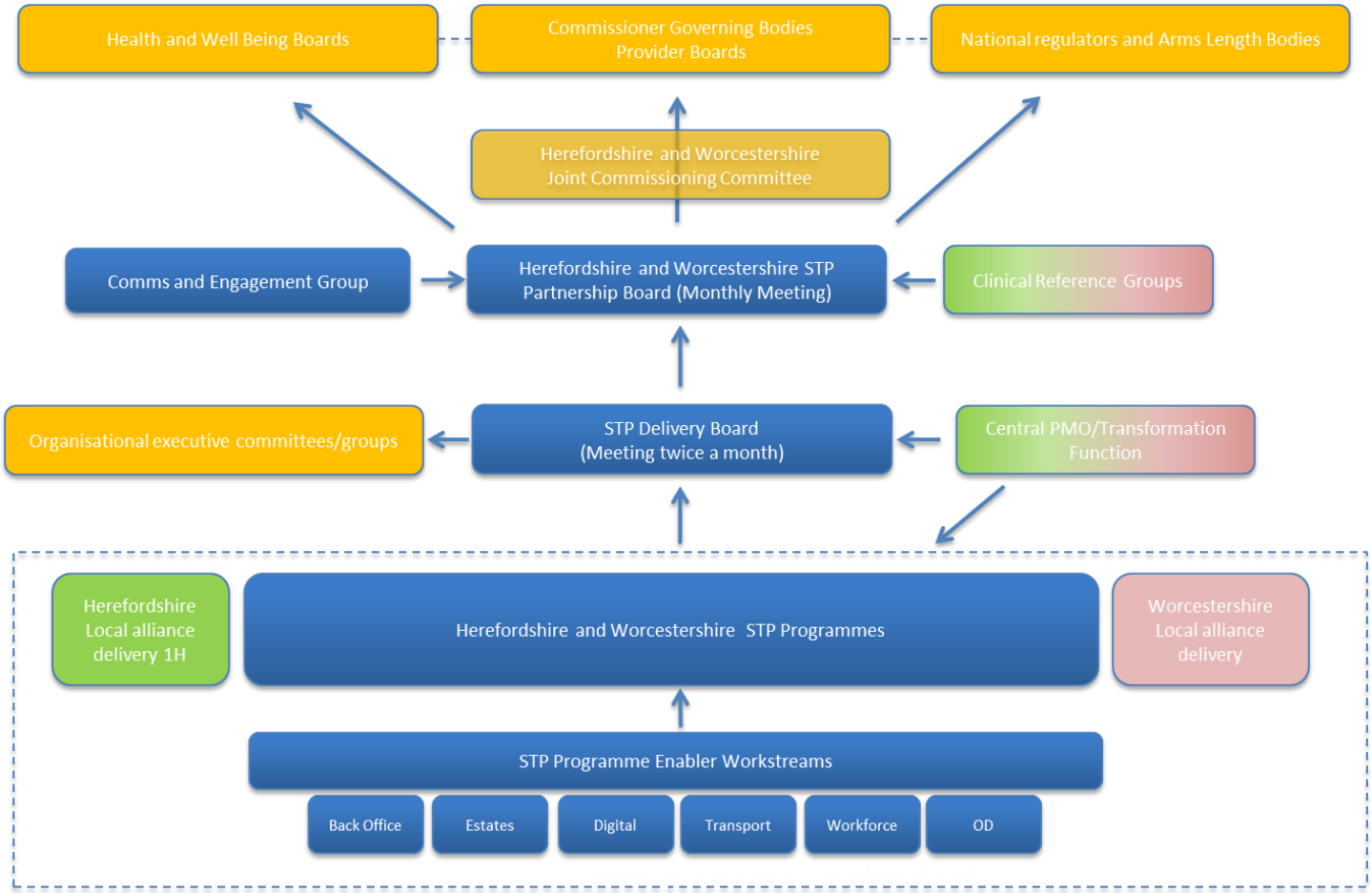
Sarah Smith
Director of Planning and Development

Title of report	Herefordshire and Worcestershire STP Governance Structure
Name of director	Sarah Smith

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 01 March 2017 **Enc G1**

Appendix One – STP Governance Structure



Title of report	Herefordshire and Worcestershire STP Governance Structure
Name of director	Sarah Smith

Date of Trust Board: 01 March 2017 **Enc G1**

Appendix Two – STP Work Programme

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 patient activation (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 STP footprint 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)	

