**Worcestershire County Council**

# Agenda

# Health Overview and Scrutiny Committee

## Wednesday, 27 April 2016, 1.30 pm
## County Hall, Worcester

All County Councillors are invited to attend and participate

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বাংলা। আপনি যদি এই দলিলের বিষয়বস্তু বুঝতে না পারেন এবং আপনার জন্য অনুবাদ করার মত পরিচিত কেউ না থাকলে,অনুগ্রহ করে সাহায্যের জন্য 01905 765765 নম্বরে যোগাযোগ করুন। *(Bengali)*

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ਪੰਜਾਬੀ। ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਮਜ਼ਮੂਨ ਸਮਝ ਨਹੀਂ ਸਕਦੇ ਅਤੇ ਕਿਸੇ ਅਜਿਹੇ ਵਿਅਕਤੀ ਤੱਕ ਪਹੁੰਚ ਨਹੀਂ ਹੈ, ਜੋ ਇਸਦਾ ਤੁਹਾਡੇ ਲਈ ਅਨੁਵਾਦ ਕਰ ਸਕੇ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਮਦਦ ਲਈ 01905 765765 'ਤੇ ਫ਼ੋਨ ਕਰੋ। *(Punjabi)*

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# DISCLOSING INTERESTS

**There are now 2 types of interests:**
**'Disclosable pecuniary interests' and 'other disclosable interests'**

## WHAT IS A 'DISCLOSABLE PECUNIARY INTEREST' (DPI)?

- Any **employment**, office, trade or vocation carried on for profit or gain
- **Sponsorship** by a 3rd party of your member or election expenses
- Any **contract** for goods, services or works between the Council and you, a firm where you are a partner/director, or company in which you hold shares
- Interests in **land** in Worcestershire (including licence to occupy for a month or longer)
- **Shares** etc (with either a total nominal value above £25,000 or 1% of the total issued share capital) in companies with a place of business or land in Worcestershire.

**NB Your DPIs include the interests of your spouse/partner as well as you**

## WHAT MUST I DO WITH A DPI?

- **Register** it within 28 days and
- **Declare** it where you have a DPI in a matter at a particular meeting
  - you must **not participate** and you **must withdraw**.

**NB It is a criminal offence to participate in matters in which you have a DPI**

## WHAT ABOUT 'OTHER DISCLOSABLE INTERESTS'?

- No need to register them but
- You must **declare** them at a particular meeting where:
  You/your family/person or body with whom you are associated have a **pecuniary interest** in or **close connection** with the matter under discussion.

## WHAT ABOUT MEMBERSHIP OF ANOTHER AUTHORITY OR PUBLIC BODY?

You will not normally even need to declare this as an interest. The only exception is where the conflict of interest is so significant it is seen as likely to prejudice your judgement of the public interest.

## DO I HAVE TO WITHDRAW IF I HAVE A DISCLOSABLE INTEREST WHICH ISN'T A DPI?

Not normally. You must withdraw only if it:

- affects your **pecuniary interests OR**
  relates to a **planning or regulatory** matter
- **AND** it is seen as likely to **prejudice your judgement** of the public interest.

## DON'T FORGET

- If you have a disclosable interest at a meeting you must **disclose both its existence and nature** – 'as noted/recorded' is insufficient
- **Declarations must relate to specific business** on the agenda
  - General scattergun declarations are not needed and achieve little
- Breaches of most of the **DPI provisions** are now **criminal offences** which may be referred to the police which can on conviction by a court lead to fines up to £5,000 and disqualification up to 5 years
- Formal **dispensation** in respect of interests can be sought in appropriate cases.

Simon Mallinson Head of Legal and Democratic Services July 2012 WCC/SPM summary/f

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# Health Overview and Scrutiny Committee
# Wednesday, 27 April 2016, 1.30 pm, Council Chamber

## Membership

**Councillors:**

| | |
|---|---|
| Worcestershire County Council | Mr A C Roberts (Chairman), Mr W P Gretton, Mrs J L M A Griffiths, Mr P Grove, Ms P A Hill, Mr A P Miller, Prof J W Raine, Mrs M A Rayner and Mr G J Vickery |
| District Councils | Mr T Baker, Malvern Hills District Council<br>Dr B Cooper, Bromsgrove District Council<br>Mrs F Oborski, Wyre Forest District Council<br>Mrs F Smith, Wychavon District Council<br>Mr A Stafford, Worcester City Council<br>Mrs N Wood-Ford, Redditch Borough Council |

## Agenda

| Item No | Subject | Page No |
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| 1 | **Apologies and Welcome** | |
| 2 | **Declarations of Interest and of any Party Whip** | |
| 3 | **Public Participation**<br>*Members of the public wishing to take part should notify the Head of Legal and Democratic Services in writing or by email indicating the nature and content of their proposed participation no later than 9.00am on the working day before the meeting (in this case 26 April 2016). Enquiries can be made through the telephone number/email address below.* | |
| 4 | **Confirmation of the Minutes of the Previous Meeting**<br>Previously circulated | |
| 5 | **Future of Acute Hospital Services in Worcestershire - Update** | 1 - 4 |
| 6 | **Quality of Acute Hospital Services - Update** | 5 - 30 |
| 7 | **Quality Accounts 2015 - 16** | 31 - 34 |
| 8 | **Health Overview and Scrutiny Round-up** | 35 - 38 |

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To obtain further information or hard copies of this agenda, please contact Emma James/Jo Weston telephone:Worcester(01905) 844964/844965,email: scrutiny@worcestershire.gov.uk

All the above reports and supporting information can be accessed via the Council's website at http://www.worcestershire.gov.uk/info/20013/councillors_and_committees

Date of Issue: Tuesday, 19 April 2016

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**AGENDA ITEM 5**

# HEALTH OVERVIEW AND SCRUTINY COMMITTEE 27 APRIL 2016

# FUTURE OF ACUTE HOSPITAL SERVICES IN WORCESTERSHIRE - UPDATE

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## Summary

1. The Health Overview and Scrutiny Committee (HOSC) is to be updated on the Future of Acute Hospital Services in Worcestershire (FOAHSW) programme, including the NHS England assurance process and the timetable going forward.

2. Representatives from the FOAHSW programme have been invited to the meeting, as well as from Worcestershire's Clinical Commissioning Groups and Worcestershire Acute Hospitals NHS Trust.


## Background

3. The HOSC has maintained regular overview of the review of acute hospital services in Worcestershire, which was initiated in 2012, prompted by a number of needs, including national evidence that certain services can be provided to a higher standard if they are centralised, a lack of doctors specialising in certain services and the increasing challenge of meeting the needs of an ageing population with more complex and long-term conditions.

