Trust Board
There will be a meeting of the Trust Board on Thursday 9 May 2019 at 10:00 in Education Centre, Kidderminster Hospital and Treatment Centre.

This meeting will be followed by a public question and answer session.

Sir David Nicholson
Chairman

Agenda			Enclosure
1	**Welcome and apologies for absence**		
2	**Staff story: Guardian for Safe Working**		
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest**	*For assurance*	**Enc A**
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **11 April 2019** as a true and accurate record of discussions.*	*For approval*	**Enc B**
5.1	**Action Log**	*For noting*	**Enc C**
6	**Chairman's Report**	*For approval*	**Enc D1**
7	**Chief Executive's Report**	*For approval*	**Enc D2**
8	**Board Assurance Framework** Chief Executive	*For approval*	**Enc E**
9	**Integrated Performance Report**		**Enc F**
9.1	**Executive Summary** Chief Executive	*For assurance*	
9.2.1	**Section 1 – Quality Performance Report** Chief Nurse		
9.2.2	**Quality Governance Committee Assurance report** Quality Governance Committee Chairman		
9.3.1	**Section 2 – Operational & Financial Performance Report** Chief Operating Officer/Interim Chief Finance Officer		
9.3.2	**Finance and Performance Committee Assurance Report** Finance and Performance Committee Chairman		

9.4.1	**Section 3 – People and Culture Performance Report** Director of People and Culture		
9.4.2	**People and Culture Committee Assurance Report** People and Culture Committee Chairman		
10	**Governance**		
10.1	**Urgent Care – Home First Worcestershire Plan** Chief Operating Officer	*For assurance*	**Enc G1**
10.2	**Report on Nursing and Midwifery Staffing Levels** Chief Nurse	*For assurance*	**Enc G2**
10.3	**Bi-annual Patients' Acuity and Dependency Winter Study** Chief Nurse	*For assurance*	**Enc G3**
10.4	**Trust Management Executive Report** Chief Executive	*For assurance*	**Enc G4**
10.5	**Stakeholder report** Director of Communications and Engagement	*For assurance*	**Enc G5**
11	**Assurance Reports**		
11.1	**Audit and Assurance Committee Report** Audit and Assurance Committee Chairman	*For assurance*	**Enc H1**
11.2	**Remuneration Committee Report** Chairman	*For assurance*	**Enc H2**
11.3	**Conditions for Licence** Chief Executive	*For approval*	**Enc H3**
11.4	**Statement of undertakings** Chief Executive	*For discussion*	**Enc H4**

Any Other Business *as previously notified*

Date of Next Meeting
The next public Trust Board meeting will be held on 13 June 2019 in the Board Room, Alexandra Hospital, Redditch

Public Q&A session

Exclusion of the press and public

The Board is asked to resolve that - **pursuant to the Public Bodies (Admission to Meetings) Act 1960 'representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'** (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

V2 Feb 2019

Meeting	Trust board
Date of meeting	9 May 2019
Paper number	A

Declarations of Interest

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Sir David Nicholson Chairman		
Presented by	Kimara Sharpe Company Secretary	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care		Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients		Continuously improve our services to secure our reputation as the local provider of choice			

Alignment to the Trust's goals							
Timely access to our services		Better quality patient care		More productive services		Well-Led	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is requested to receive the attached declarations of interest and note that the document is on the website and is updated when required.

Worcestershire Acute Hospitals NHS Trust

Enc A

TRUST BOARD OF DIRECTORS' REGISTER OF INTERESTS 2019/20

Name	Designation	Declared Interest
Sir David Nicholson	Chairman	• Sole Director – David Nicholson Healthcare Solutions • Chair of Impact Evercare 1 Billion Healthcare Provider, Africa and South Africa (based in Dubai) • Senior Advisor – Universal Healthcare, KPMG Global • Member Health Advisory Board Google/Deepmind artificial intelligence • Chair – Health Advisory Board, IPPR • Visiting Professor – Global Health Innovation, Imperial College • Chair of Universal Healthcare Forum World Innovation for Health, funded by Qatar Foundation • Non-Executive Director - Lifecycle • Spouse is Chief Executive of Birmingham Women's and Children's NHS Foundation Trust
Matthew Hopkins	Chief Executive	• Partner is Director of Communications at IBM
Paul Brennan	Chief Operating Officer/Deputy Chief Executive	• None
Anita Day	Non-Executive Director	• Non-Executive Director- Nottingham University Hospitals Trust • Principle- Anita Day Consulting • Associate- Steps Drama Learning Development • Liberal Democratic party - member
Richard Haynes	Director of Communications	• Rock House Communications Ltd – Director
Colin Horwath	Associate NED	• Davidson and Partners – partner and part owner • Birmingham Children's Trust - NED
Julie Moore	Non-Executive Director	• Professor of Healthcare Systems, Warwick University

Name	Designation	Declared Interest
		• Trustee, Prince of Wales's Charitable Foundation • Non-Executive Director Organising Committee for the Commonwealth Games 2022 • Director, Innovating Global Health China Ltd • Director, Birmingham Systems • Honorary Professor, Zhouzhang University, Henan province, China • Honorary President, Guiqian International Hospital, Guiyang, Guizhou Province, China • Novartis Industry Council – member • Special Advisor to Newton Europe
Vicky Morris	Chief Nursing Officer	• None
Richard Oosterom	Associate NED	• MyMed Ltd (company number 09768044), 2.5% shareholding
Tina Ricketts	Director of People and Culture	• None
Kimara Sharpe	Company Secretary	• Examiner, ICS Advanced Healthcare Governance • Trustee, John Taylor Hospice, *from July 2018*
Sarah Smith	Director of Strategy and Planning	• None
Robert Toole	Interim Chief Finance Officer	• RDT Management Services Ltd
Bill Tunnicliffe	Non-Executive Director	• Spouse works for Worcestershire Acute Hospital NHS Trust (Quality Matron) • Main employment - University Hospital Birmingham NHS Foundation Trust. • Associate Medical Director (UHBNHS FT) with responsibility for appraisal and revalidation of medical staff. • Co-investigator - NHIR HTA funded trial (REST study Ref 13/141/02).
Steve Williams	Non-Executive	• Governor, Warwickshire College Group;

Name	Designation	Declared Interest
	Director	• Director, Unity Ltd • Trustee, Univ Old Members trust
Mark Yates	Non-Executive Director	• None
Jackie Edwards	Deputy CNO	• None
Graham James	Deputy CMO	• Moore dental surgery, King's Heath – undertake sessional work (private practice)
Katie Osmond	Assistant Director of Finance	• Kempley Village Hall Trust – Chairman of Trustees
Robin Snead	Deputy Director of Operations	• None
Michelle McKay	Chief Executive *Until 14 December 2018*	• None
Suneil Kapadia	Chief Medical Officer *until 8 May 2019*	• Sanofi-Pasteur • Member of the independent drug monitoring committee
Philip Mayhew	Non-Executive Director *until 21 December 2018*	• 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 • Chair of Colebridge Trust and Colebridge Enterprises
Jill Robinson	Chief Financial Officer *until March 2019*	• None

Kimara Sharpe
Company Secretary
April 2019

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 11 APRIL 2019 AT 10:00 hours
The Board Room, Alexandra Hospital, Redditch

Present:

Chairman:	Sir David Nicholson	
Board members: (voting)	Paul Brennan	Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Matthew Hopkins	Chief Executive
	Suneil Kapadia	Chief Medical Officer
	Dame Julie Moore	Non-Executive Director
	Bill Tunnicliffe	Non-Executive Director
	Steve Williams	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications
	Colin Horwath	Associate Non-Executive Director *from 146/18/2*
	Richard Oosterom	Associate Non-Executive Director
	Sarah Smith	Director of Strategy and Planning
In attendance:	Kimara Sharpe	Company Secretary
Public Gallery:	Press	0
	Public	6 plus two staff members
Apologies	Vicky Morris	Chief Nursing Officer
	Tina Ricketts	Director of People and Culture
	Mark Yates	Non-Executive Director

1/19 **WELCOME**

Sir David welcomed everyone to the meeting, in particular, Mrs Edwards and Mrs Berry.

2/19 **DECLARATIONS OF INTERESTS**

Sir David congratulated Ms Day on her appointment as a Non-Executive Director at Nottingham University Hospital NHS Trust. She will continue in her role here in Worcestershire. There were no additional declarations of interest. Board members were reminded that the Register is on the website.

3/19 **STAFF STORY**

Sir David welcomed Ms Bloomer, Silver Ward, and Ms Rutter, Matron. He invited Ms Edwards to introduce the staff story.

Ms Edwards explained that the Board would be shown a video made by Sophie, a student nurse. Sophie was placed on Silver Ward and in the video, Sophie explains her feelings and how she was welcomed on the ward. As a result of her experience, she has nominated the Trust for the Nursing Times Student Placement of the year.

The Board was shown a video. Sophie explained in the video that her sister had died of

cancer at the age of 32 a month before her placement started. She was therefore very nervous of her placement on Silver Ward which was the oncology ward. She described how the cancer had affected her and she nearly gave up her training prior to the placement as it was bringing back very painful memories.

However, the placement helped her to grieve. Ms Bloomer, the ward manager had been extremely supportive and Sophie was able to speak about her sister openly. The staff on Silver had shown nothing but kindness. The placement experience has inspired her to continue her training and she is considering oncology as a career choice.

Ms Bloomer stated that when she took over Silver Ward, it was one of the most underperforming wards in the Trust with a high percentage of temporary staff. She worked using the 4ward behaviours to ensure that the ward was transformed. All staff now feel supported. There are now 20 permanent staff, compared to five when she started.

Ms Smith complimented Ms Bloomer on her work. Ms Smith had undertaken a quality visit recently and although Ms Bloomer was not on duty, the ward was running extremely well and the staff were welcoming and professional. It was one of the best visits that she has ever undertaken.

Dr Tunnicliffe thanked Ms Bloomer and stated that she was an inspiration for the workforce. Ms Bloomer explained that she has had challenges but she drew on her resilience. She also felt that her previous experience working in a large store where customer service was paramount had influenced her way of working.

Ms Day also praised Ms Bloomer. She wondered whether there was anything the Board could do to support the work being undertaken. Ms Rutter explained that an acute oncology bay was needed so that patients could bypass A&E when acutely ill. Ms Bloomer explained the poor experience of one patient who had been shuttled between A&E and the ward. She has identified an area which could be utilised.

ACTION: Review the provision of an acute bay for oncology patients (Mr Brennan)

Mr Oosterom asked what more could be done to support staff put into a similar position. Ms Bloomer stated that she did not have any support when she was appointed. She had no idea about how to be a manager. She was pleased with the action learning sets now set up but she would like to see some action coming out of the sets. She explained that when she was nominated for the national Rising Star awards, she was very proud.

Mr Williams wondered how the 4ward programme could be embedded across the whole trust. Ms Bloomer felt that the most important issue was tackling behaviour which was not one of the signature behaviours. She wondered whether all senior staff were always challenged when inappropriate behaviour was shown.

Mr Hopkins stated that he was extremely proud of Ms Bloomer and wished that she could be replicated.

Sir David expressed his thanks to Ms Bloomer and Ms Rutter. He stated that one of the accolades of being a great leader was that when you were not present, the service still worked well. This was evident with Ms Smith's quality visit. He said that Ms Bloomer was inspiring.

There was a round of applause.

4/19 **ANY OTHER BUSINESS**

There were no items of any other business.

5/19 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 14 MARCH 2019**

RESOLVED that:-

- The Minutes of the public meeting held on 14 March 2019 were confirmed as a correct record subject to the following change:
  Page 6, second paragraph from the bottom of the page:
  Change *Ms Day was pleased with the reports* to *Ms Day was pleased that the reports indicated progress was beginning to be made.*

6/19 **MATTERS ARISING/ACTION SCHEDULE**

All actions were either complete or not yet due.

7/19 **INTEGRATED PERFORMANCE REPORT**

7/19/1 **Executive summary**

Mr Hopkins introduced the Report. He explained that the most up to date data would be given by colleagues when speaking to their areas.

He stated that the key headlines were as follows:

- **Quality**
  - There has been an improvement in the care of patients following a fractured neck of femur following the relocation of the service to the Alexandra Hospital.
  - Some areas of infection, prevention and control were still a challenge.
- **Finance**
  - The 2018/19 performance was a disappointment. The financial picture remains challenged.
- **Performance**
  - The latest emergency access standard metric showed steady progress. The urgency care recovery plan was being implemented.
  - The RTT (referral to treatment) standard was part of the contracting discussions which will inform the performance over the coming year.
- **Workforce**
  - Vacancy rates have improved
  - Mandatory training rates were still unsatisfactory and he explained that staff will no longer be paid until their mandatory training has been completed.

7/19/2 **Quality Performance/Quality Governance Committee Assurance Report**

Ms Edwards stated that infection, prevention and control (IPC) remained a key priority. There had been five cases of *C Diff* in January and there was a similar picture in February and March. She was pleased with the launch of the 12 key standards which enabled staff to be held to account. The deputy CNO (IPC) was examining each case to ascertain lessons to lean and review antimicrobial stewardship.

Wirth respect to hand hygiene, compliance in areas undertaking the audits was at 97.3%. All areas needed to undertake the audits and she described the actions being taken to ensure this.

She was disappointed that there had been two grade 3 pressure ulcers. This was a key area of ward accreditation.

There was an improvement in the completion rate for the friends and family test. She explained the appropriate processes were in place (she has benchmarked against other

organisations) and key was to ensure staff asked for the forms to be completed.

She then reported that during the national Care Week, a relaxed visiting policy was being launched. This was to ensure that carers were more involved in care. The Trust was also launching a youth forum.

Ms Edwards handed over the Dr Kapadia to highlight other areas within the quality area.

Dr Kapadia stated that 85% of patients with sepsis were receiving antibiotics within 1 hour. Sepsis 6 was still below the target but plans are in place. He was pleased that mortality secondary to sepsis had fallen – the Hospital Standardised Mortality Ratio (HSMR) was now 100.

He then turned to the HSMR. The rise had been expected and was now plateauing. The in depth review of pneumonia deaths was within normal limits. He then described the work being undertaken with the palliative care team and the coding team to improve patient experience and improve the HSMR.