Title of report	Herefordshire and Worcestershire STP Governance Structure
Name of director	Sarah Smith

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc G2**

Report to Trust Board

Title	**Trust Management Group (TMG)**
Sponsoring Director	**Richard Beeken** Chair of the Trust Management Group
Author	**Kimara Sharpe** Company Secretary
Action Required	The Board is requested to: • Note the report
Previously considered by	*N/A*

Priorities (√)

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

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances
Glossary	RTT – referral to treatment STP - Sustainability and Transformation Plan STF – Sustainability and Transformation Fund

Title of report	Interim Chief Executive's Report
Name of director	Richard Beeken

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc G2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – MARCH 2017

1. Situation

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

2. Background

The Trust Management Group provides assurance to the Trust Board on operational issues. TMG now meets fortnightly.

3. Assessment

3.1 Governance arrangements

The governance structure as presented in my CEO report was approved. The membership was agreed as the Senior Divisional Leadership teams plus the executive management team. The revised terms of reference are now in the process of being developed. We will meet twice a month.

3.2 Quality Improvement Plan

Each division explained the actions that they are undertaking in response to the CQC concerns. These are incorporated within the Quality Improvement Plan which is a separate agenda.

3.3 Operational Plan 2017/18

The operational plan consists of four sections. TMG went through each section in some detail. The activity plan is based on 12 months rolling actual activity (August 15 to July 16). The financial plan for 2017/18 is a deficit of £29.988m which includes receipt of £12.663m STF. The financial risks were discussed and included agency costs ceiling, activity levels less than planned levels, loss of STF, cost improvement plans not delivered. The formal sign of procedure for the 2017/18 budgets was approved.

Clinical Service Planning is also underway (due for completion on 28 February). This uses an agreed model to understand the real capacity available and the impact on RTT performance.

The third section is the Quality Improvement Plan to deliver better processes and patient care. Finally workforce was discussed. This focussed on the vacancies and the plans being developed by the divisions.

The final element is the commitment the Trust has to the STP and the engagement needed with the key work streams.

3.4 Workforce

The challenges associated with recruiting to the vacancies that the Trust currently

has. Actions being taken were described. These included better marketing of the Trust and possibly overseas recruitment.

3.5 **RTT diagnostic recovery options**

There was considerable concern about the number of patients waiting. It was agreed that sustainable waiting time reduction needs to commence within the Trust.

In respect of two week wait, the trust has recovered and performance is sustained. For 62 day wait, the Trust has become static at 60-62%. This is closely linked to the endoscopy performance. Diagnostic underperformance is directly correlated to endoscopy performance. For RTT performance has deteriorated for the last nine months. The Trust has a critical mass of very long waiters, some over 52 weeks. Recommendations were made to the Finance and Performance Committee which will consider the options and agree the way forward.

3.6 **Hazel Ward**

It was agreed that from 8 March, Hazel ward will switch back to surgery. There will be a full quality impact assessment on the effect of this.

3.7 **Business cases**

The following business cases were agreed:

- Radiotherapy equipment (accessing national monies for upgrading and purchasing a new linac)
- Bowel screening for Hereford
- Decontamination Unit at the Alexandra Hospital

IT solution for patient safety – agreement was made to develop a full business case. This links to other electronic solutions.

4 **Recommendations**

The Board is requested to:

- Note the report

Richard Beeken
Chair of the Trust Management Group

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc H1**

Report to Trust Board

Title	**OD Leadership Development Plan**
Sponsoring Director	**Denise Harnin, Director of HR and OD**
Author	**Sandra Berry, Director of HR and OD**
Action Required	The Board is asked to re-endorse the plan of programmes outlined with a view to them commencing in March 2017.
Previously considered by	Workforce and Assurance Group

Priorities (√)

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

Related Board Assurance Framework Entries	*Risk 2894: failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems*
Legal Implications or Regulatory requirements	Duty of Care to our staff and patients.
Glossary	

Key Messages

This plan forms part of the wider OD Strategy which outlines the Trust approach in support of delivery of the overall Quality Improvement Programmes;

- Safe and Effective Care
- Urgent Care and Patient Flow
- Governance and Safety

The impending commencement of the new Chief Executive, Chief Nursing Officer and Chief Medical Officer are fundamental to the development and sign of the wider OD Strategy over the next 3-6 months.