4. The most recent update to the HOSC on 16 September 2015 (available here ) summarised the background to the on-going review. It also focused on developments also arising from review of the proposed model by the West Midlands Clinical Senate (the Senate was a group of 20 clinicians from across the country, whose role was to test the model for clinical safety and quality).

5. There have been a number of delays in the process of finalising the review, which have been acknowledged to be frustrating for everyone involved.

6. The Clinical Senate gave overall support for the proposed clinical model, but requested that more detailed work was required on emergency care pathways for the county so that a model which had widespread support could be finalised. This work has now been completed and a revised clinical model of care has been submitted to the West Midlands Clinical Senate for review.

## Clinical Model

7. To recap, HOSC Members will be aware that the main proposed changes to services in the proposed clinical model of care are:

- Separation of emergency and planned care to improve outcomes and patient experience
- Creation of centres of excellence for planned surgery

- Urgent care centre for adults and children at the Alexandra Hospital in Redditch
- Accident and Emergency remaining at the Alexandra Hospital for adults only, with robust arrangements for managing a seriously sick child if they arrive unexpectedly or their condition deteriorates and they need an inpatient stay in hospital. All partners within the Future of Acute Hospital Services in Worcestershire Programme are committed to maintaining two A&E departments in the county
- Centralisation of inpatient care for children at Worcestershire Royal Hospital with the majority of children's care remaining local. 80% of children would continue to receive all their care locally.
- Centralisation of consultant-led births at Worcester with ant-natal and post-natal care remaining local
- Centralisation of emergency surgery.

## Latest stages of the review

8. In January 2016, the clinical model for the future of Worcestershire's acute hospital services was approved by all three of Worcestershire's Clinical Commissioning Groups, and was also endorsed by Worcestershire Acute Hospitals NHS Trust. Commitment to the model has also been formally received from the Medical Staff Committee of Worcestershire Acute Hospitals which represents all the consultants working in the Trust.

9. The revised model now needs to be reviewed by the West Midlands Clinical Senate, which is due to take place by mid May 2016. Subject to endorsement by the Clinical Senate, the next stage would be gain approval from NHS England for public consultation.

## Purpose of the meeting

10. Members are invited to consider an update on progress with the future of acute hospital services for Worcestershire residents, and in doing so, may wish to discuss the following areas:

- the latest stages of the review and timetable going forward
- what efforts are being taken to complete outstanding areas of work, in order to bring the review to conclusion?
- how is the impact on staffing, services (including maternity services) and increasing financial pressures being monitored?

11. In doing so, HOSC members may want to refer to the number of concerns that were raised during its discussion in September 2015, including the on-going impact of the delay, the need for clear public communications, transport and access to hospitals, growing financial pressures as well as some concerns about the proposed model for emergency children's services at the Alexandra Hospital in Redditch.

12. The Agenda includes a separate discussion on the quality of Worcestershire Acute Hospitals NHS Trust services and the temporary emergency changes to some services, including obstetrics and neonatal, which will include consideration of how risks to service safety and sustainability caused by the on-going delay and uncertainty are

being managed, particularly in the key areas of paediatrics, obstetrics and emergency surgery.

## Contact Points

County Council Contact Points
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Specific Contact Points for this report
Emma James / Jo Weston, Overview and Scrutiny Officers: 01905 844964 / 844965
Email: scrutiny@worcestershire.gov.uk

## Background Papers

In the opinion of the proper officer (in this case the Director of Commercial and Change) the following are the background papers relating to the subject matter of this report:

- Health Overview and Scrutiny Committee on 4 July, 6 November 2012, 24 January, 25 June and 8 October 2013, 22 January, 22 January, 15 July, 8 October and 5 November 2014, 16 September 2015 - agenda and minutes available on the Council's website at: http://worcestershire.moderngov.co.uk/ieListMeetings.aspx?CId=141&Year=0

- The Future of Acute Hospital Services in Worcestershire – Report of the Independent Clinical Review Panel (January 2014) and the West Midlands Clinical Senate Report (June 2015) – both available on the FOAHSW website: www.worcsfuturehospitals.co.uk

- Future of Acute Hospital Services in Worcestershire Programme Stakeholder Newsletters: www.worcsfuturehospitals.co.uk

- Links to Press Releases August 2015 – February 2016
    - http://www.worcsacute.nhs.uk/news/temporary-relocation-of-emergency-gynaecology-services/
    - http://www.worcsacute.nhs.uk/news/temporary-relocation-of-emergency-gynaecology-services-from-alex/
    - http://www.worcsacute.nhs.uk/news/temporary-emergency-changes-to-services-to-remain-in-place/

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**AGENDA ITEM 6**

# HEALTH OVERVIEW AND SCRUTINY COMMITTEE 27 APRIL 2016

# QUALITY OF ACUTE HOSPITAL SERVICES - UPDATE

## Summary


1. The Health Overview and Scrutiny Committee (HOSC) is to receive an update from Worcestershire Acute Hospitals NHS Trust (the Trust) on the quality of hospital services, and in particular, progress with the Patient Care Improvement Plan.

2. The update will also refer to the temporary emergency changes to maternity, neonatal and gynaecology services, which were extended for the foreseeable future in February 2016, due to the need to centralise services at Worcestershire Royal Hospital because of insufficient staffing levels to maintain a separate provision at the Alexandra Hospital in Redditch.

3. The Interim Chairman, Interim Chief Executive and Improvement Director from the Trust have been invited to attend the meeting.


## Background

4. The HOSC requested regular updates during 2015 on the quality of acute hospital services – as part of its role to monitor the impact of ongoing pressures experienced by many hospital trusts, such as increased activity, greater complexity of patient needs and financial constraints. Within Worcestershire, a further pressure has been the delay in finalising a reconfiguration of acute hospital services, which has resulted in an on-going period of uncertainty for the Trust.

5. Additionally, the CQC's most recent (December 2015) inspection report led to the Trust being placed into special measures as a result of the planned inspection in July 2015.

6. Subsequently, at its 9 December 2015 meeting, the HOSC met with senior representatives from the Trust to discuss the main findings of the inspection report and the work in progress to address improvement required, via the Patient Care Improvement Plan. It was agreed that a further progress update on the Plan would be provided.

7. The Trust's update on 9 December 2015 drew attention to the many positive outcomes from the report, which it was pointed out were important to recognise and share with staff, without wanting to gloss over the overall report findings. Staff were found to be caring, there was an open culture, and the organisation was clinically led. The need for stability at Trust Board level was being addressed and whilst Accident and Emergency (A&E) remained busy, it was unrecognisable compared to the CQC's unannounced visit in March 2015.

Of the 115 domains rated, the Trust received ratings of outstanding in 2, good in 54, with 13 inadequate and the rest requiring improvement – for the latter this meant that consistency needed to improve, and not that all areas were poor.