He was pleased with the treatment of patients following a fractured neck of femur. Outcomes had also improved and mortality has reduced significantly. He was also pleased with the audit of NICE assessments showed the turnaround was now at 6 weeks.

Sir David invited Dr Tunnicliffe to speak as chair of the Quality Governance Committee. Dr Tunnicliffe supported the work that was being undertaken and stated that whilst there was improvement, he was frustrated with the slow progress in some areas. He was having another away day for members of the QGC to review the use of data within the committee and the relationship with the Clinical Commissioning Group. He was hopeful of a step change in some areas in the next few weeks.

Dame Julie asked what was found in relation to antimicrobial stewardship. Ms Edwards explained that the data collection was not robust and it had not been possible to interpret the data. The deputy CNO (IPC) was putting in place changes to enable the interrogation to take place. She went onto state that there could have been prescribing improvements for the cases reviewed. Dame Julie asked whether there was an educational programme for prescribers. Ms Edwards explained the focussed prescribing education programme which included junior doctors.

Dame Julie asked how the number of hand hygiene audits was being increased. Ms Edwards explained that a letter had been written to those areas which were not participating and a follow up would take place later in the month.

Dame Julie then turned to sepsis 6. She asked what plans were in place to ensure that the sepsis bundle was in place. Dr Kapadia described the work being undertaken with clinicians and the provision of data in real time. He was focussing on the ‘front door;’ i.e. medical assessment and medical short stay. He expressed frustration with the paper-intensive process. He reiterated that key was the reduction in deaths which has been sustained for 12 months. He admitted that the main challenge was to ensure that there was accurate documentation of the steps taken.

Ms Smith stated that there was a theme around medicines’ management. She wondered what difference an electronic prescribing system would make. Dr Kapadia stated that this would give confidence about what was taking place. It would also help to avoid some incidents.

Sir David expressed frustration with the quality discussion which had been very operational. Indicators were remaining red. Dr Tunnicliffe stated that there had been improvements – he highlighted the performance of patients needing a repair to a fractured neck of femur - but agreed that some of the discussion in the meeting should have taken place at the Committee or in other forums. Dame Julie agreed and stated that the reports should be more factual based, not aspirational.

Mr Hopkins agreed. He stated that he has been undertaking work to ensure that the right level of challenge takes place at the right level with the Trust. This should take place at the performance review meetings and the trust management executive (TME) which is responsible for running the hospitals.

Sir David acknowledged the activity that was being undertaken. Dr Tunnicliffe expressed concern that a ward accreditation would support front line staff to focus on improvements but was concerned that medical staff were not engaged. Dr Kapadia explained that ward accreditation required medical engagement. Mr Hopkins agreed to follow this area up with Dr Kapadia.

ACTION: Review medical engagement in the Ward Accreditation process. (Dr Kapadia)

RESOLVED that
The Board

- Received the Committee report for assurance

7/19/3 **Financial & Operational Performance/Finance and Performance Committee Assurance Report**

Mr Toole spoke to the financial performance. He stated that the outturn was £73.7m, broadly in line with the forecast. With respect to income, there were no major disputes. Pay was the biggest area in expenditure and there remained a significant impact of the non-permanent workforce. He stated that a weekly pay panel has been instigated. This will provide key grip and control.

In respect of non-pay he would be negotiating a spot deal for energy for the next six months.

He confirmed that the issue of impairments will not impact on the financial performance.

He then turned to 2019/20. £13m cost improvement plans (CIP) has been identified. £22m was required. There was now a refocus to reduce the run rate. He was expecting to reduce the rates of pay and the numbers employed non-substantially. He was also looking at non-basic clinical expenditure which will be picked up at TME. He was keen to ensure quality action plans were in place to identify the financial outcomes.

Sir David stated that the delivery of £73.7m meant that the Trust missed the declared outturn of £72.5m. Mr Toole explained that this was primarily due to the energy issue. Sir David stated that the missing of the outturn was an example of the Trust not 'doing what it said it would'.

Sir David then asked about the £13m CIP identified. Mr Toole explained that plans were in place to deliver £13m and there was some phasing in the first 2 months. He confirmed that the CIPs had not been risk stratified. Ms Smith stated that a delivery risk assessment had been undertaken in the submission to NHS Improvement.

Mr Toole stated that there was action being taken in crucial areas including improving

the grip and control, ensuring an adequately resourced project management office and enhanced performance review meetings to focus on savings.

Mr Williams referred to the model hospital which could show areas in which the Trust was currently inefficient and where head count could be cut. Mr Toole explained that the model hospital was a high level analysis and he was working with the Director of People and Culture to review the workforce and determine areas of opportunity.

Sir David reminded members that the Trust needed to resubmit the plan in four weeks. He was surprised that not more action had been taken, specifically about areas of opportunity within the workforce.

Mr Horwath wondered whether the Board could support the work that Mr Toole had outlined. Mr Toole explained that the management team were responsible for the actions and the right steps were being taken.

Mr Brennan explained that the model hospital data had shown that there were significant cost savings within maternity and NHS Improvement was working with the Divisional Medical Director to identify these. He was confident that the pay panel would have a significant impact on the cost base. He explained the challenge that was being undertaken with respect to each vacancy.

Dr Tunnicliffe wondered how much of the CIP was based on having the grip and control. Mr Toole confirmed that the £13m was not reliant on grip and control. He also confirmed to Ms Day that there was weekly reporting on the CIP.

Sir David invited Mr Brennan to speak to operational performance.

Mr Brennan stated that improvements were being seen but more was needed. The focus on cancer waits had resulted in 70 patients waiting over 104 days for treatment. There is a clear plan to reduce this number further. There is also a focus on ensuring no patients waits for more than 40 weeks by September under the RTT indicator. He was pleased that there was no-one waiting over 52 weeks in March.

He stated that the performance report would change in May for the new financial year. There will be a focus on the next three months.

Mr Brennan then highlighted the data relating to ambulance handovers and waiting in the corridor, both of which had improved between January and March 2019. He was aiming for 86% of people seen within 4 hours by September. Performance plans were in place to hold people to account.

All cancer standards should be met by September and diagnostics by the end of the year.

Mr Brennan finally referred to the achievement of the fractured neck of femur metric. He thanked Mr Docker and his team for the work involved in achieving the standard.

Mr Hopkins confirmed that there was weekly monitoring in place by the executive team which was not in place during 2018/19. There was a better understanding of capacity and demand. He was pleased that there was now an understanding of the cost for treating the backlog of patients. This has been highlighted to commissioners as his view was that the Trust should have the right funding to meet the NHS Constitutional standard of 92%. An extra £7.6m has been requested. He requested support from the Board in this stance.

Dr Tunnicliffe thanked Mr Brennan for a clear report and a future look at the position in respect of key metrics.

Mr Oosterom, Chair of the Finance and Performance Committee, agreed with Mr Brennan that improvements had been made. He felt that there were tangible plans in place to achieve the trajectories.

He then turned to finance. He was disappointed that the outturn was not in line with the forecast or the target. Basic controls were needed which had been discussed at the committee. He was also disappointed that the CIP had not progressed as far as he would have wished. Mr Oosterom confirmed that the draft operational plan had been submitted.

Ms Day asked what changes were needed to the draft plan. Mr Hopkins outlined the areas that needed to have more clarity which included quality, performance, workforce and finance. Trajectories were also needed as well as clarity on the run rate. He was keen that how the Trust invests capital was included. Finally, there needed to be more detail and narrative relating to the priorities.

Sir David stated that he recognised that there was a huge amount of work that was needed to be undertaken. There had been some progress on the operational standards and he endorsed the stance that Mr Hopkins outlined in respect of RTT. He was adamant that the Trust should not undertake work that it was not funded for.

RESOLVED that:
The Board

- Received the Committee report for assurance
- Confirmed that the Trust would not undertake activity in relation to RTT that it was not paid for, even if this meant the non-achievement of the 92% NHS Constitution standard

7/19/4 **People and Culture Performance**

Mrs Berry reported that vacancies have decreased by 1.66% meaning that an additional 103 staff have been appointed. A dedicated recruitment manager is now in place which had resulted in a 50% reduction in the time to hire. International recruitment for nurses has commenced.

In respect of job planning, 81% was achieved at the end of March against a trajectory of 85%.

Rates of mandatory training continue to improve. Face to face training is offered for staff. Unfortunately medical and dental staff rates have not improved. Most reasons for non-attendance at training events has been cited as clinical. She confirmed to Dame Julie that no member of staff has been taken down the disciplinary route but she also confirmed that no staff member can undertake other training or apply for clinical excellent awards unless mandatory training is up to date. Mr Hopkins confirmed that staff would be suspended on zero pay if they do not undertake their training. Dr Kapadia confirmed that the Divisional Medical Directors were working to ensure higher compliance .However in respect of junior doctors; the trust was unable to stop pay.

Mrs Berry confirmed to Ms Day that the centralised recruitment business case had now been approved.

RESOLVED that:

The Board:

- Received the report

7/19 **GOVERNANCE**

7/19/1 **Going Concern**

Mr Toole explained that the concept of "going concern" is one of the fundamental principles underpinning the accounting regime used in preparation of the financial statements. Essentially it means that as Directors, we have the resources in place to remain viable for the foreseeable future.

Mr Toole stated that this had been endorsed by the Finance and Performance Committee and the executive team. However board ratification is required.

RESOLVED that:
The Board:
Approved that

- the Trust prepares its accounts on the basis of a going concern, despite the significant cash requirement within the 2019/20 draft financial plan.

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held on Thursday 9 May 2019 at 10:00 in the Education Centre, Kidderminster Hospital and Treatment Centre, Kidderminster.

The meeting closed at 12:01 hours.

Signed _____ Date _____

Sir David Nicholson, Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – MAY 2019

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
11-4-19	Staff story	3/19	Explore the bay for acute oncology patients to avoid A&E	PB	June 2019			
11-4-19	IPR	6/19	Consider how medical staff are engaged in the ward accreditation process	CMO	June 2019			
14-3-19	IPR	148/18/3	Discussion on stroke	PB	May 2019		Scheduled for May meeting. On agenda. Action closed.	
14-2-19	IPR	146/18/2	Present the urgent care action plan to the March meeting	PB	Mar 2019	April 2019	Deferred to April TME and F&P. May Board. On agenda. Action closed.	
14-3-19	Nursing and midwifery staffing	149/18/2	Flexible working – agenda item for May meeting	TR	May 2019		Discussed at People and Culture. Commencement of Timewise study. Monitored through P&C Committee. Action closed.	
14-3-19	Mortality	149/18/1	QGC to maintain an oversight	SK			On agenda at each meeting. Action ongoing.	

9-11-18	FTSU Guardian	99/18/4	FTSU guardian and champions to attend TB	KS	May 2019		On agenda for March meeting. Action closed.	

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	D1

Chairman's Report

For approval:	x	For discussion:		For assurance:		To note:	

Accountable Director	Sir David Nicholson Chairman		
Presented by	Sir David Nicholson Chairman	**Author**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	X	Design healthcare around the needs of our patients, with our partners	X	Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients	X	Continuously improve our services to secure our reputation as the local provider of choice	X		

Alignment to the Trust's goals							
Timely access to our services	X	Better quality patient care	x	More productive services	*X*	Well-Led	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is requested to • Approve the appointment of Dr Tunnicliffe as the NED lead for clinical governance systems for doctors.

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	D1

Executive Summary

The publication *Effective clinical governance for the medical profession* (2019) aims to provide boards with a description of the core principles underpinning effective clinical governance for doctors focussing particularly on responsibilities outlined in the Responsible Officer (RO) regulations.

Principle 1, *Organisations create an environment which delivers effective clinical governance for doctors recommends* the appointment of a suitably qualified and trained non-executive director with a specific role in providing support and challenge to the board on clinical governance systems for doctors including revalidation and management of concerns.

I would like to propose that Dr Bill Tunnicliffe takes on this role for the board, working with the Chief Medical Officer and Deputy Chief Medical Officer (as the Responsible Officer) to ensure that the Trust provides the environment to deliver effective clinical governance for doctors.

Recommendations

The Board is requested to

- Approve the appointment of Dr Tunnicliffe as the NED lead for clinical governance systems for doctors.

Appendices – none

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	D2

Chief Executive's Report

For approval:		For discussion:		For assurance:		To note:	x

Accountable Director	Matthew Hopkins Chief Executive Officer		
Presented by	Matthew Hopkins Chief Executive Officer	**Author**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	X	Design healthcare around the needs of our patients, with our partners	X	Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients	X	Continuously improve our services to secure our reputation as the local provider of choice	X		

Alignment to the Trust's goals							
Timely access to our services	X	Better quality patient care	x	More productive services	*X*	Well-Led	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is requested to • Approve the terms of reference for the Trust Management Executive • Note this report

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	D2

Executive Summary

Trust Management Executive: The terms of reference for the TME are presented for approval to the board as appendix 1. Members will be aware of the importance that I place on this meeting and I am pleased with how it is developing. We will review the terms of reference in 3 months to ensure that TME is meeting its objectives.

Executive team changes: I should like to thank Dr Suneil Kapadia for his leadership as Chief Medical Officer and wish him well in the future. I have put in place processes to recruit to a substantive Chief Finance Officer, a Chief Digital Officer and an interim Chief Medical Officer.

CQC inspection dates: We have had notification that the CQC well-led inspection will take place on 19-21 June. Several non-executive directors will be interviewed as part of this inspection and details have been circulated. We have also been informed of the partial inspection of core services. This will take place between 14 and 29 May.

Nursing associates: The first cohort of nursing associates have completed their training. They will play a crucial role of filling a gap in skills between current health care assistants and registered nurses and represent an important step in developing new roles to address our workforce challenges.

Annual Frank Farr Award: Dr Ashim Lahiri has been awarded the annual Frank Farr award for his exemplary commitment and contribution to training radiologists in the West Midlands.

Silver medal: Julia Rhodes has been awarded the Society and College of Radiographers Silver medal for outstanding dedication and contribution to radiology.

I am sure the Trust Board will join me in congratulating them both.