Date of meeting: 1 March 2017 **Enc H1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – MARCH 2017

1. Situation

To provide to the Trust Board a position statement on the progression of a Trust OD Leadership and Development Plan.

2. Background

The Trust needs to undergo significant organisational and cultural change in order to deliver the future agenda. The purpose of this document is to outline the OD Leadership and development approach developed to support the delivery of the Trust strategic objectives through enabling real and lasting change and improving both individual and organisational effectiveness and capability.

3. Assessment

The attached plan is a summary of the proposal of leadership Development Programmes developed to be commenced from March 2017.

a. Board Development Programme

An outline Board Development Plan is attached which will induct new Non-Executive Directors and Executive Directors to the Trust Board. The programme will provide on-going Board Development to support the entire Board to work optimally as a unitary body. Such interventions will include knowledge of the NHS for newly appointed NED's and knowledge of WAHT for new board members. The programme will be supported by personal executive coaching and strategic time out events.

b. Clinical and Senior Managers' Development Programme

Programme to commence in March 2017 for Senior Manager and Clinical leaders who are currently in senior management roles within the Trust. The programme has been designed following a training needs analysis completed with Executive Directors and Senior Managers in August 2016 by Ann Skidmore OD Consultant. This was followed by a stakeholder event held with the Chairman, Interim Director of Finance, Head of Information and Divisional Directors and is designed with the aim of developing a higher capability level of its clinical and senior leaders to better equip them to lead and manage the organisation to provide purpose and direction, lead change and growth, develop capabilities and performance and achieve results and best practise.

The programme contains 15 modules overall and commences with a 360 Degree Management Know diagnostic tool for all participants. The first three modules focus specifically on performance management, as

an agreed priority for the organisation.

In addition the programme is underpinned by 1:1 coaching support, action learning sets and a suite of "back to basics" skills days to compliment the programme.

c. Clinical Leadership Development Programme

A Programme developed by Faculty of Medical Leadership for a programme of 20 to 24 consultants initially. These will be split fairly evenly between established and aspiring/new leaders. For established leaders the programme will be an initial 1:1 meeting, tailored advice/coaching/mentorship and support backed up with regular sessions each month. For aspiring and new leaders the first meeting will be in small groups rather than individuals, with a more formal programme for the half day sessions every month. Coaching and support will also be part of the programme.

Programmes will last about 6 months, focussing on individual needs, plus the current and future needs of the organisation. In addition individuals already in medical leadership roles will be included in the trust senior manager development programme outlined above.

d. "Future Leaders" Development Programme

This is a first line manager's development programme accredited with the Insitiute of Leadership and Management to include modules regarding understanding the "leadership role", understanding teams, managing staff, problem solving and making decisions.

A Team Leader programme is also in place for supervisors and team leaders accredited with the Institute of Leadership and Management to introduce them to developing themselves as a future leaders, improving the performance of the team and providing a quality service.

To support the implementation of the above programmes and ongoing support for all of the OD interventions a 6 month fixed term contract has been offered to an OD Practitioner which commenced in February 2017.

4 Recommendation

The Board is asked to re-endorse the approach the plan of programmes outlines with a view to commencement in March 2017.

Denise Harnin
Director of OD and HR

Title of report	OD Leadership Development Plan
Name of director	Denise Harnin, Director of HR and OD