8. The HOSC was shown a grid where services were rated against the key criteria, and shaded as green (good), amber (requires improvement) or red (inadequate). Two overall inadequate ratings (safety and leadership) resulted in an overall inadequate rating for the Trust.

9. Whilst acknowledging the innovative work in hand to progress the Patient Care Improvement Plan since the CQC's inspection, the 9 December 2015 discussion raised a number of concerns from HOSC members, including the need for clear communications to reassure the public and dispel rumours, the need for better systems to improve patient waiting times and discharge, staffing and recruitment, capacity at Worcestershire Royal Hospital, financial pressures and the onset of pressures from seasonal winter illnesses.

10. Concern was also expressed about the need for stability and the negative impact of the on-going delay to the reconfiguration of acute hospital services in Worcestershire – an update on which is provided elsewhere in this Agenda.

11. The Care Quality Commission is due to revisit the trust in November 2016.

## Purpose of Meeting

12. Members are invited to consider and comment on progress being made to address the quality of services at the Trust.

13. Following the discussion, HOSC Members are asked to consider whether any further information is required and identify any specific elements for potential future scrutiny.

## Supporting Information

- Appendix 1 – Monitoring Report March 2016

## Contact Points

County Council Contact Points
Worcestershire County Council: 01905 763763
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Specific Contact Points for this Report
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Email: scrutiny@worcestershire.gov.uk

## Background Papers

In the opinion of the proper officer (in this case the Head of Legal and Democratic Services) the following are the background papers relating to the subject matter of this report:

- Agenda and Minutes of the Health Overview and Scrutiny Committee on 16 September and 9 December 2015 http://worcestershire.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=141
- Care Quality Commission Press release, 2 December 2015 http://www.worcsacute.nhs.uk/news/care-quality-commission-report/
- Care Quality Commission report on Worcestershire Acute Hospitals Trust (December 2015) http://www.cqc.org.uk/provider/RWP#sthash.mEq4ofeI.dpuf
- Worcestershire Acute Hospital NHS Trust Press Release, 2 December 2015 http://www.worcsacute.nhs.uk/news/care-quality-commission-report/
- Press releases on temporary emergency changes to maternity, neonatal and gynaecology services August 2015 to February 2016:
    - http://www.worcsacute.nhs.uk/news/temporary-relocation-of-emergency-gynaecology-services/
    - http://www.worcsacute.nhs.uk/news/temporary-relocation-of-emergency-gynaecology-services-from-alex/
    - http://www.worcsacute.nhs.uk/news/temporary-emergency-changes-to-services-to-remain-in-place/

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# Worcestershire Acute Hospitals NHS Trust
# CQC Chief Inspector of Hospitals Visit
# Monitoring Report March 2016

## Urgent Care and Patient Flow

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 30/09/16 |
|---|---|---|---|---|---|---|---|---|
| **MUST DO** | | | | | | | | |
| M1 | Improve the access and flow of patients in order to:<br>•reduce delays from critical care for patients being admitted to wards;<br>•reduce the unacceptable number of discharges at night;<br>•reduce the risks of this situation not enabling patients to be admitted when they needed to be or discharged too early in their care;<br>•reduce occupancy to recommended levels; and improve outcomes for patients. | COO | → Weekly % discharges before 12 midday<br>→ Weekly % stranded patients (NEL LoS > 7 days)<br>→ Weekly bed days delayed (ICU step-down) | A | New Clinical Site Coordination Team to be implemented at WRH in March 2016.<br>Revised SOP to be developed in March 2016 that prioritises ICU step down patients<br>Daily Discharge targets to be implemented for complex and simple discharges at ward level from April 2016<br>Achieve 35% of discharges before 12 midday (current performance 18%)<br>Stranded patient LOS daily reviews to be escalated within Divisions from March 2016<br>Implement Older Persons Assessment and Liaison service in March 2016 to avoid admissions | A | A | G |
| M2 | Ensure there are the appropriate numbers of qualified paediatric staff in the ED to meet national guidelines. | CNO | → Monthly % dual trained in post<br>→ Monthly % PILS/EPLS trained<br>→ Monthly % NLS trained | A | We do not meet the dual trained nursing quota but have mitigated with appropriate PILS/EPLS training. 97% ED paediatric training completed. University paediatric 5 day course completed by 4 RNs and 6 planned for later this year. Training commencing for all staff 1 day NLS training. Currently recruiting 3 band 5 paediatric nurses in March | A | A | G |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
|---|---|---|---|---|---|

| Urgent Care and Patient Flow | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 30/09/16** |
| M3 | Ensure that the risk matrix in Medical Assessment Unit is completed to the frequency required by the trust policy. | CNO | → Results of assessment in March 2015 | **G** | MAU complete a risk matrix every two hours which illustrates the level of activity and acuity. A scoring system provides the trigger for escalation. This risk matrix forms part of the MAU SOP. Fully in use. Assessment of use of risk matrix due in March 2016 | **G** | **G** | **G** |
| M4 | Ensure that there is sufficient levels of medical staff cover throughout the week to ensure patient reviews are carried out in a timely manner | CMO | → Weekly % revised rota compliance<br>→ % emergency admissions patients reviewed by suitable Consultant/MDT members within 14 hours | **A** | Establish baseline in Medicine and Surgery Divisions. Establish appropriate levels of cover and monitor rota compliance.<br>Medical workforce plan baseline established | **A** | **A** | **A** |
| M5 | Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the service including the provision of daily ward rounds. | CNO | → Weekly shift fill rates by Ward<br>→ Monthly BPWR compliance rate | **A** | Internal training sessions x 16 re Best Practice Wards Rounds/SAFER bundle<br>Safer staffing levels remain positive<br>Exemplar best practice wards rounds in place on 7 Wards and 11 Champions in place. Recognition this needs to be re energised for sustainability and roll out<br>Planning a ward sister development programme on | **A** | **A** | **G** |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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| Urgent Care and Patient Flow | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 30/09/16** |
| | | | | | ward leadership<br>Medical workforce plan baseline established | | | |
| M6 | Ensure consultant cover meets with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum | CMO | → Weekly % compliance with RCEM recommend-ations | **R** | Business case being developed for additional ED Consultant – implementation to be staged | **R** | **R** | **R** |
| **SHOULD DO** | | | | | | | | |
| S1 | Ensure a county-wide consultant on call rota is achieved as part of the ED transformation programme. See also M6 | CMO | → Monthly average number of ED Consultants rostered to be on call each day | **A** | The Trust has in place an integrated rota that works countywide that means that the Consultants on call can cover either site in extremis. The Trust currently cannot aspire to a single countywide rota | **A** | **A** | **A** |
| S2 | Ensure delays in ambulance handover times are reduced to meet the trust target of 80% of patients conveyed by ambulance have handovers carried out within 15 minutes of arrival (baseline 41.1% Jan 2015) and 95% of patients handed over within 30 minutes (82.2% Jan 2015). | COO | → Monthly % ambulance handovers with 15mins<br>→ Monthly % ambulance handovers within 30 minutes | **A** | Performance in January 2016: 41.7% handovers within 15 mins; 86.0% handed over within 30 mins.<br>Jointly signed letter to front line staff clarifying the SOP, roles and responsibilities for handover circulated in March 2016<br>Admin support on the ambulance desk in ED at WRH to support the clinical handover by entering the patient PIN number | **A** | **A** | **G** |
| S3 | Ensure the changes to manage | COO | → Weekly no of patients in the | **A** | Full capacity protocol in place. To be revised in March 2016 to include update on criteria for | **A** | **A** | **G** |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
|---|---|---|---|---|---|