NHS I/NHS E (Midlands) update: the following senior appointments have been made:

- Director of Commissioning: Alison Tonge
- Medical Director and Chief Clinical Information Officer: Dr Nigel Sturrock
- Chief Nurse: Siobhan Heafield
- Director of Performance and Improvement: Jeff Worrall
- Director of Workforce and Organisational Development: Steve Morrison

The posts of Finance Director and Director of Strategy and Transformation have not yet been appointed. Dr Rashmi Shukla, Director of Public Health for the Midlands, will be part of the regional leadership team. There remains in place locality teams for system specific contact and relationships

NHS Assembly announced to help deliver the Long Term Plan: The Assembly members are drawn from national and frontline clinical leaders, patients and carers, staff representatives, health and care system leaders and the voluntary, community and social enterprise sector. The group will meet for the first time in Spring, and then quarterly afterwards, bringing their experience, knowledge and links to wider networks to inform discussion and debate on the NHS's work and priorities. The Assembly will be co-chaired by leading GP Dr Claire Gerada, and former head of the King's Fund think tank, Professor Sir

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	D2

Chris Ham.
Integrated Care for Older People: I attended the launch of the Integrated Care for Older People (ICOPE) Strategy representing the Trust in the QIA Panel.

Background

This report is to brief the board on various local and national issues.

Issues and options

None

Recommendations

The Board is requested to

- Approve the terms of reference for the Trust Management Executive
- Note this report

Appendices – TME terms of reference

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	D2

Terms of Reference

TRUST MANAGEMENT EXECUTIVE

Version: 1.2

Terms of Reference approved by: Trust Management Executive

Date approved: April 2019

Author: Company Secretary

Responsible directorate: CEO

Review date: August 2019

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	D2

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

TRUST MANAGEMENT EXECUTIVE

TERMS OF REFERENCE

1 Authority

The Trust Management Executive (TME) is authorised by the Trust Board.

2 Purpose

TME will be the primary executive decision making body for the Trust. It is set up to drive the strategic agenda for the Trust. TME will drive the business objectives for the Trust. It will ensure that the key risks are identified and mitigated as well as ensuring that the Trust achieves its financial and operational performance targets.

3 Membership

Chief Executive
Deputy Chief Executive/Chief Operating Officer
Chief Medical Director
Chief Nursing Officer
Chief Financial Officer
Director of People and Culture
Director of Communications and Engagement
Director of Strategy and Planning
Company Secretary
Divisional Medical Director – Surgery
Divisional Medical Director – Women and Children
Divisional Medical Director – Speciality Medicine
Divisional Medical Director – Urgent Care
Divisional Medical Director – Specialised Clinical Services
Chief Digital Officer (Associate Director of Information, Performance &IT to cover)
Director of Medical Education
Director of Estates and Facilities
Chief Pharmacist
Deputy CMO

If Executive Directors are unable to attend, deputies can attend in their absence. If DMDs are unable to attend, the Divisional Director of Nursing or the Divisional Operations Director may attend in their absence. It is the responsibility of the Director who cannot attend to fully brief the deputy.

Other staff will be invited as appropriate.

4 Arrangements for the conduct of business

4.1 Chairing the meetings

The CEO shall chair TME and the Deputy CEO will be the deputy chair.

4.2 Quorum

A quorum will be when 50% of members (9) are in attendance, including two divisional medical directors and two voting members of the Trust Board.

4.3 Frequency of meetings

The Group shall meet at least 12 times a year (once a month).

4.4 Attendance

Members are expected to attend all meetings, with a minimum of at least 12 meetings per year.

4.5 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.

4.6 Urgent matters arising between meetings

If there is a need for an emergency meeting, the Chair will call one.

4.7 Secretariat support

Secretarial support will be through the CE secretariat.

5 Duties

In discharging the purpose above, the specific duties of TME are as follows:

- Oversee the development of the annual plan for the Trust.
- Manage the delivery of the plan.
- Manage the delivery of the financial recovery plan.
- Identification of the risks to the delivery of the strategic objectives and ensuring mitigation of those risks.
- Oversee the divisional working and receive reports relating to the performance of the divisions as they relate to the achievement of the plan.
- Ensure that risks to patients are minimised through the application of a comprehensive risk management system.
- Ensure those areas of risk within the Trust are regularly monitored and that effective disaster recovery plans are in place.
- Escalate to the Audit and Assurance Committee 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 risks to the operation, resources or reputation of the Trust.
- Approve service delivery change plans or make recommendation to Trust Board for approval.
- Receive and action relevant external and internal reports on trust activity, regulatory compliance and peer reviews.
- Monitor the actions associated with internal audit reports, by exception.
- Review progress against key quality and people and culture plans.

- Oversee the corporate performance of the Trust and take appropriate action to rectify if required.
- Approve business cases up to the delegated limit and onward to Finance & Performance Committee as appropriate.

6. Relationships and reporting

6.1 TME is accountable to the Trust Board and will report to the Trust Board at each meeting.

6.2 TME will receive reports from:

- Clinical Governance Group
- Recruitment and Retention Groups
- 4Ward Steering Group
- Risk Management Group
- Health and Safety Group
- Education and Learning Group
- Equality and Diversity Group
- Strategy and Planning Group
- Performance Review Meetings
- Cancer Improvement Group
- Information Governance Steering Group
- Emergency Planning Group

TME will set up task and finish groups as appropriate.

7 Review Period

Terms of reference will be reviewed by August 2019.

KS/ToR TME 0419 final

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust board
Date of meeting	9 May 2019
Paper number	E

Board Assurance Framework

For approval:	x	For discussion:		For assurance:		To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Kimara Sharpe Company Secretary	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	x	Design healthcare around the needs of our patients, with our partners	x	Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients	x	Continuously improve our services to secure our reputation as the local provider of choice	x		x

Alignment to the Trust's goals							
Timely access to our services	x	Better quality patient care	x	More productive services	*x*	Well-Led	x

Report previously reviewed by		
Committee/Group	Date	Outcome
People and Culture	April 2019	Approved
Quality Governance	April 2019	Noted
Trust Management Executive	April 2019	Approved
Finance and Performance	April 2019	Requested • Review of current risk score (risk 7) • Review of risk 5

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	All

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is requested to • approve the May update of the Board assurance Framework (appendix) • note that a revised BAF aligning to the new priorities will be presented to the Board in July

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust board
Date of meeting	9 May 2019
Paper number	E

Executive Summary

This report presents the updated Board Assurance Framework (BAF). The changes to the BAF from the version presented in January are as follows:

- All actions relating to the gaps in control are strategic, not operational
- Risk 1 – increase in risk score from 12 to 16
- Risk 2 – decrease in risk score from 16 to 12
- Risk 5 – verbal update at meeting
- Risk 6 – increase in risk score from 15 to 20
- Risk 7 – increase in risk score from 15 to 16 (request from Finance and Performance Committee)
- Target dates for risk ratings have been introduced for each risk to show a clear pathway from the current position to the final position over a period of years.
- Interim dates for target risk ratings have been introduced for some risks where there is a long lead time
- Insertion of previous risk scores, giving three data points
- Insertion of the initial date of identification of the risk

It has been recognized that the BAF risks need to be rated. A gap analysis has been undertaken between the current risk score (as at April 2019) and the target risk score (as at various dates) to rank the risks according

The risks are ranked as follows (shown graphically over the page):

No	Risk	Score (current risk score – target risk score)
6	IF we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfill our financial duties RESULTING IN the inability to invest in services to meet the needs of our patients. we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfill our financial duties RESULTING IN the inability to invest in services to meet the needs of our patients.	14
7	IF we are not able to unlock funding for investment THEN we will not be able to modernise our estate, replace equipment or develop the IT infrastructure RESULTING IN the lack of ability to deliver safe, effective and efficient care to patients	14
3	IF we do not deliver the statutory requirements under the Health and Social Care Act (Hygiene code) THEN there is a risk that patient safety may be adversely affected RESULTING IN poor patient experience and inconsistent/varying patient outcomes	13

Meeting	Trust board
Date of meeting	9 May 2019
Paper number	E

4	IF we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning THEN we will fail the national quality and performance standards RESULTING IN a negative patient experience and a failure to exit special measures and to attain STF funding	11
10	IF we do not deliver a cultural change programme. THEN we may fail to attract and retain staff with the values and behaviours required RESULTING IN lower quality care for our patients	10
12	IF we have a poor reputation THEN we will be unable to recruit or retain staff RESULTING IN loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care	10
1	IF we do not have in place robust clinical governance for the delivery of high quality compassionate care THEN we may fail to consistently deliver what matters to patients RESULTING IN negative impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	8
8	IF we do not have effective IT systems which are used optimally THEN we will be unable to utilise the systems for the benefit of patients RESULTING IN poorly coordinated care for patients and a poor patient experience	8
9	IF we are unable to sustain our clinical services THEN the Trust will become unviable RESULTING IN inequity of access for our patients	8
11	IF are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU THEN there is a risk to the sustainability of some clinical services RESULTING IN lower quality care for our patients	8
5	IF there is a lack of a strategic plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a major impact on the trust's ability to deliver safe, effective and efficient care to patients	6
2	IF we do not deliver the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained change RESULTING IN required improvements not being delivered for patient care & reputational damage	6

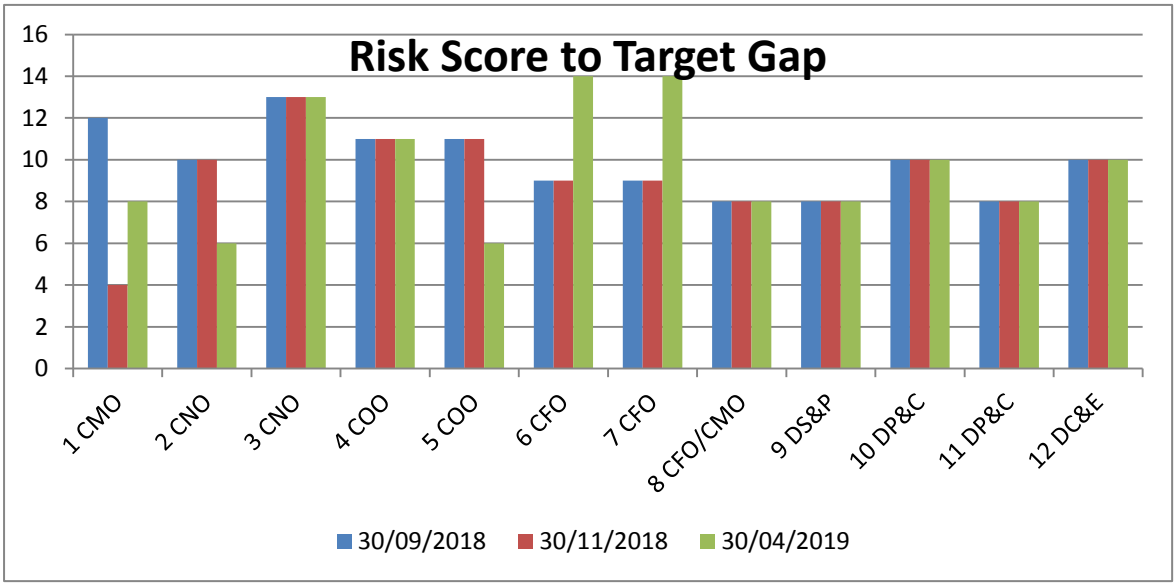
Meeting	Trust board
Date of meeting	9 May 2019
Paper number	E

Background

The BAF has been presented to the board in September, November and January. It has been reviewed by the executive directors and the version attached has been developed into a strategic document, showing the strategies associated with each risk.

Issues and options

The gap between the current risk score and the target risk score can be seen below:



This clearly shows that the five largest gaps are related to finance, infection control, performance, culture and reputation. This gives the nuance that Board members have requested in relation to the risk scores.

Recommendations

The Board is requested to

- approve the May update of the Board assurance Framework (appendix)
- note that a revised BAF aligning to the new priorities will be presented to the Board in July

Appendices

Appendix 1 – the BAF as at April 2019.

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS		CURRENT 30 APRIL 2019			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
						RISK RATING 30 SEPT 2018	LIKELIHOOD	CONSEQUENCE	RISK RATING				
1	3927 ------ 2017	IF we do not have in place robust clinical governance for the delivery of high quality compassionate care THEN we may fail to consistently deliver what matters to patients RESULTING IN negative impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	Chief Medical Officer	Quality Governance		12	4	4	16	⇧	April 2019	June 2019	6
2	3930 ------ 2018	IF we do not deliver the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained change RESULTING IN required improvements not being delivered for patient care & reputational damage	Chief Nurse	Quality Governance		16	3	4	12	⇩	April 2019	June 2019	8

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS		CURRENT 30 APRIL 2019				LAST REVIEW	NEXT REVIEW	PAGE NUMBER
						RISK RATING 30 SEPT 2018	LIKELIHOOD	CONSEQUENCE	RISK RATING	CHANGE			
3	3931 ------ 2018	IF we do not deliver the statutory requirements under the Health and Social Care Act (Hygiene code) THEN there is a risk that patient safety may be adversely affected RESULTING IN poor patient experience and inconsistent/varying patient outcomes	Chief Nurse	Quality Governance		16	4	4	16	⇔	April 2019	June 2019	10
4	3932 ------ 2018	IF we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning THEN we will fail the national quality and performance standards RESULTING IN a negative patient experience and a failure to exit special measures and to attain STF funding	Chief Operating Officer	Finance and Performance		20	4	5	20	⇔	April 2019	June 2019	12

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS		CURRENT 30 APRIL 2019					
						RISK RATING 30 SEPT 2018 / RISK RATING 30 NOV 2018	LIKELIHOOD	CONSEQUENCE	RISK RATING	CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
5	3933 ------ 2018	IF there is a lack of a strategic plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a major impact on the trust's ability to deliver safe, effective and efficient care to patients	Chief Operating Officer	Finance and Performance		20 / 20	3	5	15	⇩	April 2019	June 2019	13
6	3934 ------ 2018	IF we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfill our financial duties RESULTING IN the inability to invest in services to meet the needs of our patients.	Chief Financial Officer	Finance and Performance		15 / 15	4	5	20	⇧	April 2019	June 2019	14
7	3941 ------ 2018	IF we are not able to unlock funding for investment THEN we will not be able to modernise our estate, replace equipment or develop the IT infrastructure RESULTING IN the lack of ability to deliver safe, effective	Chief Financial Officer	Finance and Performance		16 / 15	4	4	16	⇧	April 2019	June 2019	16