OD Plan - Leadership Programme Schedule - commencing 2017

Programme Aim	Programme	Target Group	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Jun-18	Jul-18	Aug-18
Board Development to support Board a unitary board.	Board Development Programme	Non-Executive Directors (NED) New Appointees				**Induction / Orientation** Organisational Structure Challenges; Finances, Workforce, STP																					
						Clinical Structure ● Develop Understanding ● Divisional Structure Roles	Time with 4 Divisional Pathway Teams 1/2 Day visit each Understanding risk, challenges / developments																			
		NHS TDI Induction						**NHSI Role of NED** Expectations Accountability Conducting the Role																			
		Trust Board Developments							**Board Away Days 3 x Year** Strategic Time Out Review Vision & Values Setting tone from top How to live Values Defining Board objectives			**Board Away Days 3 x Year** Strategic Time Out Review Vision & Values Setting tone from top How to live Values Defining Board objectives				**Board Away Days 3 x Year** Strategic Time Out Review Vision & Values Setting tone from top How to live Values Defining Board objectives										
											Unitary Board Understanding Unitary concept Difference in Behaviours, practices															
								Board Performance Board members skills assessment Identify gaps Development Programme to address skill gaps Non-Exec/Exec appraisal																	
													Improving Collaboration Meetings, away days with External Partners Work towards alignment to Health Care Strategy Countywide														
Improve Leadership Skills and Competency	Clinical & Senior Managers Programme	All Band 8's and Above				Programme Launch all cohorts.	Completion of Mgt Know 360 Feedback	Mgt Know 360 Degree Feedback	Cohort 1, 2 and 3 commences Module 1 - Performance Mgt	Module 2 for 3 cohorts- Performance Management Contd	Module 3 for 3 cohorts - Performance Management Contd	Cohort 1 commences - Module 4 - Managing Self	Module 5 - Managing Self	Module 6- Managing Self	Module 7 - Managing Self	Module 8- Managing Others	Module 9 - Managing Others	Module 10 - Managing Others	Module 11 - Managing Others	Module 12- Managing the Organisation	Module 13- Managing the Organisation	Module 14- Managing the Organisation	Module 15- Managing the Organisation			
													Cohort 2 commences - Module 4 - Managing Self	Module 5 - Managing Self	Module 6- Managing Self	Module 7 - Managing Self	Module 8- Managing Others	Module 9 - Managing Others	Module 10 - Managing Others	Module 11 - Managing Others	Module 12- Managing the Organisation	Module 13- Managing the Organisation	Module 14- Managing the Organisation	Module 15- Managing the Organisation			
																Cohort 3 commences - Module 4 - Managing Self	Module 5 - Managing Self	Module 6- Managing Self	Module 7 - Managing Self	Module 8- Managing Others	Module 9 - Managing Others	Module 10 - Managing Others	Module 11 - Managing Others	Module 12- Managing the Organisation	Module 13- Managing the Organisation	Module 14- Managing the Organisation	Module 15- Managing the Organisation
	1:1 Coaching																										
	Human Factors Training	All Band 7's and Abov	Implementing Human Factors 1 day Workshop			Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop		Implementing Human Factors 1 day Workshop	

OD Plan - Leadership Programme Schedule - commencing 2017

Programme Aim	Programme	Target Group	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Jun-18	Jul-18	Aug-18
Improve Basic Management skills and	**Master classes**	All Band 7's and					Understanding & Managing Budgets	HR Master class	Report and Business Plan Writing	Understanding and Using Information	Understanding & Managing Budgets	HR Master class	Report and Business Plan Writing	Understanding and Using Information	Understanding & Managing Budgets	HR Master class	Report and Business Plan Writing	Understanding and Using Information	Understanding & Managing Budgets	HR Master class	Report and Business Plan Writing	Understanding and Using Information					
Develop skills and knowledge of future leaders/Managers	**Award Programme for First Line /Aspiring Managers**	Band 6				Programme Launch/Briefing & Module 1 (Developing Yourself)	Module 2 - Understanding Leadership	Module 3 - Understanding Communication Process	Module 4 Individuals Tutorials	Module 5 - Understanding Teams	Module 6 - solving Problems and Making Decisions	Module 7 - Evaluating options and implementing decisions	Module 8 - Evaluation and Review														
		Band 6								Programme Launch/Briefing & Module 1 (Developing Yourself)	Module 2 - Understanding Leadership	Module 3 - Understanding Communication Process	Module 4 Individuals Tutorials	Module 5 - Understanding Teams	Module 6 - solving Problems and Making Decisions	Module 7 - Evaluating options and implementing decisions	Module 8 - Evaluation and Review										
	Award Programme	Band 4 and 5						Programme Launch/Briefing	Module 1 - Developing yourself as a team leader	Module 2- Managing yourself as a team leader	Module 3 - Improving the performance of the team	Module 4 - Providing Quality to Customers	Evaluation and Review	Programme Launch & Briefing	Module 1 - Developing yourself as a team leader	Module 2- Managing yourself as a team leader	Module 3 - Improving the performance of the team	Module 4 - Providing Quality to Customers	Evaluation and Review								
Improve Clinical Leadership Skills and Competency	**Clinical Leadership Programme**	Established Clinical Leads		Review of clinical Leads Roles and Skills requirements		Phase 2 Incorporate Phase 1 findings into leadership programme																					
	Aspirant Clinical Leader	Aspiring Clinical Leaders		Phase 1- scoping and 1:1's		Phase 2 Incorporate Phase 1 findings into leadership programme																					
	New Consultants Development Programme	Consultants New in post in last 6 months		1:1 meetings with New consultants		Phase 2 Incorporate Phase 1 findings into programme																					
Develop a Coaching Culture	**Award in Coaching**	Band 6 and above	Programme Launch and Module 1- Understanding coaching	Module 2 - coaching in practise		1:1 Review	Module 3 - Reflective Review	Evaluation of Programme	Programme Launch and Module 1- Understanding coaching	Module 2 - coaching in practise	1:1 Review	Module 3 - Reflective Review	Evaluation of Programme	Programme Launch and Module 1- Understanding coaching	Module 2 - coaching in practise	1:1 Review	Module 3 - Reflective Review	Evaluation of Programme									
	Coaching Skills Worksh	Band 5 and above	2 Day Programme					2 day Programme			2 day Programme			2 day Programme				2 day programme									