| Urgent Care and Patient Flow | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 30/09/16** |
| | overcrowding and patient safety in ED are sustainable. | | ED corridor<br>→ Weekly % discharges before 12 midday<br>→ Weekly % stranded patients (NEL LoS > 7 days) | | boarding patients. Crowding largely relates to 'exit block' from the ED to the main hospital | | | |
| S4 | Ensure patients receive an initial assessment within 15 minutes of arrival (baseline 77.3%, Jan 2015). | COO | → % of ED attenders assessed within 15 minutes compared with with target and with Peer Trusts | **A** | DDOps for Medicine to focus on triage at AGH and KTC to improve the average | **A** | **A** | **A** |
| S5 | Continue to engage with local organisations to improve patient flow to ensure that patient waiting for hospital beds in ED can be transferred in a timely manner to prevent breaches | COO | → Monthly no of DTOCs<br>→Monthly % of stranded patients | **A** | Baseline 79 DTOCs Jan 2015.. DTOCs reduced to 26 in Jan 2016, System Resilience Group and Best Practice Urgent Care Board action plan in train, supported by ECIP to reduce % stranded patients | **A** | **A** | **G** |
| S6 | Evaluate the effectiveness of the Patient Flow service to ensure it meets patient needs and improves access and flow of services | COO | → Monthly no of DTOCs<br>→ Monthly no of stranded patients (NEL LoS > 7 days) | **A** | Review undertaken, implementation of actions underway, including in-reach, revised governance, multi-disciplinary multi-agency approach to discharge coordination to be confirmed at March 2016 SRG | **A** | **A** | **G** |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
|---|---|---|---|---|---|

## Urgent Care and Patient Flow

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 30/09/16 |
|---|---|---|---|---|---|---|---|---|
| S7 | Ensure unplanned re-attendance to ED within seven days meets the target of 5%. | COO | → Monthly % ED re - attendance | **A** | Performance is 5.8%. Analysis of cases underway in March and action plan on repeat attendances to be developed in April | **A** | **A** | **G** |

## Reducing Avoidable Mortality

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 30/09/16 |
|---|---|---|---|---|---|---|---|---|
| **MUST DO** | | | | | | | | |
| M7 | Evaluate and improve practice in response to the results from the hip fracture audit for 2014 | CMO | Monthly % to theatre within 36 hours compared with target and Peer Trusts | **A** | Countywide actions In place:-<br>Prioritisation of #NOF cases to be done first on the PM Trauma Theatre Sessions; this is driven by the Trauma Nurse Practitioners & Clinical Teams and is supported by the Hip Fracture Escalation policy.<br>Trauma Nurse Practitioners submit a Daily Report to monitor #NOF performance countywide to COO & Surgical Division.<br>Monthly #NOF performance reviewed and discussed at the Countywide Directorate Meetings attended by the Clinical Teams.<br>Business case for weekend Trauma sessions submitted to allow for dedicated sessions.<br>Regular Orthogeriatric input required. | A | A | A |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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| **SHOULD DO** | | | | | | | | |
| S8 | Record Mortality and Morbidity reviews in order to demonstrate lessons from any reviews are learned and these can be shared throughout the trust | CMO | Monthly % eligible primary and secondary reviews presented at the weekly Operational Governance Meeting | **A** | The primary review process is well established with compliance increasing.<br>In **March 2016** those primary reviews resulting in the need for a secondary review will be discussed at the M&M section of the weekly OGM – 100% compliance by end of March<br>From **April 2016** secondary reviews will be presented at Week 2 of the OGM cycle<br>From **May 2016** the outcome of all secondary reviews will be presented to Week 2 of the OGM cycle. Where action plans are developed as a result of the secondary reviews, progress will be tracked Week 2 of the OGM cycle.<br>By the September OGM meeting the process of ensuring actions are completed and that the impact is assessed will be part of business as usual for the meeting. | **A** | **A** | **G** |
| S9 | Ensure the morbidity and mortality meeting minutes clearly document discussions | CMO | As S1 | **A** | The mortality section of the weekly OGM will continue to be clearly minuted.<br>Systems in development to ensure that individual directorates and divisions clearly minute all M&M meeting discussions | **A** | **G** | **G** |





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## OD Plan/GGI recommendations Action Plan

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 31/09/16 |
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| **MUST DO** | | | | | | | | |
| M8 | Ensure that suitably qualified staff in accordance with the agreed numbers set by the trust and taking into account national policy are employed to cover each shift | DoHR/ OD/ CNO/ CMO | → Monthly shift fill rates by Ward<br>→ Monthly Qualified and Unqualified Nurse turnover<br>→ % nursing agency expenditure by Division<br>→ % medical agency expenditure by Division | **A** | Appointment process at Band 5 Nurse and HCA assessments reviewed.<br>Recruitment events held both on the Alexandra Hospital and Worcester hospital site.<br>Senior Nurse Team attended recruitment event with UW students.<br>Agreed with UW to increase number of student nurse placements.<br>Business case for overseas recruitment completed.<br>Implemented new exit interview process and analysing reasons for leaving.<br>New roles group developed and implementation of new roles commenced.<br>Ward Administrator role developed and post being advertised in March 2016.<br>Band 4 Assistant Practitioner role developed, job description agreed and matched.<br>Band 4 Assistant Practitioner programme commissioned with UW.<br>Medical workforce plan baseline established | **A** | **A** | **A** |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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| OD Plan/GGI recommendations Action Plan | | | | | | | | |
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| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 31/09/16** |
| M9 | Ensure all staff meet the trust wide mandatory training target of 95% compliance<br>*Mandatory training target revised to 90% and agreed by Workforce Assurance Group in line with other trusts compliance targets across West Midlands to 90%* | DoHR/ OD | → Monthly aggregate mandatory training rates and rates by topic | **A** | Review undertaken of all departments identifying staff that have not completed their mandatory training requirements.<br>Topic Leads made contact with all staff with out of date mandatory training.<br>Compliance reports produced weekly and provided to each Head of Department. Poor performing Departments escalated to relevant Divisional Director of Operations.<br>5 of the 10 mandatory training topics now achieving over 90% remaining 5 topics all on target to achieve 90% target by end of June 2016. | **A** | **G** | **G** |
| M10 | Ensure that staff providing care or treatment to patients receive appropriate support, and training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform | DoHR/ OD | → Monthly % staff appraisal rates, medical, clinical and non-clinical | **A** | Appraisal data analysed and all managers whose compliant percentage is below 85% received notification of which staff have not received an annual appraisal.<br>All staff who have not received an appraisal in the last 12 months received letter informing them of course of action to take to ensure appraisal undertaken.<br>Departmental training plans requested from all heads of departments to be received by 30.3.16 so enable collation of all departments training requirements.<br>Weekly training update to all staff produced to be implemented week commencing 14.3.16.<br>Trust Training Directory updated weekly. | **A** | **G** | **G** |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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| OD Plan / GGI recommendations Action Plan | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 31/09/16** |
| **SHOULD DO** | | | | | | | | |
| S10 | Ensure staff are aware of the trust's strategy and vision for the future | DoHR/ OD | → Monthly staff engagement results from Trust 'Pulse' surveys and → Quarterly staff engagement results from 'Chat Back' surveys | **A** | 2015 National Staff Survey revealed low levels of satisfaction through staff engagement at WAHT Trust has engaged with Optimise to develop Listening into Action (LiA) from April 2016 Trust's own Big Conversation being rolled – out alongside improved internal communications strategy. Trust developing its own monthly staff 'Pulse' survey (from April 2016) and quarterly 'Chat Back' Survey | **A** | **A** | **A** |





| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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| CIH Governance and Safety Improvement Plan | | | | | | | | |
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| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 31/09/16** |
| **MUST DO** | | | | | | | | |
| M11 | Review the existing incident reporting process to ensure that incidents are reported, investigated, patient harm graded in line with national guidance, actions correlate to the concerns identified, lessons learnt are disseminated trust wide, and reports are closed appropriately | CNO | → Monthly number of serious incidents open > 60 days – trust wide and specific to Women and Children's<br>→ % new incidents with 72hr update received (Women and Children's) | **A** | Improvements in all areas of the incident management process, particularly Women's and Childrens<br>Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT) | **A** | **G** | **G** |
| M12 | Ensure that risk registers are reviewed regularly in a timely fashion | CNO | → Monthly % risks overdue for review<br>→ Monthly % risks with overdue actions | **A** | Improvement trust wide in 15/16.<br>Sustained improvement planned in 16/17<br>Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT) | **A** | **G** | **G** |
| M13 | Take steps to ensure that all staff are included in lessons learnt from incidents and near misses, including lessons learned from mortality reviews, with effective ward based risk registers and safety dashboards being in place and understood | CNO | | **A** | Ward based quality dashboard phase 1 and 2 in place and due to report March 16 – phase 3 for roll out in May 16<br>Directorate based risk registers in place which identify ward based risks and mitigation<br>Weekly lessons learnt from incidents and SIs disseminated throughout the organisation and a | **A** | **G** | **G** |



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| CIH Governance and Safety Improvement Plan | | | | | | | | |
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| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 31/09/16** |
| | by all staff. | | | | lesson of the month in place<br>Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT) | | | |
| M14 | Risk assessments must be completed and used effectively to prevent avoidable harm such as the development of pressure ulcers | CNO | → Monthly no of avoidable pressure ulcers by ward | G | Matrons audits and ward based dashboards indicate adherence to pressure ulcer prevention plans | G | G | G |
| M15 | Ensure patients nutrition and hydration status is fully assessed recorded and acted upon in a timely manner. | CNO | → Monthly audit results by ward | G | Matrons audits and ward based dashboards indicate adherence to nutrition and hydration care plans | G | G | G |
| M16 | Ensure complaints investigated in a timely manner with appropriate audit trail and that learning is shared. Respond to complaints within agreed timeframes and summary data and meeting minutes should be explicit as to which location the complaint relates to and where performance times need to be improved | CNO | → Monthly % complaints responded to with 25 days by Division<br>→ Monthly no of complaints re-opened by Division | A | New processes implemented.<br>Location now available. Triangulation of learning from patient experience event undertaken in Feb 16 – key learning actions being agreed<br>Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT) | A | G | G |
| M17 | Ensure patients receive appropriate training and information about self-medication such as self-administration of heparin prior to discharge home. | CNO | → Monthly number of reported incidents relating to patient self - administration | A | A framework is in place to facilitate self-administration of medicines by patients<br>The Trust Medicines Policy outlines the criteria and policy by which patients may self-administer their medicines.<br>The procedure by which self- administration by patients should be undertaken is outlined in | A | A | G |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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## CIH Governance and Safety Improvement Plan

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 31/09/16 |
|---|---|---|---|---|---|---|---|---|
| | | | of medicines. | | MedsPolSOP13 of the Medicines Policy<br>An improvement programme together with the necessary audit/assurance will be discussed and planned at the meeting on 3rd March. This will be undertaken in conjunction with appropriate patient engagement to ensure that any changes/developments to these policies and procedures reflect the needs of our local population. | | | |
| M18 | Ensure all medicines are prescribed and stored in accordance with trust procedures. | CNO | → Audit results from Deep Dive in March and August | A | Audit programme in place. Deep dive of results to occur in March and link to operational governance meeting. Aiming for full assurance August 16 | A | A | G |
| **SHOULD DO** | | | | | | | | |
| S11 | Ensure that adherence to the Duty of Candour regulation is recorded in incident reports in line with requirements. | CNO | → % incident reports with DoC adherence recorded | A | Weekly operational governance meeting ensures and records duty of candour compliance. Further training planned to embed processes<br>Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT) | A | G | G |
| S12 | Resolve the issues relating to the faulty refrigeration storage units and inadequate water system in the mortuary | CNO | → Monthly number of exceptions to refrigerator temperature tolerances | G | The shower has been replaced and repairs were carried out to the water system which has stopped the problems experienced with the temperature of the water.<br>The temperature of the fridges is monitored on an on-going basis. At WRH a bid to replace the fridges is currently agreed by the PFI team. At AGH the | G | G | G |