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS		CURRENT 30 APRIL 2019			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
						RISK RATING 30 SEPT 2018 / RISK RATING 30 NOV 2018	LIKELIHOOD	CONSEQUENCE	RISK RATING				
		and efficient care to patients											
8	3936 ------ 2018	IF we do not have effective IT systems which are used optimally THEN we will be unable to utilise the systems for the benefit of patients RESULTING IN poorly coordinated care for patients and a poor patient experience	Chief Financial Officer/Chief Medical Officer	Finance and Performance/ Quality Governance Committee		16 / 16	4	4	16	⇔	April 2019	June 2019	17
9	3937 ------ 2017	IF we are unable to sustain our clinical services THEN the Trust will become unviable RESULTING IN inequity of access for our patients	Director of Strategy and Planning	Finance and Performance		16 / 16	4	4	16	⇔	April 2019	June 2019	19
10	3938 ------ 2017	IF we do not deliver a cultural change programme. THEN we may fail to attract and retain staff with the values and behaviours required RESULTING IN lower quality care for our patients	Director of People and Culture	People and Culture		15 / 15	3	5	15	⇔	April 2019	June 2019	20

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS		CURRENT 30 APRIL 2019					
						RISK RATING 30 SEPT 2018	RISK RATING 30 NOV 2018	LIKELIHOOD	CONSEQUENCE	RISK RATING	CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
11	3939 ------ 2018	IF are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU THEN there is a risk to the sustainability of some clinical services RESULTING IN lower quality care for our patients	Director of People and Culture	People and Culture		16	16	4	4	16	⇔	April 2019	June 2019	22
12	3940 ------ 2018	IF we have a poor reputation THEN we will be unable to recruit or retain staff RESULTING IN loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care	Director of Communications and Engagement	None – Trust Board		16	16	4	4	16	⇔	April 2019	June 2019	23

Glossary – page 24

BAF RISK REFERENCE *Summary for Datix entry*	1 Lack of robust clinical governance	**DATE OF REVIEW**	February 2019
DATIX REF	3927 (Linked to corporate risks 3946)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we do not have in place robust clinical governance for the delivery of high quality compassionate care THEN we may fail to consistently deliver what matters to patients RESULTING IN negative impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	**INITIAL**	4	5		⇧
	TARGET Dec 19	2	4		
	PREVIOUS	3	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Deliver safe, high quality compassionate patient care
GOAL (S)	Better quality patient care; Well Led
CQC DOMAIN	Safe, Caring, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Medical Officer
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Named divisional governance leads contributing to divisional performance reviews	Quality Governance Committee (monthly) and Trust Board (bimonthly) monitoring via Integrated Performance Report and Learning from Deaths	2
2	Quality Improvement Strategy (QIS) and associated plans	Clinical Governance Committee (CGG) reviewed QIS bimonthly	1
3	Appointment of medical examiners	Mortality reviews increasing	0
4	Mortality Review Group/Serious Incident Group/Improving patient outcomes	CGG review of the outcomes of the Groups	1
5	Risk Management Strategy	Reviewed by QGC, Audit and Assurance Committee & Trust Board	2
6	Systems and processes to monitor the performance of complaints and SI management	Internal Audit reports on SI and complaints management	3
7	Clinical Governance Group monthly meetings to review outcomes	Monthly reporting to Quality Governance Committee	2

REF	CONTROL	ASSURANCE	LEVEL
8	Performance Review Meetings	TLG	0
9	External return in respect of medical appraisal	NHS E/Trust Board	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Framework for clinical governance	Development of a framework	Dec 2019	
2		Interim report on the development of a framework	Sept 2019	

BAF RISK REFERENCE *Summary for Datix entry*	2 Failure to deliver the Quality Improvement Strategy and the CQC 'must and should dos'	**DATE OF REVIEW**	February 2019
DATIX REF	3930 (linked to corporate risks 3946)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET		RATING	L	C	R	CHANGE
IF we do not deliver the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained change RESULTING IN required improvements not being delivered for patient care & reputational damage	**2020**	2x4	**INITIAL**	4	4		⇩
			TARGET 2021	2	3		
			PREVIOUS	4	4		
			CURRENT	3	4		

CONTEXT

STRATEGIC OBJECTIVE	Deliver safe, high quality compassionate patient care
GOAL	Better quality patient care
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Nurse
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Implementation of the Quality Improvement Strategy (QIS) (trust wide)	Clinical Governance Group – bimonthly	1
2	Reporting from the CGG to the Quality Governance Committee including the action plan	Quality Governance Committee – bimonthly	2
3	Quality Improvement Plans developed for Divisions	CGG – bimonthly	1
4	Collaboratives in place to underpin the implementation of the QIS (*e coli*, nutrition, falls (rolled out), pressure ulcers (rolled out), staff retention, ACP fast track)	Trust Infection Prevention and Control committee Quality Governance Committee monthly	1 2
5	On-going quality audits	Report to CGG	1
6	Board members undertaking safety walk abouts	Report to Quality Governance Committee quarterly	2
7	Risk management strategy in place to ensure best practice in risk	Risk Management Strategy approved by QGC, Audit and Assurance	2/3

REF	CONTROL	ASSURANCE	LEVEL
	management and risk maturity	Committee, Trust board	
8	Development and use of the RAIT	Quality Governance Committee	2
9	Band 7, 8 & CNS development sessions	People and Culture Committee	2
10	Back to the floor audits		0
11	All divisions with Quality Improvement Plans in place	CGG	1
12	Ward to Board reporting every month with trajectories	Performance Review Meetings/Divisional meetings	1
13	Risk Maturity assessment	Oxford University Hospitals	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1		Ongoing sustained implementation of the Quality Improvement Strategy including a refreshed strategy and year 2 divisional plans	Mar 2021	
2	Annual monitoring of quality improvement strategy	Publication of Quality Account	Jun 2019	
3	Annual monitoring of quality improvement strategy	Publication of Quality Account	Jun 2020	

BAF RISK REFERENCE *Summary for Datix entry*	3 Lack of delivery of statutory requirements of the Hygiene Code	**DATE OF REVIEW**	February 2019
DATIX REF	3931 (linked to corporate risks 3852)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET		RATING	L	C	R	CHANGE
IF we do not deliver the statutory requirements under the Health and Social Care Act (Hygiene code) THEN there is a risk that patient safety may be adversely affected RESULTING IN poor patient experience and inconsistent/varying patient outcomes	Mar 2020	2x3	INITIAL	4	4		⇔
			TARGET	1	3		
			PREVIOUS	4	4		
			CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Deliver safe, high quality compassionate patient care
GOAL	Better quality patient care
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Nurse
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Action plan in place	Presented QGC monthly	2
2	Quarterly IPC reports	Presented to QGC	2
3	Reporting from NHS I visit	Report presented to Trust Board	2
4	Contract management	Managed through F&P	1
5	C4C environmental audits in place	Reported via IPC to CGG	1
6	PLACE inspections (1x year)	TIPCC/QGC	2
7	10 key standards	Quality assessments	1
8	Deputy DIPC		0

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1		Ongoing sustained implementation of the Quality Improvement Strategy including a refreshed strategy and year 2 divisional plans	Mar 2021	
2	Annual monitoring of quality improvement strategy	Publication of Quality Account	Jun 2019	
3	Annual monitoring of quality improvement strategy	Publication of Quality Account	Jun 2020	
4	PFI contract monitoring	Implementation of the new governance structure for the PFI contract (including KPIs)	TBC	

BAF RISK REFERENCE *Summary for Datix entry*	4 The Trust is unable to ensure efficient patient flow through our hospitals	**DATE OF REVIEW**	February 2019
DATIX REF	3832 (linked to corporate risks 3482, 3483)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning THEN we will fail the national quality and performance standards RESULTING IN a negative patient experience and a failure to exit special measures and to attain STF funding	**INITIAL**	4	5		⇔
	TARGET Dec 19	3	3		
	PREVIOUS	4	5		
	CURRENT	4	5		

CONTEXT

STRATEGIC OBJECTIVE	Deliver safe, high quality compassionate patient care
GOAL	More productive services
CQC DOMAIN	Safe, Responsive, Effective

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Operating Officer
RESPONSIBLE COMMITTEE	Finance and Performance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Patient flow programme	F&P Committee	1-2
2	RTT recovery plan/cancer plan/diagnostics plan	F&P Committee	1-2
3	Capacity and demand modelling work	F&P Committee/A&E delivery Board/Carnall Farrah	1-2-3
4	Service reconfiguration actions	HOSC/A&E Delivery Board/NHS I & NHS E Winter Assurance Summit	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Urgent care Improvement Plan	Develop an Urgent Care Improvement Plan	May 2019	
2		Determine milestones for delivery	May 2019	
3		Implement Plan		

BAF RISK REFERENCE *Summary for Datix entry*	5 Lack of a strategic demand management	**DATE OF REVIEW**	February 2019
DATIX REF	3933 (linked to corporate risks 3482)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF there is a lack of a strategic plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a major impact on the trust's ability to deliver safe, effective and efficient care to patients	**INITIAL**	4	5		⇩
	TARGET	3	3		
	PREVIOUS	4	5		
	CURRENT	3	5		

CONTEXT

STRATEGIC OBJECTIVE	Design healthcare around the needs of our patients, with our partners
GOAL	Timely access to our services
CQC DOMAIN	Safe, Responsive, Effective

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Operating Officer
RESPONSIBLE COMMITTEE	Finance and Performance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	System level winter plan and escalation framework	A&E Delivery board	3
2	System escalation calls	NHS I/NHS E/CCGs on the calls	3
3	Capacity plans from partners	A&E Delivery Board	3
4	STP wide system plan	STP Board	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1				

BAF RISK REFERENCE *Summary for Datix entry*	6 The Trust is unable to ensure financial viability and make the best use of resources for our patients.	**DATE OF REVIEW**	February 2019
DATIX REF	3934 (linked to corporate risks 3768, 3792)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGETS		RATING	L	C	R	CHANGE
IF we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfill our financial duties RESULTING IN the inability to invest in services to meet the needs of our patients.	**2020**	**5x3**	**INITIAL**	5	3		⇧
	2021	**4x3**	**TARGET 2022**	3	2		
			PREVIOUS	5	3		
			CURRENT	5	4		

CONTEXT

STRATEGIC OBJECTIVE	Ensure the Trust is financially viable and makes the best use of resources for our patients
GOAL	More productive services
CQC DOMAIN	Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Finance Officer
RESPONSIBLE COMMITTEE	Finance & Performance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Weekly reporting	Review by NHS Improvement	3
2	Sustainability plan in place	Monitored by Trust Leadership Group and Finance and Performance Committee. Reported to Trust board.	1/2
3	Operational budgets developed at divisional and directorate level	Divisional fortnightly confirm and challenge/monthly performance review meetings	1
4	Medium Term Financial Strategy	F&P/NHS Improvement	2
5	Weekly review by executive team	Executive team	1
6	CIP for 19/20	F&P/trust Board	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	MTFS	Develop the MTFS	Nov 2019	
2	Annual plan	Develop 2020/21 annual plan	March 2020	
3		Develop 2021/22 annual plan	March 2021	

BAF RISK REFERENCE *Summary for Datix entry*	7 The Trust is unable to ensure financial viability and make the best use of resources for our patients.	**DATE OF REVIEW**	February 2019
DATIX REF	3941 (linked to corporate risks 3772, 3792)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGETS		RATING	L	C	R	CHANGE
IF we are not able to unlock funding for investment THEN we will not be able to modernise our estate, replace equipment or develop the IT infrastructure RESULTING IN the lack of ability to deliver safe, effective and efficient care to patients	**2020**	**3x5**	**INITIAL**	3	5		⇧
	2021	**3x4**	**TARGET 2022**	2	3		
			PREVIOUS	3	5		
			CURRENT	4	5		

CONTEXT

STRATEGIC OBJECTIVE	Ensure the Trust is financially viable and makes the best use of resources for our patients
GOAL	More productive services
CQC DOMAIN	Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Finance Officer
RESPONSIBLE COMMITTEE	Finance & Performance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Capital prioritisation group constituted to prioritise capital spend	Decisions reviewed and endorsed by Strategy and Planning Group, TLG, F&P	1-2
2	Loan funding request	Overseen by Finance and Performance Committee	2
3	IT prioritisation group	Strategy and Planning Group	1

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	MTFS	Develop the MTFS	Nov 2019	
2	Annual plan	Develop 2020/21 annual plan	March 2020	
3		Develop 2021/22 annual plan	March 2021	
4	Capital funding	Bid for targeted capital monies when available through the STP	N/A	

BAF RISK REFERENCE *Summary for Datix entry*	8 Ineffective IT systems	**DATE OF REVIEW**	February 2019
DATIX REF	3936 (linked to corporate risks tbc)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we do not have effective IT systems which are used optimally THEN we will be unable to utilise the systems for the benefit of patients RESULTING IN poorly coordinated care for patients and a poor patient experience	**INITIAL**	4	4		⇔
	TARGET	2	4		
	PREVIOUS	4	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Deliver safe, high quality compassionate patient care
GOAL	More productive services, Better quality patient care, Well Led
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Finance Officer/Chief Medical Officer
RESPONSIBLE COMMITTEE	Finance & Performance Committee/ Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	IT Strategy group constituted with clinical & NED involvement	Strategy and Planning Group	2
2	Dedicated support in place to support development of strategy		0
3	Active membership of STP Digital work stream	STP Partnership board	3
4	Monitoring ICE and Bluespier	Divisional governance meetings	1
5	Reporting from divisional governance meetings	Divisional performance review meetings	1
6	Internal audit report on clinical systems	Internal audit/Audit and Assurance Committee	3
7	Data Quality Audits	Audit and Assurance Committee	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Lack of a Digital ICT strategy which includes working across the STP area	Digital Strategy to be developed	May 2019	
2		Develop milestones	June 2019	
3		Review target risk rating	June 2019	