Programmes commenced
Programme Planned

Programmes commenced
Programme Planned

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc I1**

Report to Trust Board

Title	**Public Consultation on the Future of Acute Hospital Services in Worcestershire**
Sponsoring Director	**Sarah Smith** **Director of Planning and Development**
Author	**Sarah Smith, Director of Planning and Development**
Action Required	• Receive the update on the consultation process
Previously considered by	N/A

Priorities (√)

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

Related Board Assurance Framework Entries	Service reconfiguration
Legal Implications or Regulatory requirements	N/A
Glossary	

Key Messages

This report details the activity to date with the consultation on the Future of Acute Hospital Services in Worcestershire

Date of meeting: 1 March 2017 **Enc I1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 1 MARCH 2017

1. Situation

Public Consultation on the Future of Acute Hospital Services in Worcestershire started on January 6th 2017 and will run for 12 weeks until March 30th 2017. This report gives an update on the consultation so far.

2. Background

Public Consultation on the Future of Acute Hospital Services in Worcestershire started on January 6th 2017 and runs for 12 weeks until March 30th 2017. The public consultation is on the proposed clinical model which proposes moving:

- Most planned orthopaedic surgery from Worcestershire Royal Hospital to the Alexandra Hospital
- Some planned gynaecology surgery from Worcestershire Royal Hospital to the Alexandra Hospital
- More planned surgery – eg breast surgery from Worcestershire Royal Hospital to the Alexandra Hospital
- More ambulatory care (Medical care provided on an outpatient basis including diagnosis, observation, consultation, treatment, intervention and rehabilitation) from Worcestershire Royal Hospital to the Alexandra Hospital
- More day case and short stay surgery to Kidderminster Hospital
- All hospital births from the Alexandra Hospital to the Worcestershire Royal Hospital
- Inpatient children's services from the Alexandra Hospital to the Worcestershire Royal Hospital. (Outpatient and urgent services for children with minor and moderate illnesses will remain at the Alexandra Hospital)
- Emergency surgery from the Alexandra Hospital to the Worcestershire Royal Hospital

Irrespective of the changes 95% of people would continue to receive their care in the same hospital as now and 80% of children who currently receive their treatment at the Alexandra Hospital would continue to do so.

Both Accident and Emergency Departments would remain open 24-hours a day but due to the transfer of inpatient children's beds, the A&E at the Alexandra Hospital would be for adults (over 16 years old) only. Both the Alexandra and Worcestershire Royal Hospitals would have new Urgent Care Centres which would treat adults and children with minor and moderate illnesses and injuries. Diagnostic tests and outpatient appointments would take place in all three hospitals, as now.

3.1 Consultation activities

Consultation activities have been focused around public drop in sessions and attendance at targeted meetings of groups and communities. Drop in sessions have been held at all the county's acute and community hospitals and in community centres and libraries.

Title of report	Future of Acute Hospital Services in Worcestershire
Name of director	Sarah Smith

Meetings have been held with youth groups, disability groups, dementia carers, older people, town councils and we are continuing to target those in the recognised inequality categories and those likely to be most affected by the proposed changes.

Summary of the Public Consultation on the Future of Acute Hospital Services in Worcestershire at the end of week six	
Meetings and drop in sessions	33
Numbers of people attending	872
Number of questionnaires returned	1,603

A verbal update on the number of people attending drop in sessions and completing the questionnaire will be given at the meeting.