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| CIH Governance and Safety Improvement Plan | | | | | | | | |
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| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 31/09/16** |
| | | | | | fridges have been confirmed as requiring replacement in 2016 and a capital bid request for replacement has been submitted. | | | |
| S13 | Ensure investigations of incidents have clear learning points and actions to prevent similar incident occurring, particularly in relation to staff assault. | CNO | → Monthly no of incidents relating to staff assault | **G** | Weekly operational governance meeting ensures measurable actions and disseminates learning | **G** | **G** | **G** |
| S14 | Ensure all medicines storage areas have systems for measuring and recording temperatures | CNO | → Monthly number of exceptions to temperature tolerances | **A** | Sample audit of systems occurring first week March | **A** | **A** | **A** |
| S15 | Ensure all risks are risk assessed and are on the risk register with mitigated actions taken (part 1) | CNO | → Summary results of risk survey | **A** | Further trust wide risk survey currently being undertaken to confirm all risks captured Receiving support around governance arrangements from 'buddy' Trust (Oxford University Hospitals NHS FT) | **A** | **G** | **G** |
| S16 | Ensure sufficient security measures are in place on the Kidderminster site to protect staff, patients and visitors. (part 2) | CNO | → Monthly number of security incidents reported at KTC | **A** | All security actions completed on action plan. Portering service undergoing management of change process to enhance role re security | **A** | **G** | **G** |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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## Women and Children Improvement Plan

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 30/09/16 |
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| **MUST DO** | | | | | | | | |
| M19 | Ensure that patient records are safe from removal or the sight of unauthorised people. (part 1) | CNO | → Results from spot checks | A | Trust wide communications in place and quality champions spot checks commenced<br>Riverbank now has lockable cabinet. | A | G | G |
| M20 | Develop a robust system to ensure children and young people who present with mental health needs are suitably risk assessed when admitted to the department to ensure care and support provided meets their needs. | CNO | → Monthly no of incidents related to lack of appropriate care and support | G | An agreed county wide protocol is in place that outlines CAMHs support. No related incidents in last five months<br>Receiving support from 'buddy' Trust (Birmingham Women's and Children's NHS FTs) | G | G | G |
| M21 | Ensure that midwives have the appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic. | CNO | Monthly % midwives completing Mandatory Midwifery Training | G | An ODP or recovery nurse is provided for 30 minutes post spinal or GA in recovery 24/7, handing over to the midwife once appropriate to do so/ prior to transfer to postnatal ward.<br>Obstetric anaesthetists are assigned to maternity for all shifts and provide support and advice as required/ indicated.<br>Enhanced care topic is now included on 3 day mandatory midwifery training<br>Checklist in place for orientation of AGH midwives to WRH theatre processes.<br>Receiving support from 'buddy' Trust (Birmingham Women's and Children's NHS FTs) | G | G | G |
| M22 | Ensure the facilities in the Early Pregnancy Unit are fit for purpose. | CNO | | G | Works took place in Aug 15 to expand the facility into 2 rooms. Risk assessment for EPAU completed for AGH site shows low risk.. Walk round has taken place at The AGH to consider relocation of EPAU | G | G | G |





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| Women and Children Improvement Plan | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 30/09/16** |
| | | | | | and other ambulatory Gynaecology services in the future as part of Trust ASR capital development programme 2016/17 – 2018/19<br>Receiving support from 'buddy' Trust (Birmingham Women's and Children's NHS FTs) | | | |
| **SHOULD DO** | | | | | | | | |
| S17 | Respond to complaints within agreed timeframes and summary data should be explicit as to which location the complaint relates to. Meeting minutes should clarify which area of Women's and Children's complaints relate to and where performance times need to be improved. | CNO | → Monthly % complaints responded to with 25 days by Division<br>→ Monthly no of complaints re-opened by Division | **G** | Processes in place within division with improved performance against low numbers of complaints<br>Receiving support from 'buddy' Trust (Birmingham Women's and Children's NHS FTs) | **G** | **G** | **G** |
| S18 | **Evesham:** Review arrangements for utilising the full theatre capacity to ensure patients are treated sooner | CNO | → Monthly utilisation – Evesham Theatres | **G** | Weekly process in place to maximise all theatre capacity including Evesham. | **G** | **G** | **G** |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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## Outpatient and Diagnostics Improvement Plan

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 30/09/16 |
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| **MUST DO** | | | | | | | | |
| M23 | Review the environment within outpatients to ensure that the seating is fit for purpose | COO | → Results from spot checks | G | 9 High chairs with arm rests were purchased and installed in the fracture clinic waiting area for elderly patients and were in place by October 2015. Quality Champions to undertake spot checks in all outpatient areas | G | G | G |
| M24 | Review the existing arrangements with regards to the management of referrals in to the organisation in order that the backlog of patients on an 18 week pathway are seen in accordance with national standards | COO | → Monthly % RTT pathways completed within 18 weeks of referral. | A | Delivered the aggregate 'Incomplete' RTT standard in Dec 2015 and Jan 2016. RTT performance is likely to deteriorate from 92% within 18 weeks to approximately 90% in a planned way from February 2016 onwards due to capacity constraints. Our focus is on prioritising urgent and cancer patients and communication with longer waiting patients and harm reviews/action for patients to take if there is any deterioration in their condition | A | A | A |
| M25 | Ensure that equipment within the radiology department is fit for purpose | COO | → Monthly % patients seen outside of national diagnostic waiting time standard | G | All radiology equipment has been maintained to a standard and frequency of checks by approved contractors according to a strictly adhered to schedule. The Regional Radiation Physics Protection Service conducts regular QA reviews for assurance. The DDOps in CSS/TACO will present a summary report to TMC in May 2016. | G | G | G |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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## Outpatient and Diagnostics Improvement Plan

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 30/09/16 |
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| | | | | | | | | |
| **SHOULD DO** | | | | | | | | |
| S19 | Address non-compliances identified by the 2014 National Emergency laparotomy audit-compliance including the provision of a sustained 24-hour Interventional radiology (IR) service. | COO | → Number of reported incidents relating to lack of 24/7 cover | **A** | The CMO has organised a meeting with University Hospitals Coventry and Warwickshire NHS Trust IR team to build on our current radiotherapy links to scope a networked IR arrangement for 24/7 cover. An informal arrangement is currently in place. | **A** | **A** | A |

## Emergency Surgery (Including Hospital at Night)

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 30/09/16 |
|---|---|---|---|---|---|---|---|---|
| **MUST DO** | | | | | | | | |
| M26 | Ensure there is a sustainable system in place to ensure all surgical patients receive safe and timely care. | CMO | → Increase in number of direct emergency surgery admissions to WRH from AGH catchment | **A** | Implementation plan developed following risk assessment and agreement from QSS committee to proceed with centralisation at WRH. Revised Consultant rota being developed whilst additional capacity is secured at WRH to realise the full transfer | **A** | **A** | **G** |
| **SHOULD DO** | | | | | | | | |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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| Emergency Surgery (Including Hospital at Night) | | | | | | | | |
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| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 30/09/16** |
| S20 | Review and risk-assess the provision of the critical care outreach team service which was not being provided for 24 hours a day. | CMO | → Monthly % of cardiac arrests and unexpected deaths at night. | **A** | Self-Assessment Gap Analysis undertaken by the Critical Care Unit, against the draft D16 Service Specification for Adult Critical Care Outreach Risk assessment has commenced and will include a review of the Trusts 'Recognising And Responding To Early Signs Of Deterioration In Hospital Patients' Procedure (WAHT-CRI-016) and the National Outreach Forum Operational Standards and Competencies for Critical Care Outreach Services. A variety of factors are being considered in the risk assessment including level of experience of responders, ability to attend patient promptly, and availability of support staff and services 24/7. The risk assessment will include analysis of Resuscitation Audit data, Mortality reviews, and the Hospital Standardised Mortality Ratio (HSMR). | **A** | **A** | **G** |
| S21 | Address non-compliances identified by the 2014 National Emergency laparotomy audit-compliance including the provision of a sustained 24-hour Interventional radiology service. | CMO | → % compliance with the audit standards | **A** | Updated status to be confirmed. As of Nov 2015:<br>• 6 standards met<br>• 3 standards partially met<br>• 2 standards not met | **A** | **A** | **G** |