BAF RISK REFERENCE *Summary for Datix entry*	9 Inability to sustain our clinical services	**DATE OF REVIEW**	February 2019
DATIX REF	3937 (linked to corporate risks to be developed)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we are unable to sustain our clinical services THEN the Trust will become unviable RESULTING IN inequity of access for our patients	INITIAL	4	4		⇔
	TARGET	2	4		
	PREVIOUS	4	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Continuously improve our services to secure our reputation as the local provider of choice.
GOAL	More productive services
CQC DOMAIN	Responsive, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of Strategy and Planning
RESPONSIBLE COMMITTEE	F&P Committee (Strategy and Planning Group)

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Trust clinical services strategy being developed	Trust Board	2
2	STP clinical strategy/reference group	STP Partnership Board	3
3	Strategic partnership agreement with University Hospitals Coventry and Warwickshire NHS Trust	Trust Board	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Lack of clinical services strategy	Develop strategy	Sept 2019	Monthly reports to TB
2		Develop milestones	Oct 2019	
3		Review target risk scores	Oct 2019	

BAF RISK REFERENCE *Summary for Datix entry*	10 Failure to deliver cultural change programme	**DATE OF REVIEW**	February 2019
DATIX REF	3938 (linked to corporate risks 3842)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET		RATING	L	C	R	CHANGE
IF we do not deliver a cultural change programme. THEN we may fail to attract and retain staff with the values and behaviours required RESULTING IN lower quality care for our patients	**2021**	**2X5**	**INITIAL**	3	5		⇔
			TARGET 2023	1	5		
			PREVIOUS	3	5		
			CURRENT	3	5		

CONTEXT

STRATEGIC OBJECTIVE	Invest and realise the full potential of our staff to provide compassionate and personalised care
GOAL	Better quality patient care
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of People and Culture
RESPONSIBLE COMMITTEE	People and Culture Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	4ward programme led by the Trust Board	People and Culture Committee	2
2	People and Culture Strategy approved and action plan being implemented.	Report to People and Culture Committee	2
3	Freedom to Speak Up Guardian in place, policy approved, support network in place.	Report to People and Culture/Audit and Assurance Committees and Trust Board	2
4	Report from Health Education England in respect of junior doctors. Framework for junior doctors in line with HEE standards	People and Culture Committee	2
5	Range of policies in place to support staff in their day to day work e.g. occupational health	None	0
6	Wisdom in the Workplace	TLG	0

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1		Implementation of 4ward programme	2023	

BAF RISK REFERENCE *Summary for Datix entry*	11 Failure to recruit, retain and develop staff	**DATE OF REVIEW**	February 2019
DATIX REF	3939 (linked to corporate risks 3831, 3832, 3833)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU THEN there is a risk to the sustainability of some clinical services RESULTING IN lower quality care for our patients	**INITIAL**	4	4		
	TARGET 2021	2	4		
	PREVIOUS	4	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Invest and realise the full potential of our staff to provide compassionate and personalised care
GOAL	Timely access to our services; Better quality patient care; More productive services
CQC DOMAIN	Safe, Caring, Effective, Well led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of People and Culture
RESPONSIBLE COMMITTEE	People and Culture Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Recruitment and Retention plan approved	Approved by Trust Board. Monitored through People and Culture Committee	2
2	Workforce transformation programme in place	Monitored through Trust leadership Group	1
3	People and Culture Strategy approved	Approved by Trust board. Monitored through People and Culture Committee	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1		Implementation of the Learning and Development Plan	2021	
2		Implementation of the recruitment and retention action plan		

REF	GAP	ACTION	BY WHEN	PROGRESS

BAF RISK REFERENCE *Summary for Datix entry*	12 Reputational damage	**DATE OF REVIEW**	February 2019
DATIX REF	3940 (linked to corporate risks 3482)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we have a poor reputation THEN we will be unable to recruit or retain staff RESULTING IN loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care	**INITIAL**	4	4		⇔
	TARGET	2	3		
	PREVIOUS	4	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Invest and realise the full potential of our staff to provide compassionate and personalised care Continuously improve our services to secure our reputation as the local provider of choice
GOAL	Better Quality Patient Care
CQC DOMAIN	Responsive, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of Communication and Engagement
RESPONSIBLE COMMITTEE	Trust Board

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Proactive media management	Weekly report to trust board (real time news) Communications report to Trust Board	1-2
2	Internal programme of communication and engagement built around 4ward	Report to 4ward and People and Culture Committee	1-2
3	On-going programme of stakeholder engagement	Communication report to Trust Board	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	No Communications strategy	Develop a communications strategy	Sept 2019	

Glossary

N/A	Not applicable
ACP	Advanced clinical practice
AH	Alexandra Hospital
ASR	Acute Services Review
CEA	Consultant Excellence Awards
CGG	Clinical Governance Group
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CQC	Care Quality Commission
EU	European Union
HR	Human Resources
ICE	Pathology and radiology reporting system
IPC	Infection Prevention and Control
ISS/Engie	Providers of support services under contract to the PFI
MTFS	Medium Term Financial Strategy
NHS I	NHS Improvement
#NOF	Patients who have fractured their femur
QGC	Quality Governance Committee
QIS	Quality Improvement Strategy
PMO	Project management office
PRM	Performance Review Meetings
SOP	Standard operating procedures
SQUID	Safety and Quality Information Dashboard
SRO	Senior responsible officer
STF	Sustainability and transformation fund
STP	Sustainability and transformation partnership
Tbd	To be determined
WRH	Worcestershire Royal Hospital

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	9th May 2019
Paper number	F

Integrated Performance Report – Month 11 and 12

For approval:		For discussion:		For assurance:	✓	To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Matthew Hopkins CEO	**Author**	Nicola O'Brien – Head of Information and Performance

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	✓	Design healthcare around the needs of our patients, with our partners	✓	Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients		Continuously improve our services to secure our reputation as the local provider of choice	✓		

Alignment to the Trust's goals							
Timely access to our services	✓	Better quality patient care	✓	More productive services	✓	Well-Led	✓

Report previously reviewed by		
Committee/Group	**Date**	**Outcome**
Quality Governance Committee	18th April 2019	Limited Assurance
People and Culture Committee	23rd April 2019	Limited Assurance
Finance and Performance Committee	29th April 2019	Limited Assurance

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	1 – 3, 4 – 7, 9

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☒ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is asked to: 1) Review the Integrated Performance Reports provided in Month 11 and 12, noting the change in internal governance processes that has affected the monthly data presented. 2) Note areas of improved and sustained performance.

Meeting	Trust Board
Date of meeting	9th May 2019
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	3) Seek assurance as to whether: a) the risks of under-performance in each area have been suitably mitigated, and; b) robust plans are in place to improve performance in 19/20.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	9th May 2019
Paper number	F

Executive Summary

The Integrated Performance Report (IPR) provides the Board Members with an update on the Trust's quality of care, operational and financial and workforce performance against the priority metrics which form part of NHSI's Single Oversight Framework (SOF) and the Trust's own internal reporting priorities.

Included are the key messages from each area, detailing actions agreed to improve performance, along with summary grids of performance and assurance reports from the three Committees.

The NHS Constitutional standards are the Emergency Access Standard and Access to Elective treatment within 18 weeks.

The main points the Board needs to be aware of are:

Quality, Safety and Effectiveness

(Note: This data relates to February 2019 in line with the reporting to the Quality Governance Committee)

- **Falls resulting in serious harm** increased from 0.04 in January to 0.09 per 10,000 bed days in February. The trajectory was 0.07 per 10,000 bed days, so we are now above and not achieving trajectory.
- With a further 5 **CDifficile** cases confirmed in February it is clear we will not meet the national objectives for 2018/19 on Clostridium difficile infection. Neither will we meet the national objectives for 2018/19 for E coli bacteraemia or MSSA bacteraemia. As part of our infection prevention activity we will be completing an audit of single rooms that can be used for isolation during April. This will inform the demand and capacity available for isolating patients with potential CDiff.
- We have been under the tolerance level of 4.69 **medical incidents** per 1,000 bed days five times in the last twelve months. The performance is variable month to month. We have been below our baseline for medical incidents that have caused harm for eight out of twelve months, but the performance is variable month to month. We want to ensure that all the medicine incidents that occur are reported so that we can identify any themes, share learning and ensure we comply with best practice. To encourage reporting we are developing a communications strategy and have included medicine incidents in the Key Standards that will be used to drive forward improvements.
- **Sepsis** compliance remained below the target level (>90%). Of 100 patients audited (who met the requirement to be treated for sepsis), 43 did not receive the SEPSIS bundle within one hour (43%). Of the 21 patients who met the requirement to be treated for neutropenic sepsis, 19 patients received their antibiotics within one hour.
- Our rolling 12 month **HSMR** mortality rate continues to be above the expected rate of 100 at 111.39 for January 2019 (latest published data). The SHMI score for January (latest published data) remains within the 'as expected' category at 111.32. Our crude mortality for January (latest published data) is under the rate recorded for the same month in the previous two years.
- We continue to have challenges with the completion of **primary mortality reviews** being completed within 30 days, with Divisions reporting several weeks of backlog

with allocations.

- The **fractured neck of femur (FNOF)** metric did not meet the target in February with performance at 82.76%. Of the 58 patients who were operated on, 48 of them were within 36 hours; all 10 of the patients who waited longer were deemed medically unfit to be operated on.

FINANCE

(Note: This data relates to March 2019 in line with the reporting to the Finance and Performance Committee)

- The Trust has recorded a pre audited control total deficit of (£73.7)m pre Provider and Sustainability Funding (PSF) for the 2018/19 financial year against a plan of £(41.5)m, adverse £(32.2)m than the original operating plan. This out turn position is consistent with the revised forecast outturn confirmed with NHSI. Inclusion of the PSF plan increases the pre audited YTD adverse variance to (£50)m. The control total deficit measure excludes the impact of any impairments or donated asset accounting.
- As a result of the financial position, we have continued to rely on additional cash support from the Department of Health and Social Care (DHSC). We continue to request cash in line with financial performance on a monthly basis.
- In 2018/19 we are reporting £7.6m of gross CIP / savings delivery whilst incurring £1.9m of cost. This was against a £22.4m savings target.
- Agency expenditure for the year of £23.7m exceeds the agency ceiling of £17.2m by £6.6m.
- On the three key financial duties, the Trust has:
    - **Not achieved** its Breakeven Duty
    - **Achieved** the External Financing Limit
    - **Met** its Capital Resource Limit

OPERATIONAL PERFORMANCE

(Note: This data relates to March 2019 in line with the reporting to the Finance and Performance Committee)

Patient Flow and the Emergency Access Standard

- We have seen movement with the Emergency Access Standard between February (73.48%) and March (77.68%) at Trust level. There was a reduction in reported 60 minute ambulance handover breaches for March, 227 down from 522 in February.
- There was a reduction in reported 60 minute ambulance handover breaches for March, 227 down from 522 in February, 72% of all breaches were reported at WRH.
- In the latest published data (March) for all Trusts for the Emergency Access Standard, we remain in the bottom quartile.
- The additional capacity that has been opened during January and February appears to be contributing towards a reduced occupancy level at WRH, which at the end of March is at the lowest level it has been all financial year – 96.31%. The ALX is at its lowest occupancy level since July, with occupancy at the end of March of 89.63%.
- Urgent Care recovery plan is now in implementation phase. The pilot Wards have been identified, these Wards will be guided on how to improve discharge planning to facilitate earlier discharges.
- There will be a refreshed focus on the Stranded and Super Stranded patients to

ensure that these patients have a robust discharge plan and any delays in discharge are escalated to the correct place for action.
- We are also recruiting a Director of Capacity and Flow and medical recruitment continues.

Cancer

- In February 2WW performance was 94.05% (latest published data), placing us in quartile 2 nationally
- Our trust-wide 2WW performance in March (validated at 92.18%) has dropped below the operational standard of 93% for the first time since September 2018.
- The 62 day performance remains a challenge for the organisation though it has improved month on month since January 2019. Based on validated March data, the total number of patients seen in March (157) is currently 30.5 fewer than in February (187.5) and there is a significant decrease in treated patients breaching (46 down from 62.5).
- In February, we were in the bottom quartile of all Trusts, with 62 day performance of 67.74% (latest published data).
- The number of patients waiting 104 days was 24 in March compared to 25 in February. Of the 24 patients waiting only one patient is waiting for treatment in a tertiary centre (Gynaecology patient).
- We are working on options to improve our services for suspected and diagnosed cancer patients in Breast and Urology. This will be supported by the commissioning support unit (CSU) in April, looking at opportunities to improve and streamline these pathways.
- We have submitted our trajectories for the Cancer metrics as part of the planning submission to NHSE/I.

Referral to treatment

- In February, performance of 80.14% RTT placed our Trust in the bottom quartile of all trusts (latest published data).
- March performance is 80.77%.
- The waiting list is currently 35,422 with 6,811 patients having waited over 18 weeks to receive their first definitive treatment.
- There are 357 patients who have been waiting over 40 weeks for their first definitive treatment, 38 fewer than in February. We are focusing on reducing this cohort of patients to zero by September 2019.
- We are continuing to develop a training programme to ensure that all staff understand, and are clear about the application of guidance in the Access Policy to deliver the best services and care for our patients and their families.

Diagnostics

- In February, performance of 8.12% of patients waiting 6+ weeks for a diagnostic test placed our Trust in the bottom quartile of all trusts (latest published data).
- Performance again improved against the previous month with 7.60% of patients breaching, down from 8.12% in February. At month end, 561 patients were waiting

longer than 6 weeks for a diagnostic which is a reduction of 74 patients, and the overall waiting list has decreased by 446 to 7,377.

- Endoscopy remains the modality with the highest backlog (420 patients at end of March) equating to 75% of all breaches
- Over 50% of patients due for cystoscopy (225/445) are waiting over 6 weeks which is a continuation of performance from February.
- We are currently working on identifying additional capacity externally to the Trust for short term outsourcing in radiology, and internally via additional waiting list initiatives for radiology and endoscopy.