Further drop in sessions have been arranged:

- Alexandra Hospital, March 6th 11am-3pm
- Salters Medical Practice, Droitwich, March 8th 2-5pm
- Worcestershire Royal Hospital, March 10th 11am-3pm
- Kidderminster Hospital, March 13th 11am-3pm

3.2 **Emerging Themes**

The emerging themes are as follows:

- Transport
- Appointment and Operation times
- Future of the Alexandra Hospital
- Capacity

3.3 **Next steps**

The consultation is due to end on March 30th which will be one week into the Local Government election purdah period. No decisions on future services can be undertaken until after the local elections on May 5th. This gives the programme time to analyse the responses to the consultation in depth. A final report on the consultation will be taken to the three CCG Governing Body meetings at the end of May 2017.

4 Recommendation

Receive the update on the consultation process

Sarah Smith
Director of Planning and Development

Title of report	Future of Acute Hospital Services in Worcestershire
Name of director	Sarah Smith

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 1 March 2017 **Enc J1**

Report to Trust Board (in public)

Title	**Audit and Assurance Committee report**
Sponsoring Director	**Bryan McGinity** **Chair – Audit and Assurance Committee**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Board is recommended to: • Approve the revised terms of reference • Note the report from External Audit • Note the internal audit reports approved • Note the contents of the report
Previously considered by	N/A

Priorities (√)

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

Related Board Assurance Framework Entries	The Committee reviews and provides assurance on the overall management of the BAF risks.
Legal Implications or Regulatory requirements	
Glossary	

Key Messages

This is the routine report from the Audit and Assurance Committee to the Trust Board and covers the meeting held on 12 January 2017.

Date of meeting: 1 March 2017 **Enc J1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 1 MARCH 2017

1. Situation

The Audit and Assurance Committee met on 12 January 2017. This report details the business undertaken at that meeting.

2. Background

The Audit and Assurance Committee provides assurance on systems and processes in place at the Trust. It is a key assurance committee.

3. Assessment

3.1 Referral to Treatment (RTT)

The Deputy Chief Operating Officer was able to explain the different types of validation undertaken with respect to the RTT waiting list. There are administrative, divisional team and clinical validation. Currently approximately 5000 notes are reviewed on an on-going basis. She also explained that she has worked with the national support team to determine whether the way that this is undertaken is best practice.

The Committee referred the issue of validation to the Finance and Performance Committee to review.

3.2 External Audit

The report from External Audit showed no concerns for the preparatory work being undertaken in the month of February for the Annual Accounts.

3.3 Internal Audit

The Head of Internal Audit reported that the internal audit plan for 2016/17 was progressing satisfactorily. He stated that he was beginning to consider his opinion for 2016/17 and he reminded members that he had issued a limited assurance audit opinion for 2015/16. He was expecting to do the same in 2016/17 due to the Trust remaining in special measures. He acknowledged that financial control was good.

The Committee approved the following reports:

- Patients' property and money: This repeat audit showed that the policy was not being followed. Moderate assurance was given and the audit would be repeated in 2017/18. A group had been set up to relaunch the policy.
- Core financial systems: The audit gave significant assurance and there were no high level recommendations.
- Data Quality – cancer waits: Significant assurance had been given and all the actions identified had been completed.

3.4 Anti-Fraud update

The Committee received the routine update on the current fraud cases. Members expressed concern about the lack of attendance at induction by the Anti-Fraud officer and requested that this be reviewed.

The Anti-Fraud officer confirmed that the number of cases that the Trust has at any one time is consistent with other Trusts.

3.5 Local Security Management Service update

The routine report showed that the Trust was not routinely using administrative sanctions. He also had concerns about the lack of adherence to the policy relating to patients' property.

3.6 Data Quality Audit

The Committee received the six monthly review from the Associate Director of Performance. Coding have improved the coding of the primary procedure. A data quality manager is commencing in April and interviews for the data quality clinical champion are taking place in February.