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| High Dependency Unit Review | | | | | | | | |
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| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 30/09/16** |
| **MUST DO** | | | | | | | | |
| M27 | Review the High Dependency Units to bring their data collection and provision of care and treatment up to all Faculty of Intensive Care Medicine Core Standards. | CMO | → Monthly proportion of current HDU patients identified as requiring level 2 care<br>→ Monthly proportion of level 2 patients receiving level 2 care in an appropriate environment | **A** | Established Task and Finish Group<br>Agreed Terms of Reference<br>Agreed project workstreams<br>Benchmarked current service against Intensive Care Medicine Core Standards | **A** | **A** | **A** |
| M28 | Ensure there is a timely and appropriate response from the medical teams to the Critical Care Unit requests for support, follow-up and patient discharge. | COO | → Monthly number of ICU patients discharged directly to place of residence | **A** | The Trust is developing with Consultant Medical Staff a set of key professional clinical standards in line with the national aspiration to sustainably and consistently provide 7 day emergency services, and this requirement will be made explicit therein. | **A** | **A** | **G** |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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| Sign up to Safety | | | | | | | | |
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| **Ref** | **Item** | **Lead** | **Improvement Measures** | **Current Status RAG** | **Comment** | **Forecast 31/03/16** | **Forecast 30/06/16** | **Forecast 30/09/16** |
| **MUST DO** | | | | | | | | |
| M29 | Ensure that patient records are accurate, complete and fit for purpose (Part 2) | CMO | → % compliance with record keeping audit standards | **A** | The record keeping audit will be modified in **March 2016** to include all areas of concern.<br>From **April 2016** the audit will be completed fortnightly (10 records each ward) and reported to each ward area manager/clinical lead<br>The outcomes will be reported using SPC methodology (proportion of records with 100% compliance) for each division. Methodology developed in April 2016 – reporting in divisional performance packs from **May 2016** (to include March/April figures).<br>Overall aim is 95% of records with 100% compliance with standards and no record with less than 90% compliance by September 2016 | **A** | **A** | **G** |





| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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## Infection Prevention Control Peer Review

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/06/16 | Forecast 30/09/16 |
|---|---|---|---|---|---|---|---|---|
| **SHOULD DO** | | | | | | | | |
| S22 | Ensure staff are aware of Middle East Respiratory Syndrome (MERS), a viral respiratory infection caused by the MERS-coronavirus that can cause a rapid onset of severe respiratory disease in people and the actions required if a patient presents with associated symptoms. | CNO | → Results of spot checks | G | Trust wide communications and IP awareness raising in emergency portals undertaken. Quality Champions to undertake spot checks | G | G | G |

## HEWM visit to Medicine Action Plan

| Ref | Item | Lead | Improvement Measures | Current Status RAG | Comment | Forecast 31/03/16 | Forecast 30/04/16 | Forecast 31/05/16 |
|---|---|---|---|---|---|---|---|---|
| **MUST DO** | | | | | | | | |
| M30 | Ensure there are effective systems in place for the ongoing management of outlying patients. | COO | → Weekly number of medical patients outlying in other ward areas | A | Policy drafted and presented to TMC in February 2016, to be signed off in March 2016 via Divisional boards and published in April, which sets out clear standards for care and the SOP for outlying patients. | A | G | G |



| Red | Delayed or currently unattainable | Amber | In progress and achievable | Green | Achieved and sustainable |
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worcestershire countycouncil

**AGENDA ITEM 7**

# HEALTH OVERVIEW AND SCRUTINY COMMITTEE
# 27 APRIL 2016

# QUALITY ACCOUNTS 2015-16

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## Summary

1. The Health Overview and Scrutiny Committee (HOSC) is asked to consider and agree an approach for providing comment on the draft Quality Accounts of local organisations providing NHS services.

2. The following healthcare providers are seeking comments from the HOSC before finalising their Quality Account for 2015-16:

- West Midlands Ambulance Service NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- Worcestershire Health and Care NHS Trust
- Primrose Hospice, Bromsgrove


## Background

3. All providers of NHS healthcare services in England are required to publish an annual Quality Account – essentially annual reports to the public about the activities undertaken and quality of services provided. This includes independent and charitable organisations, unless they are classed as 'small providers'.

4. Each Quality Account is submitted to the Secretary of State and published on the NHS Choices website by 30 June each year. Further information about Quality Accounts is available here.

5. The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The Quality Account is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality Accounts therefore go above and beyond regulatory requirements, which focus on essential standards. If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

6. Quality Accounts are both retrospective and forward looking and are organised in 3 parts. Quality Accounts must cover the following:

Part 1 (mandatory)

- a **statement on quality** from the Chief Executive (or equivalent) of the organisation and a statement from the senior employee outlining that to the best of that person's knowledge the information in the document is accurate;

Part 2 (mandatory)
- **priorities for improvement** – the forward looking section of the report to show plans for quality improvement and why those priorities for improvement were chosen. The organisation should also demonstrate how the organisation is developing quality improvement capacity and capability to cover these priorities;
- **statements relating to quality of NHS services provided** – content common to all providers to make them comparable;

Part 3
- **review of quality performance** – report on the previous year's quality performance;
- an **explanation of who the organisation has involved** and engaged with to determine the content and priorities contained in the Quality Account;
- any **statements provided by the organisation's commissioners, local scrutineers and local Healthwatch**, including an explanation of any changes made to the final version of the Quality Account after receiving these statements.

7. NHS England has also indicated an expectation for organisations to report on the Family and Friends Test.

8. The public, patients and others with an interest in their local provider will use a Quality Account to understand:
    - where an organisation is doing well and where improvements in service quality are required;
    - what an organisation's priorities for improvement are for the coming year; and
    - how an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.

9. Commissioners and healthcare regulators, such as the Care Quality Commission, will use quality accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.

10. The process of producing a Quality Account is an opportunity for organisations and clinicians to collect, review and analyse information relating to quality, so that they can decide where improvement is needed in such a way that it becomes part of the core business of the organisation. It can also help with benchmarking against other organisations.