PEOPLE AND CULTURE

(Note: This data relates to March 2019 in line with the reporting to the Finance and Performance Committee)

- Our vacancy rate has decreased by 0.45% from 9.75% to 9.30%, due to increased recruitment activity and reduced establishment. Our staff in post increased by 17.98 wte this month.
- Consultant job plan compliance rates have improved by a further 12% this month to 76%. Compliance is being addressed through the Allocate suite of solutions.
- There has been a 1% reduction in medical PDR's to 89%; however, non-medical appraisal rate has remained the same as last month at 77%.
- The Trust's compliance rates for mandatory training remained at 84% across all 11 topics (33 levels) plus MCA and DOLS. 5 out of 33 topics have deteriorated this month but 2 of these remaining within 1% of target.
- The cumulative sickness rate for the 12 months has marginally increased to 4.20% which is 0.02% higher than the same period last year. The Trust was below the Model Hospital benchmark of 4.27% on the latest data available (October 2018) and three divisions are below the target of 4% this month.
- The overall staff turnover rate has reduced by 0.03% to 12.3% which remains above our target range of 10-12%. Turnover has increased for Medical staff, AHP's and Admin but has reduced in month for all other staff groups except student nurses.

Recommendations

The Board is asked to:

1) Review the Integrated Performance Reports provided in Month 11 and 12 noting the change in internal governance processes that has affected the monthly data presented.
2) Note areas of improved and sustained performance.
3) Seek assurance as to whether:
   a) the risks of under-performance in each area have been suitably mitigated, and;
   b) robust plans are in place to improve performance in 19/20.

Appendices

1) Trust Board IPR – M11 and M12 2018-19*
2) Trust Board IPR Dashboards – M11 and M12 2018-19*

**As approved by the internal governance process*

Enc F

Trust Board

Integrated Performance Report

March 2019

Month 12

9th May 2019

Quality & Safety | Metric Updates

Falls with harm

- Falls resulting in serious harm increased from 0.04 in January to 0.09 per 10,000 bed days in February. The trajectory was 0.07 per 10,000 bed days, so we are now above and not achieving trajectory.
- NHSI Falls Prevention Collaborative was launched February 2019 with a focus on the number of falls free days on both MAU's.
- Roll out the initiatives implemented: "Stay in the Bay", "Find your Feet" and "Kit where you Sit".

Pressure Ulcers

- We have consistently been below and achieving the trajectory for Grade 3 pressure ulcers. We had 6 x Grade 2 in February, 3 of which occurred within Urgent Care. Investigations are under way with a targeted approach of 'Stop the Pressure' – a national campaign for both ED and MAU.
- This will be monitored each month by the Divisional Nurse Director and Tissue Viability Team.

Mixed Sex Accommodation

- There were 34 reported mixed sex accommodation breaches in February compared to the 50 recorded in January.
- Due to the on-going capacity challenges, stepping patients down from the intensive care environment remains very difficult
- We are committed though the MSA Policy to ensuring those patient experiencing a MSA are aware and privacy and dignity needs are being addressed. This is being monitored by Wards and audited with support from patient public forum members.

Complaints

- Performance had increased from 75.60% in January to 77.27% in February for complaints responded to within 25 working days. Therefore we are below target. The lack of timely responses in relation to complaints regarding car parking have contributed to this decline.
- There are, no complaints open over 6 months for the third consecutive month.

Quality & Safety | Metric Updates (2)

Fractured Neck of Femur (#NOF)

- The #NOF metric did not meet the target in February with performance at 82.76%. Of the 58 patients who were operated on, 48 of them were within 36 hours; all 10 of the patients who waited longer were deemed medically unfit to be operated on.
- Improved performance is expected to continue with the implementation of Golden Patients programme, Ambulatory Trauma Pathways, Quarterly audits and the Consultant on-call rota which will provide county-wide cover

Sepsis Screening and Treatment Audit

- The screening audit was completed for 89.62% of patients that were required to have it; this was 285 of 318 patients. 43 of 100 (43%) patients sampled received the sepsis 6 bundle within 1 hour and 89 of the 100 (89%) who required antibiotics received them within 1 hour.
- Mortality for sepsis i.e. "within normal limits" and we are not an outlier.
- Specialised medicine are currently the lowest performing area – so we are now targeting the performance in this area via the Governance teams and this is now considered a focal area for CGG to monitor. We anticipate similar performance in March and then improvements in the subsequent months.

Friends & Family Test

- All areas : A&E, In patient wards , Maternity and Outpatients saw an increase in both response rates and recommendation rates in February 19. However to reach target levels of >30% response for inpatient ward areas improvements area required for specialised medicine, SCSD, paediatrics, Outpatients > 10% and ED >20% across all three hospital sites.
- Corporate actions to be taken in April 19 : FFT positive comments scrolling on whiteboards across trust for enhanced staff visibility and purpose, Patient experience Lead Nurse recruited who will lead "on the floor", increased focus on initiatives in place (the use of FFT app and printed cards) . A recruitment drive for targeted volunteer support to generate a better response rate. New boxes to be delivered across trust to all areas. Re-vamped ward boards focusing on feedback launching in Patient Experience Week. Patient Experience Champions (second wave) continues, growing *#togetherwearepatientexperience* movement.

Mortality Rate

- The year to date HSMR score is now improving after nine months of consecutive rises.
- Despite the recent month on month increases in the crude death rate, this remains lower compared to the same period in 2018 and 2017.
- 43% of all assigned Mortality Reviews for the period March 2018 to February 2019 were completed within the 30 day target.
- Coding issues around comorbidity will be investigated.
- Pneumonia and bronchitis deaths have now returned to the expected level.

Quality & Safety | Metric Updates (3)

Medicine Incidents per 1,000 bed days

- The number of medicine incidents per 1,000 bed days dropped slightly following relative stability of around 4 each month to it's lowest level since March 2018.
- The Medicines Safety Committee is to continue with oversight and support for the investigation of medicines incidents
- There is a developing communications strategy across our Trust to promote the reporting of medicine related incidents
- Medicine related incident reports in progress of development for all divisions in line with reporting schedule with feedback on actions to Medicines Safety Committee

% of medicine incidents causing harm

- 17.5% (14 of 80 patients) medicine incidents caused harm, the lowest performance since November 2018.
- Quality Improvement methodology will be used to identify actions and provide focus on medicine incidents causing harm e.g. time critical medicines.
- Key Standards for reducing avoidable harm due to medicines incidents are in development. These will be focused on some of the themes identified in reviews of reported medicines incidents and on-going monitoring of safe and secure handling of medicines

Infection Prevention and Control

- Trust will not meet the national objectives on Clostridium difficile infection, E coli bacteraemia or MSSA bacteraemia for 2018-19.
- The situation in respect of e coli reflects the national position.
- An audit of single room use for isolation will occur in April which will access the demand and capacity available for isolating patients with potential C Diff.
- We will share learning and preventive measures through focused meetings with Divisions to prevent cases of C Diff.

Hand Hygiene

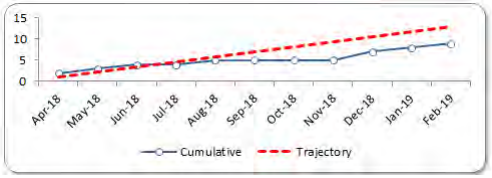
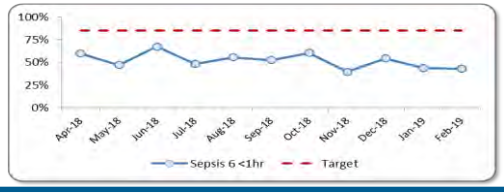
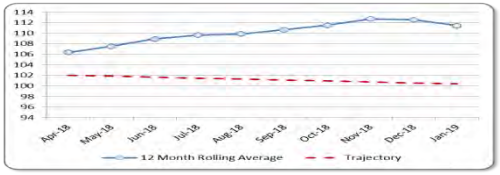
- Whilst Hand Hygiene in ward areas is improving, there is still a challenge with regards to practices for visitors to the area. The uniform policy is a key driver for improving this and will facilitate staff to staff challenge
- The Key Standards linked to the Hygiene code are still being embedded
- The Key Standards will form part of the Ward Accreditation Programme
- E-Learning has been purchased which provide training aseptic no touch techniques

Month 11 2018-19 Quality & Safety Summary

Safe
Effective
Patient Experience

RAG rated against Internal Trajectory

NHS Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in 2019/20?
Are we preventing our patients from acquiring pressure ulcers?	To reduce the number of avoidable grade 3 / deep and ungradeable hospital acquired pressure ulcers.	1	There was 1 grade 3 hospital acquired pressure ulcer, and we have consistently remained below the agreed trajectory for 18/19.		Pressure ulcer prevention training sessions continue across the organisation	<13
Are we ensuring that patients receive all elements of the sepsis 6 bundle?	To improve the % of patients receiving all elements of the sepsis 6 bundle within 1 hour.	43%	Compliance with the sepsis 6 bundle remains challenging. Of the 100 patients requiring treatment who were sampled, 43 received all elements within 1 hour.		Focal point for CGG in April with scrutiny of progress/barrier on the Div Quality Improvement Plans	>90%
Are we maintaining the expected standards of hand hygiene?	To improve the compliance with Hand hygiene practice, and participating in audits.	96.55% 75.83%	Compliance to practice is above trajectory at 96.55%, however audit participation is 75.83%, with the area of most improvement being SCSD at 63%		Mid month audit results will be sent to inform DDNs of their position so that they can challenge staff to complete the audits. Staff have been advised to escalate to managers any breach of the Key Standards.	100% >=97%
Are our patients at risk of contracting C.Difficile during their stay?	There should be no more than 31 cases of *C.Difficile* in the year.	5	There were 5 confirmed cases of hospital acquired C. difficile. 4 were in Specialised Medicine and 1 in Surgery.		Training will be in place from April. Hand Hygiene is a key indicator to reducing C Diff cases.	<=53*
Are we reducing mortality for patients whilst under our care?	To monitor and seek to reduce mortality for patients using the Hospital Standardised Mortality Ratio.	111.39 (Jan.)	HSMR rolling average was **111.39 in Jan**-19. Performance is stabilising from trajectory, however we remain an outlier for the 6th month in a row.		Recruitment of additional ME's to ensure timely and consistent reviews and allows Divisions to focus on delivery of service improvements. Rescheduling of the Mortality Review meetings to a time more consistent with Clinician availability.	<=100
Are we treating our patients in the required timeframes?	To improve the time to theatre for patients with fractured neck of femur (#NOF)	82.76%	The #NOF metric met target again in January with 48 of 58 patients in theatre within 36 hours.		British Orthopaedic Association (BOA) Peer Review planned for Jun-19. Ambulance service pathway for appropriate hip fracture patients to Redditch operational since Jan 2019.	>=85%

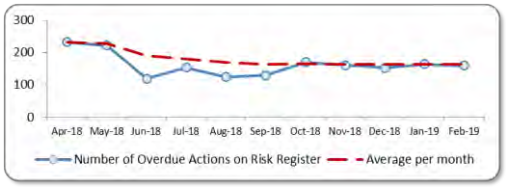
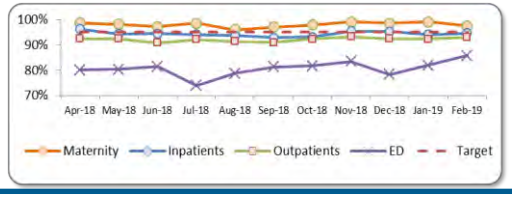
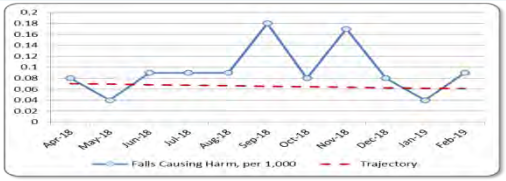
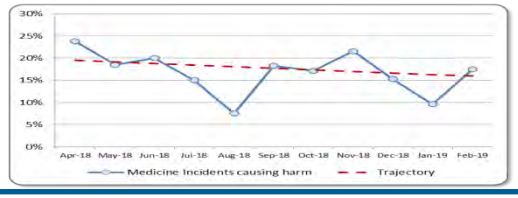
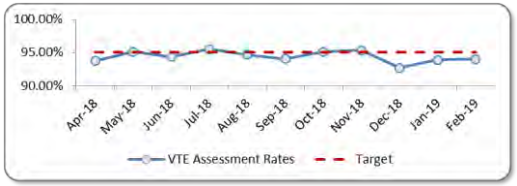
*Please note - for 19/20, there has been a change to Cdiff guidance; the definitions now include hospital onset healthcare associated and community onset healthcare associated.

Month 11 2018-19 2018-19 Quality & Safety Summary

RAG rated against Internal Trajectory (Vicky Morris)

Safe
Effective
Patient Experience

NHS Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in 2019/20?
Risk Are we reviewing risks to ensure patient safety?	To reduce the number of risks overdue a review. **175**	The average number of risks overdue for review per month between Apr-18 and Feb-19 is 156.			
Risk Are we managing risks to ensure patient safety?	To reduce the number of overdue actions relating to risks. **160**	The number of overdue actions decreased 164 in January to 160 in February.			
FFT Are we providing a positive experience for our patients?	To improve the Recommended Friends & Family score for all areas. Mat. 97.42% ↓ A&E 85.71% ↑ IP 94.60% ↑ OP 92.99% ↑	Maternity score remained above target and the other areas below target but improved in Feb-19. Jan-19 benchmarking places this Trust in the bottom quartile for IP and A&E and top quartile for Maternity.		Appointment of Quality Improvement Matron to support wards. Text messaging service review planned.	>=95%
Falls Are we preventing our patients from suffering falls?	To reduce the number of falls that occur in our hospitals and, consequently those that result in serious harm. **5.81** ↑ **0.09** ↑	Both the falls per 1,000 bed days and those resulting in serious harm increased in February. Specialty Medicine had the highest number of falls (77) and the 2 falls causing serious harm.		Evaluation of the initiatives implemented: "Stay in the Bay", "Find your Feet" and "Kit where you Sit"	TBC
Medical Incidents Are we prescribing, administering and supplying the right medicines?	To improve the reporting of medical incidents that occur in our hospitals and reduce those that result in serious harm. **3.44** ↓ **17.5%** ↑	There were 3.44 medicine incidents per 1,000 bed days; 80 in total. 14 (17.5%) medicine incidents caused harm to patients. Specialty Medicine reported the highest number (23), 7 of which caused serious harm.		Promotion of the reporting of medicine related incidents Quality Improvement methodology will be used to identify actions and provide focus.	>=30%
VTE Are we screening our patients for VTE in a timely way?	To improve the % of patients who receive a VTE assessment within 24 hours. **93.99%** ↑	The VTE assessment rate has increased slightly in February. Urgent Care is the lowest performing Division. Q3 benchmarking places this Trust in the bottom 25% of all Trusts.		Work with ward clerks to improve accuracy and timeliness of recording. Report on medic completion rates ensuring accountability of consultants.	>=95%

Forecast Status: Decline – expected to worsen. Stable – not expected to change significantly. Improve – Expected to improve

RAG ratings for FFT metrics indicate performance against national targets.. RAG rating on the Dashboards are against national or locally agreed standards.