3.7 Other

The Committee received the following updates:

- Review of debts write off
- Contract management board update
- Terms of reference – these are attached for the Board to approve

4 Recommendation

The Board is recommended to:

- Approve the revised terms of reference
- Note the report from External Audit
- Note the internal audit reports approved
- Note the contents of the report

Bryan McGinity
Chair – Audit and Assurance

Date of meeting: 1 March 2017 **Enc J1**

Terms of Reference

AUDIT AND ASSURANCE COMMITTEE

Version: 2.2

Terms of Reference approved by: A&A Committee/Board

Date approved: January 2017 (A&A Committee)

Author: **Company Secretary**

Responsible directorate: Finance

Review date: March 2018

Date of meeting: 1 March 2017 **Enc J1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE

1 Purpose

The Audit and Assurance Committee has been established to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives.

2 Constitution

The Committee is established by the Trust Board and is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

3 Membership

Three non-executive directors, one of which shall be appointed chair by the Trust board.

The Chair of the Trust shall not be a member of the Committee.

4 Attendance

The following shall be in attendance at each meeting:

- The Director of Finance and Performance
- Assistant Director of Finance
- The Head of Internal Audit or representative
- External Auditors
- Local Anti Fraud Specialist
- Company Secretary

The Chief Executive and other executive directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

In addition, the Chief Executive should be invited to attend, at least annually, to discuss with the Audit and Assurance Committee the process for assurance that supports the Annual Governance Statement.

5 Administrative support

The administrative support shall be through the Company Secretary.

6 Attendance

Except in exceptional circumstances, members are required to attend all of the meetings per year.

7 Quoracy

A quorum shall be two members.

8 Frequency of meetings

There should be a minimum of 5 meetings per year, scheduled on a bi-monthly basis.

The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. The holding of such a meeting shall be at the discretion of the Chair of the Audit Committee.

The Committee may meet the internal/external auditors privately as required.

9 Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

10 Duties

The duties of the Committee can be categorised as follows:

10.1 Governance, Risk Management and Internal Control

The Committee will review the adequacy of:-

1. The Assurance Framework as the key source of evidence that links strategic objectives to risks, controls and assurances and the main tool that the Trust Board uses in discharging its overall responsibility for internal control. Thus, the Committee should review whether;

- The format of the Assurance Framework is appropriate for the organisation
- The processes around the Framework are robust and relevant
- The controls in place are sound and complete
- The assurances are reliable and of good quality
- The data the assurances are based on is reliable

2. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

3. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

4. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

5. The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Anti Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work, and that of the audit and assurance functions that report to it.

10.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Assurance Committee, Chief Executive and Trust Board. This will be achieved by:-

1. Consideration of the provision of the Internal Audit Service, including the cost of the audit.
2. Review and approval of the Internal Audit strategy, operational plan and detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.
3. Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
4. Ensuring that the Internal Audit function is adequately resourced, suitably qualified and has appropriate standing and access within the organisation.
5. Annual review of the effectiveness of internal audit, including consideration of the Internal Audit Annual Report.

10.3 External Audit

The Committee shall review the work and findings of the External Auditor appointed by Auditor Panel and consider the implications and management's responses to their work. This will be achieved by:-

1. Consideration of the appointment and performance of the External Auditor.
2. Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other Internal Audit and External Auditors in the local health economy.
3. Discussion with the External Auditor of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee**.**

4. Review all External Audit reports, including agreement of the annual audit letter before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.
5. Ensure compliance with Ethical Standards (previously undertaken by the PSAA)

10.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies). All whistle blowing final reports will be presented to the Committee. The Committee will report these to the Trust board in public at the next available Trust board meeting.

The Committee shall also ensure that the Trust appoints external auditors in compliance with the requirements of the Local Accountability and Audit Act 2014 and The Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015.

In addition, the Committee will through an agreed annual work plan, review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work.

10.5 Anti Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

10.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions or major change programmes within the organisation as appropriate.

10.7 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the Trust Board

The Committee shall review the Annual Report and financial statements before submission to the Board, focusing particularly on:-

- The wording in the Annual Governance Statement, and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgments in preparation of the financial statements.
- Significant adjustments resulting from the audit.

- Letter of Representation

- Qualitative aspects of financial reporting

11 Reporting Structure

The Minutes of Committee meetings shall be formally recorded and a report of each meeting submitted to the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embedding of risk management in the organisation, the integration of governance arrangements and the appropriateness of the supporting evidence.

12 Record of Business

Minutes of Committee meetings shall be produced and circulated to members of the Committee no later than five working days following each meeting.

Agendas and associated papers shall be sent out no later than five working days before the meeting.

13 Review Period

The Committee's membership and terms of reference will be reviewed annually by 31st March.

January 2017