11. This also provides an opportunity for providers to engage with their stakeholders and the public, in the review of information relating to quality and decisions about priorities for improvement.

## Role of HOSC

12. HOSCs, along with commissioners and local Healthwatch, are given the opportunity to comment on a provider's Quality Account before it is published (30 day consultation

period), as it is recognised that they have a role in the scrutiny of local health services, including the ongoing operation of and planning of services.

13. HOSCs are considered to be ideally placed to ensure that a provider's Quality Account reflects the local priorities and concerns voiced by their constituents.

14. If an important local healthcare issue is missing from a provider's Quality Account then the HOSC can use the opportunity in the form of a statement to be included in a provider's Quality Account to highlight this omission.

15. HOSCs should not feel that they have to comment on areas of the Quality Account where they do not have relevant knowledge. However, conversations between providers and HOSCs should start at the beginning of the planning process for the production of a Quality Account so both the provider and the HOSC are aware each other's expectations in the process.

16. The role of HOSCs in providing assurance over a provider's Quality Account is a voluntary one, and depending on the capacity and interests of the HOSC, the committee may decide to prioritise those providers where members and their constituents have a particular interest.

17. Given the support for Quality Accounts expressed by Robert Francis in his report on Mid Staffordshire NHS Foundation Trust, the Chairman is keen that the HOSC should try to provide comments.

## Suggested HOSC Approach for Quality Accounts 2015-16

18. Each Trust works to a different reporting schedule leading up to the 30 June publication deadline, it is therefore difficult to programme a HOSC to consider and agree all Members comments from all Quality Accounts in a timely manner.

19. It is proposed that once received, each Quality Account is circulated to HOSC Members. Lead Members (those nominated by HOSC to have an oversight of an organisation) will be asked to draft an initial statement, which will be circulated to the Committee. Other Members will then be invited to add comments and after consultation, the Chairman will agree the statement for submission within the 30 day consultation period.

## Purpose of the Meeting

20. Members are asked to note the report and consider and agree the suggested approach for commenting on Quality Accounts 2015-16.

## Contact Points

County Council Contact Points
Worcestershire County Council: 01905 763763
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Specific Contact Points for this Report
Emma James / Jo Weston, Overview and Scrutiny Officers, Tel: 01905 844964 / 844965
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## Background Papers

In the opinion of the proper officer (in this case the Head of Legal and Democratic Services) the following are the background papers relating to the subject matter of this report:

- Department of Health Mini Guide for Quality Accounts: A Guide for Local Involvement Networks and Overview and Scrutiny Committees https://www.gov.uk/government/publications/quality-accounts-mini-guides-for-quality-accounts-a-guide-for-local-involvement-networks-link-and-overview-and-scrutiny-committees-oscs
- Agenda and Minutes of the Health Overview and Scrutiny Committee on 22 April 2015 http://worcestershire.moderngov.co.uk/ieListDocuments.aspx?CId=141&MId=396&Ver=4

# HEALTH OVERVIEW AND SCRUTINY COMMITTEE
# 27 APRIL 2016

# HEALTH OVERVIEW AND SCRUTINY COMMITTEE ROUND-UP

**Summary**

1. To receive a round-up of information on:

    - County Council activities in relation to health
    - District Council activities in relation to health
    - NHS Board meetings
    - Consultations in Worcestershire
    - Urgent health issues in Worcestershire; and
    - Items for future meetings of the Health Overview and Scrutiny Committee

## Background

2. In order to ensure that Members of the Health Overview and Scrutiny Committee (HOSC) are fully informed about issues relating to health scrutiny in Worcestershire, communication will be essential. To assist in this, an item will be placed on the agenda for each meeting of the HOSC to consider consultations, County Council activities, District Council activities, urgent health issues arising in Worcestershire and future agenda items. Regard for the Council's statutory requirements in relation to access to information will be critical.

## County Council Activities in Relation to Health

3. A range of County Council services can impact upon and also be impacted upon by health services. Recognising that the health-related work of the County Council will be of interest to the District Councillors on the Health Overview and Scrutiny Committee, an oral update on such activities, and on other matters the Chairman has been involved in, will be provided at each meeting by the Committee Chairman at each meeting of the HOSC.

## District Council Activities in Relation to Health

4. The statutory power of health scrutiny, including the power to require an officer of a local NHS body to attend before the Council, rests with the County Council. However, it is recognised that a number of District Councils within Worcestershire are undertaking work in relation to local health issues, under their duty to promote the economic, social or environmental well-being of their area.

5. Recognising that the work of the District Councils will be of value and interest to the wider HOSC, an oral update will be provided on such activities by District Councillors at each meeting of the HOSC.

## NHS Board Meetings

6. To help HOSC Members to keep up to date and maintain their knowledge of health issues around the County, it was agreed that a 'Lead Member' would be identified for each of the local NHS bodies to attend their Board Meetings and then provide an oral update at each meeting of the Scrutiny Committee.

## Consultations in Worcestershire

7. The HOSC has a duty to respond to local Health Trusts' consultations on any proposed substantial changes to local health services. An oral update will be provided at each meeting of the HOSC on both developments relating to consultations previously undertaken and forthcoming consultations.

## Urgent Health Issues in Worcestershire

8. Worcestershire County Council's constitution makes provision for urgent items to be considered. Standing Order 12.2 specifies that the Chairman of the HOSC "may bring before the meeting and cause to be considered an item of business not specified in the summons or agenda where the Chairman is of the opinion, by reason of special circumstances (which shall be specified in the minutes) that the item should be considered at the meeting as a matter of urgency".

9. Additionally, Standing Order 9.4.2 allows for the Chairman of the HOSC at any time to call a special meeting of the Health Overview and Scrutiny Committee. Standing Order 9.4.3 allows for at least one quarter of the members of the HOSC to requisition a special meeting of the HOSC. Such a requisition must be in writing, be signed by each of the Councillors concerned, identify the business to be considered and be delivered to the Director of Commercial and Change. In accordance with Access to Information Rules, the Council must give five clear days' notice of any meeting.

## Items for Future Meetings

10. It is necessary that the HOSC's ability to react to emerging health issues in a timely manner and the public's expectation of this is balanced against Worcestershire County Council's statutory duty to ensure that meetings and issues to be considered are open and transparent and meet legislative requirements. This agenda item must not be used to raise non-urgent issues. Any such issues should be raised with the Scrutiny Unit at least two weeks in advance of a scheduled meeting of the HOSC.

## Contact Points

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## Background Papers

In the opinion of the proper officer (in this case the Head of Legal and Democratic Services) the following are the background papers relating to the subject matter of this report:

- Worcestershire County Council Procedural Standing Orders, May 2015 which can be accessed on the Council's website here

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