Quality Governance Committee Assurance Report

Accountable Non-Executive Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Dr Bill Tunnicliffe - Non-Executive Director	Martin Wood – Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	1, 2, 3, 9

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

The Committee met on 18th April 2019. The Committee was not quorate so was only able to discuss the items as follows:-

Board Assurance Framework (BAF): The Committee have noted their risks for inclusion in the BAF together with the removal of risk 5 relating to the winter plan. Further work is to be undertaken to make more explicit the progress made in reducing the risk level and when this will be achieved. The content of the BAF will be discussed at the Committee's Away Day in May 2019.

Quality, Safety and Clinical Effectiveness – Integrated Performance Report – Month 11: The Committee focused their discussion on the following. Firstly, they remain concerned over hand hygiene compliance and have offered to support Executives to improve performance which remains below the required standard. Secondly, on mortality where the work being undertaken to improve performance has been noted but concerns remain over the lack of performance improvement.

ED Harm Reviews: As a result of concerns raised by the Clinical Commissioning Group, a retrospective review of 40x 12 hour breach RCA's and Harm reviews has been undertaken. The findings of this review were that no harm had been caused to patients, however, the review did highlight that harm reviews were not regularly undertaken. The review also demonstrated that the governance around the RCA process needed to be strengthened and additional staff training required. Changes have been made in relation to the improved documentation and process of reporting 12 hour breaches and the improving harm review/risk assessment performance as a consequence. Limited assurance.

GIRFT Update: Our GIRFT rating is amber showing a mixed picture on delivery of outcome/actions requiring remedial work. The current issues relate to a lack of internal overview and scrutiny of reporting and governance. To date the reporting governance has not been robust, and without internal Executive sign off GIRFT reports. Governance has been managed at divisional level, but without comprehensive monitoring of improvement actions to ensure timely updating of improvement action plans. We are on track to deliver the outcomes/actions fully by the end of April 2019 to achieve green status.

Quality Governance Committee Assurance Report

Accountable Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Bill Tunnicliffe - Non-Executive Director	Martin Wood – Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	1, 2, 3, 9

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

Infection Control Update: A review of Clostridium difficile cases has highlighted cleanliness, antimicrobial prescribing, hand hygiene and isolation as themes requiring action. An outbreak of Vancomycin Resistant Enterococci was declared on ITU at WRH on 22 February 2019. There have been a total of 8 cases to date. A range of control measures have been implemented, and outbreak meetings continue to be held.

The Chief Nursing Officer is writing individually to all non-participating hand hygiene areas to clarify what is expected from them. She has written again to all Divisional Nurse and Medical Directors to set out the requirement to achieve 90% hand hygiene compliance by the end April 2019, and then maintain this on a continuing basis.

The Committee have expressed significant concern over the poor compliance in achieving Safeguarding level 2 training.

A new risk has been added to the Risk Register regarding the decontamination of medical devices.

The Chief Nursing Officer is pursing an alternative to the Dyson fans including contact Dyson for them to resolve the infection control issue.

The roll-out of the Key Standards to Prevent Infection to all areas is complete. This will align and form part of the ward accreditation process.

Limited assurance.

Annual Governance Statement (AGS) The AGS has been noted with the suggestion that the learning from SIs be made more robust.

Other reports discussed:-

- Outlier Alert for Elective Caesarean Section Rates
- Dr Foster Mortality Outlier Alert for Septicaemia (except in labour)

Quality Governance Committee Assurance Report

Accountable Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Bill Tunnicliffe - Non-Executive Director	Martin Wood – Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	1, 2, 3, 9

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Background

The Quality Governance Committee is set up to assure the Board with respect to the quality agenda.

Issues and options

None.

Recommendations

The Board is requested to receive this report for assurance.

Appendices

- TB IPR Dashboard M11 and M12 2018-19

Finance | Key Messages

Deficit and Key Financial Duties	•The Trust has recorded a **pre audited** control total deficit of (£73.7)m pre Provider and Sustainability Funding (PSF) for the 2018/19 financial year against a plan of £(41.5)m, adverse £(32.2)m than the original operating plan. This out turn position is consistent with the revised forecast outturn confirmed with NHSI. Inclusion of the PSF plan increases the pre audited YTD adverse variance to (£50)m. The control total deficit measure excludes the impact of any impairments or donated asset accounting. •On the three key financial duties, the Trust did not deliver a breakeven position, but has met its Capital Resource Limit (CRL) and achieved the External Financing Limit.
Variance from Plan	•Largely driven by both inability to achieve targeted patient care income and as well as lack of identification and under delivery of cost improvement plans. Operational variances include increased expenditure as a result of diagnostic demand, premium costs of supporting vacancies and the provision of additional capacity. These adverse variances have been partially offset by reserves and continuing vacancies. As a result of the above position, the Trust has not accessed any of the PSF allocations assigned to financial performance, nor the operational element related to emergency care performance throughout the 2018/19 financial year.
Bank and Agency	•Agency expenditure for the year of £23.7m exceeds the agency ceiling of £17.2m by £6.6m. This variance was primarily driven by additional bed capacity and CIP premium pay reduction slippage. Bank expenditure totalled £22.6m resulting in a total spend on temporary staffing of £46.3m. This represents 16% of the pay bill. In addition to the development of a robust, granular bank and agency reduction plan to reduce reliance on the temporary workforce moving forward, a weekly Executive led pay panel has commenced. The panel rigorously assess all requests to cover vacancies as well as review of existing Bank and Agency commitments.
CIP (Savings Improvement Plans)	•In 2018/19 we are reporting £7.6m of nominal gross CIP delivery whilst incurring £1.9m of cost. This was against a £22.4m target. The assessment from 2018/19 CIP performance includes late development of schemes and lack of clear roles and responsibilities and thus ownership and deliverability in operational plans. In particular, scaled up programmes of work in respect of theatre and outpatient productivity and workforce transformation did not translate into measurable cost efficiencies. The approach to 2019/20 CIP planning has been at a more granular level.
Cash Balance	•As a result of the financial position, we have continued to rely on additional cash support from the Department of Health and Social Care (DHSC). We continue to request cash in line with financial performance on a monthly basis. Cash limitations will prevent repayments of existing and future revenue support loans without refinancing existing borrowings or a change to the existing financing regimes for Trusts that are in financial difficulties. Based on this scenario, the Trust are in on-going discussions with NHS Improvement and DHSC regarding the planned repayments due in 2019/20 for revenue support loans. Capital loans are repaid through the capital programme.
Capital	•The Trust had an overall capital plan of £19.2m in 2018/19 and has spent £18.1m. The £1.1m underspend is due to slippage in the replacement of PFI equipment against the finance model. Trust capital funds (internally generated funds, loans and PDC) were fully utilised in 2018/19 to deliver risk prioritised schemes.

Use of Resources
Risk Rating Summary
(Robert Toole)

	Metric Definition	How we did YTD at M12	Risk Rating		Previous Month YTD	Full Year Plan (Forecast)
Are we spending more than the income we receive?	I&E surplus or deficit / total revenue.	(18.10%)	4	Adjusted financial performance deficit of **£73,712k** (£73,712k/ total operating income £407,044k = **(18.10%).**	4	4
How close are we to our financial plan?	YTD actual I&E surplus/deficit in comparison to YTD plan I&E surplus/deficit.	(12.50%)	4	I&E margin YTD actual of **(18.10%)** less I&E margin YTD plan of **(5.60%)** = **(12.50%)**.	4	1
How many days' worth of cash do we have?	Measures the days of operating costs held in cash, cash-equivalent and liquid working capital forms.	(106.73)	4	Working Capital of (£133,007) / YTD Operating Expenditure of £454,848 multiplied by the number of YTD days (365) = (106.73).	4	4
Do we have sufficient income to cover the interest owed on our borrowings?	Degree to which the organisation's generated income covers its financing obligations.	(2.298)	4	Revenue available for capital service (£47,670k)/ capital service **£20,745k** = **(2.298)**	4	4
Is our agency spend within the imposed limits?	Total agency spend compared to the agency ceiling.	(37.0%)	3	Total agency spend of **£23,689k** less agency ceiling of **£17,291k** / divided by agency ceiling of **£17,291k** = **(37.0%).**	3	3

Operational Performance | Key Messages

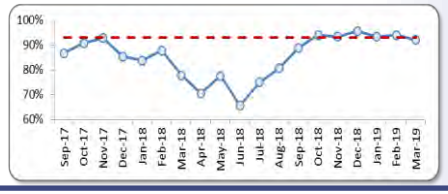
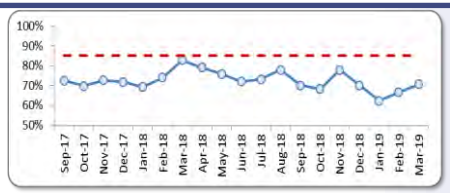
2WW Cancer	• Prior to March's validated performance, 2 week wait operational performance had been achieved for 5 consecutive months. • Action plans are in place to for Divisions to maintain their 2 week capacity in order to continue to achieve performance at the operational standard through 2019/20.
2WW Breast Symptomatic	• Having been achieved in February, the operational standard dropped below target level again in March. • The forward planning template and daily calls with the Directorate where escalation is required will support the aim of achieving and maintaining the operational standard.
62 Day Cancer	• Although the number of treatments remains high, the attempts to reduce the 62+ day backlog continue to impinge on performance. • Divisions are currently formulating an action plan to support the delivery of the Trust-wide trajectory which sees the Trust achieving operational standard from Jul-19 onwards. The focus remains on reducing the number of patients waiting 104+ days. • Upcoming issues and concerns regarding compliance to the cancer standards are discussed at the Performance Management Group chaired by the Deputy COO/COO.
EAS 4 Hours	• EAS performance improved again against the previous month, reaching the highest performance since Sept-18. Despite an increase in attendances, fewer patients breached the 4 hour standard. • The underlying metrics also saw improvements in performance with fewer super stranded patients, 12 hour breaches and a shorter average length of stay in March.
RTT	• Both the total number of patients waiting and those waiting 18+ weeks for treatment decreased marginally in March and as a result performance saw a marginal improvement. • A specialty based trajectory, based on known and planned capacity to meet on-going demand is being worked on to, as a minimum, ensure that our position does not worsen and specifically reduce the number of patients waiting 40+ weeks. The number of patients waiting 40+ weeks has been decreasing since Dec-18.
Diagnostics	• There was an increase in performance with the number of patients waiting 6+ weeks decreasing from February to March. • There remains concern that the CT and Endoscopy capacity is not sufficient to meet demand which delays our ability to perform at the expected standard. • A Rapid Action Plan has been drawn up in response to a CCG Contract Performance Notice and this will be monitored for impact over the course of 2019/20.

Month 12 2018-19 Operational Performance Summary

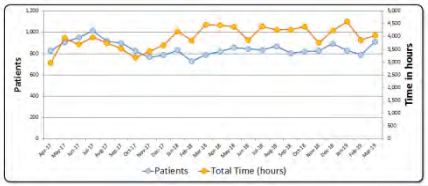
RAG rated against Internal Trajectory (Paul Brennan)

Worcestershire Acute Hospitals NHS Trust

Cancer Waiting Times

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in April?
Did we see urgent cancer patients quickly?	**93%** of potential cancer patients seen by a specialist within **2 weeks**.	**92.18%**	We saw 92.18% of our cancer patients within 2 weeks. **156 patients** waited longer than 2 weeks.		• Cancer forward planning template in place with all directorates • Continued focus on 2WW and 104 days escalation. • Gap analysis undertaken to identify bottlenecks with associated work-groups to address these	93.93% FORECAST STATUS: DECLINE / STABLE / IMPROVE
Did we see patients with potential breast cancer quickly?	**93%** of patients with potential **breast cancer** seen by a specialist within **2 weeks**	**84.80%**	84.80% of patients were seen within 2 weeks. **26 patients** waited longer than 2 weeks.			45.96% FORECAST STATUS: DECLINE / STABLE / IMPROVE
How quickly did we start treating cancer patients?	**85%** of cancer patients to start treatment within **62 days** of urgent GP referral.	**70.70%**	70.70% of patients started treatment within 62 days. **46 patients waited longer before starting treatment**. There were **24 patients** still waiting 104 days or more for treatment at the end of the month.		• Working with CSU to find opportunities in the Urology pathway commencing April / May	74.93% FORECAST STATUS: DECLINE / STABLE / IMPROVE
Are we seeing patients with an emergency within 4 hours?	The Trust should see **95%** of patients within 4 hours from arrival to admission, transfer or discharge	**77.67%**	The Trust performance was 77.67%. **3,752 patients** breached the 4 hours standard, WRH achieved 60.15% (↓), ALX 75.46% (↓). **16 patients** waited 12+ hours to be admitted after their decision to admit.		• NHS Improvement Urgent Care specialists have been in the Trust supporting plans for improvement. • A recruitment strategy is being developed for consultants.	75.41% FORECAST STATUS: DECLINE / STABLE / IMPROVE

EAS

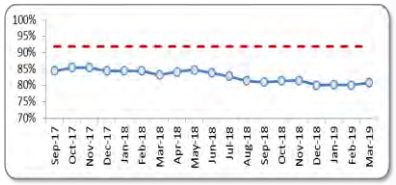
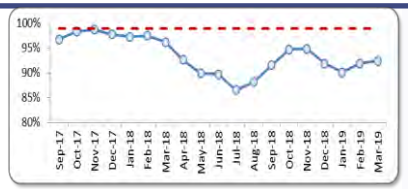
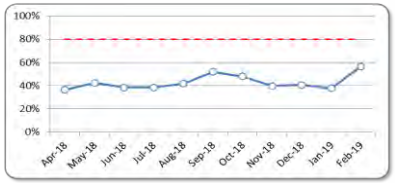
	Description	How we did	Trend	Key actions	What trajectory are we aiming for in April?
Are ambulance patients waiting a long time to be seen?	No patient arriving by ambulance should wait over 1 hour to be handed-over to ED staff	**ALX 64** ↓ **WRH 163** ↓	**227 patients** arriving by ambulance remained under the care of the ambulance crew for over 60 minutes. This is **295 fewer patients** waiting over 60 minutes than in February.			203 FORECAST STATUS: DECLINE / STABLE / IMPROVE
Are patients being treated on the corridor and for how long?	Corridor care is not acceptable , but when it does occur performance will be monitored against our plans to stop it happening.	**913 patients** **266 Minutes average**	**913 patients** spent time on the corridor in March. This is 124 more patients than in February. The average time spent on the corridor is around **270 minutes.**			- FORECAST STATUS: DECLINE / STABLE / IMPROVE

Forecast Status against most recent performance: Decline – expected to worsen. Stable – not expected to change significantly. Improve – Expected to improve

Month 12 2018-19 Operational Performance Summary

RAG rated against Internal Trajectory (Paul Brennan)

Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in April?
RTT Did we start treatment within18 weeks?	**92%** of patients on a 'referral to treatment' (RTT) pathway should be seen within 18 weeks.	**80.77%**	**80.77%** of patients are waiting less than 18 weeks for treatment. **6,811 patients have been waiting over 18 weeks.** No patient has waited over **52 weeks.** The 40-51 cohort **decreased from 395 to 357.**		The Trust focus is on reducing the over 40 week waiters and implementing the actions agreed as part of the 2019/20 planning.	86.47% FORECAST STATUS DECLINE **STABLE** IMPROVE
Diag. When a patient needs a diagnostic test, do we do this within 6 weeks?	A minimum of **99%** of patients who need a diagnostic test should wait less than 6 weeks	**92.40%**	**92.40%** of patients requiring a diagnostic test were waiting less than 6 weeks for their test. **7.60%** were waiting 6 or more weeks which equates to **561** patients.		Rapid Action Plans written and recovery trajectories modelled on available capacity.	92.37% FORECAST STATUS DECLINE **STABLE** IMPROVE
Stroke* Are we directly admitting stroke patients to the specialist ward?	**At least 90% of patients should be directly admitted to the stroke ward.**	**39.4%***	Only **13 of 33 patients** were admitted to the stroke ward within 4 hours.		Ring-fencing of stroke beds to ensure beds are readily available for stroke patients and can stay on stroke unit throughout their stay in hospital.	38.5% FORECAST STATUS DECLINE **STABLE** IMPROVE
Stroke* Are we scanning stroke patients soon enough?	**At least 80% of patients should receive a CT scan within 1 hour of arrival.**	**56.4%***	**22 of 39** patients had their CT scan within 60 minutes.		The SCN specialists are completing their IRMER training to be able to request CT's. Process flow meeting has taken place with all clinical parties and the finalised straight to scanner pathway needs to be embedded.	43.5% FORECAST STATUS DECLINE **STABLE** IMPROVE

*February 2019 Stroke data at 17/04/2019

Forecast Status against next month's performance: Decline – expected to worsen. Stable – not expected to change significantly. Improve – Expected to improve.

Finance & Performance Committee Assurance Report

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom - Non-Executive Director	Richard Oosterom - Non-Executive Director	Kimara Sharpe - Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	4, 5, 6, 7

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

The Committee met on the 29th April 2019.

Board Assurance Framework: The Committee discussed the updated BAF and suggested changes to be made in the next review, in particular with the controls and gaps. The Committee were asked to remove risk 5 but we felt that this risk was still needed. We approved the update, with the caveat of risk 7 on capital where we asked the executive team to review the current risk rating given the national lack of access to capital.

Integrated performance report: We were pleased with the increasing quality of the IPR and the focus on the forecasted performance of the coming 3 months. We were disappointed with the decline in breast two week wait performance. With respect to RTT, the signed contract with the clinical commissioning groups we are not funded to deliver the NHS Constitutional standard. Our trajectory for March 2020 (82.4%) is therefore what the commissioners are buying. This is disappointing for the people of Worcestershire as well as ourselves. Key for us is not having any 52 week waiters. We are aiming for zero waiters over 40 weeks by September 2019. Endoscopy still remains a challenge and we have requested an update on the additional provision at the next meeting. We reviewed the trajectories for 2019/20 in detail. We received a detailed brief on the major incident called before Easter to clear the surge areas and the ED corridor. We were encouraged by the results and are pleased that the team is turning the lessons learned into business as usual, particularly in around timely discharges, having discharge plans in place for all patients and keeping the ward data up-to-date. Limited assurance

Stroke performance: We received a detailed briefing on stroke performance. Whilst we do transfer patients to a stroke ward, we do not do this in a timely manner. We are awaiting the ward changes to reduce the beds on the stroke ward to ensure that there is a better focus on stroke patients (currently there are many general medical patients on the stroke ward). We were pleased that the TIA performance has improved due to the seven day service now in place. We were pleased with the progress but we were disappointed with the quality of the report, which was out of date and lacked robust actions. The detail will be included within the IPR in future.

Financial performance – month 12: At the end of the 2018/19 financial year we heard that the Trust was stating a cumulative pre Provider Sustainability Fund (PSF) control total deficit of £(73.7)m, in line with the latest forecast (unaudited). This is against a (£41.5)m planned deficit, resulting in a (£32.2)m adverse variance against plan. Inclusion of PSF £17.8m increases the adverse variance to (£50.)m. This deficit was mainly due to the CIP under-delivery, income shortfall and bank and agency spend. We heard that there is still a requirement to understand the PFI contract in more detail in order to manage it more appropriately. This function has been transferred to the Chief Operating Officer and a review is currently underway. We were pleased to learn that there is a strategic group being set up by the Chief Executive to drive through higher standards. A timetable for these actions is being developed. Overall we were disappointed with the financial performance for the year. Limited assurance

Contract management: We received the list of the top 10 expenditure contracts. A robust list of all contracts is being developed and a timetable is currently being developed. We are securing savings within the top 10 contracts. We have requested that one of the NEDs is involved in reviewing the contracts.

Finance & Performance Committee Assurance Report

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom - Non-Executive Director	Richard Oosterom - Non-Executive Director	Kimara Sharpe - Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	4, 5, 6, 7

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary (cont.)

Operational plan: It was good to hear the contract with the main CCG's has been closed, in line with the assumptions in our submitted preliminary Operational Plan. The remaining key challenges are to cover the 15m cost of the additional bed capacity and to build a CIP that not only covers the 13M already built in the submitted plan, but delivers 22.5M as originally targeted. The first item is being taken forward with the healthcare system (commissioners and health and care trust) and NHS Midlands will be facilitating further discussions. The CIP is still work in progress. For 7.6m plans are solid and completely integrated in the divisional budgets. For 5.4m the team is developing corporate programs (e.g. procurement, workforce and productivity). The team feels there is more opportunity of saving premium agency costs and has set itself a target of £9m reduction. We were assured that better controls around workforce are now in place, which is a change from 2018/19. A programme board will be put in place with sub groups. Budgets will be built with the detail required. Although we can see that the right things are being addressed, we are far from a solid plan that we can be confident about to deliver. We offered support for the executives from the non-executive directors. There needed to be a step change in the operational plan development for the resubmission in mid-May. Limited assurance

Use of resources:. The assessment is due on 7 May. The Committee received a report outlining the preparations for the visit.

Effectiveness of the Committee: We were disappointed that neither lead executive was present at the meeting. We are reviewing our way of working to ensure that we follow the commitments we made at our away half day and we will follow this up at the next meeting.

Background

The Finance and Performance Committee is set up to assure the Board with respect to the finance and performance agenda.

Issues and Options

None.

Recommendations

The Board is requested to receive this report for assurance.

Appendices

- TB IPR Dashboard M11 and M12 2018-19

People & Culture Performance | Key Messages

Job Plans

- Consultant Job plan compliance rates have improved by a further 12% this month to 76%.
- Compliance is being addressed through the Allocate suite of solutions, which overachieved on its target of 60% compliance by 28th February but fell short of the 85% by 31st March. However, this target was achieved on 11th April 2019. Divisions supported by HR are working hard to achieve the challenging target of 95% by 31st May 2019.

Appraisals/ PDR's

- There has been 1% reduction in medical PDR's to 89%. However, non-medical appraisal rate has remained the same as last month at 77%. The slippage is primarily within corporate with a 11% drop and AMIT with a 3% reduction. Women and Children division has improved by 4% and SCSD is the highest compliance at 81% against a Model Hospital benchmark of 83%.
- Our lowest compliance rate by staff group continues to be within the Scientific, Therapeutic and Technical group despite a further 3% improvement this month.
- None of the divisions met the target of 85% by 31st March 2019 and will continue to be held to account for delivery at the monthly performance review meetings.

Mandatory Training

- The Trust's compliance rates for mandatory training remained at 84% across all 11 topics (33 levels) plus MCA an DOLS. 5 out of 33 topics have deteriorated this month but 2 of these remaining within 1% of target.
- The greatest improvement this month is within Medical and Dental staff at 4% but they are still our lowest compliance at 71%. Estates and Ancillary and Administrative and Clerical have both deteriorated by 2% this month.
- Each division was set a target of 85% by 31st March 2019 and are held to account for delivery at the monthly performance review meetings. 3 of the 7 divisions met this target.

Sickness Absence

- Cumulative sickness rate for the 12 months has increased by 0.01% to 4.20% which is 0.02% higher than the same period last year.
- The Trust was below the Model Hospital benchmark of 4.27% on the latest data available (October 2018)
- 3 divisions are below the target of 4% this month.
- All divisions continue to be supported by HR to undertake back to work interviews and formal sickness absence management meetings.

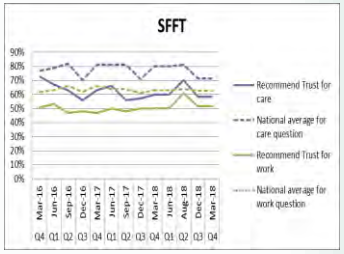
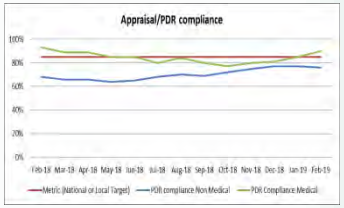
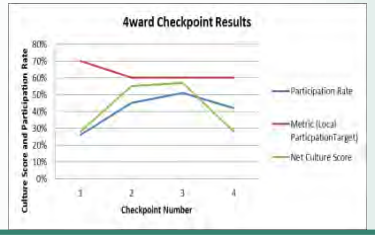
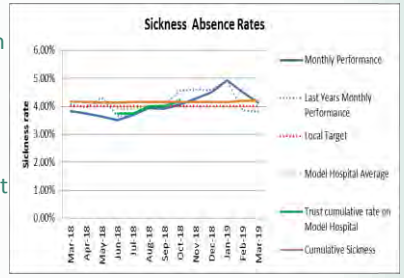
Turnover

- The overall staff turnover rate has reduced by 0.03% to 12.3% which remains above our target range of 10-12%.
- Turnover has increased for Medical staff, AHP's and Admin but has reduced in month for all other staff groups except student nurses.
- Recruitment plans are in place with job fairs and assessment centres scheduled throughout the year, publicised through press, social media and advertised through NHS Jobs.
- International Recruitment initiative for registered nurses is ongoing. 50 offers have been made to date.

Month 12 2018-19 Engaged Workforce Summary

(Tina Ricketts)

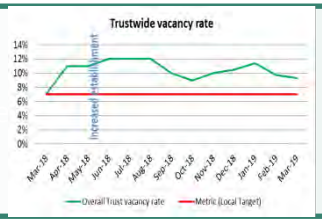
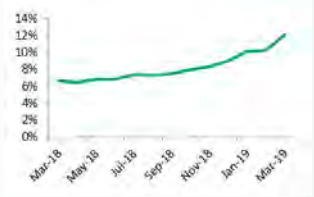
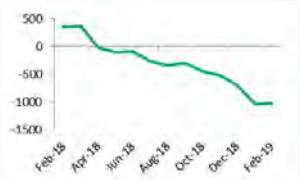
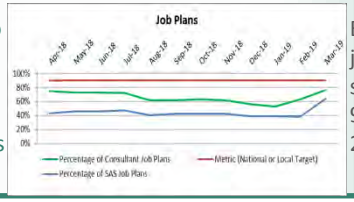
Worcestershire Acute Hospitals NHS Trust

Description	How we did		Trend	Key actions	What are we aiming for in Apr ?
Would our own staff recommend us?	National quarterly measure of whether staff would recommend our Trust for treatment (T) or work (W)	58% (T) 52% (W)	Q3 SFFT data was incorporated in the Annual Staff Opinion Survey. The national position has deteriorated by 10% (T) and 1% (W). Trust position has deteriorated by 12% (T) and 9% (W) compared to Q2 SFFT but has improved by 2% (W) and 1.5% (T) from last years Staff Survey.		Improve culture, retention and staff experience so that staff report higher satisfaction. An action plan will be developed from the Staff Survey. Q4 SFFT to be issued in March.	Improved position to National average – 71% (T) & 63% (W)
Are our staff having annual appraisals?	All of our staff should have an annual appraisal/PDR. Separated into Medical (M) and Non-Medical (NM)	89% (M) 77% (NM)	Appraisal rates have reduced 1% for Medics but have remained at 77% for Non-Medics. This is due to fact that appraisals have not been spread out throughout the year.		Divisions to continue to be held to account. ESR also automatically notifies staff and managers of expiry dates. Further publicity around the 2018 pay award which links incremental progression to appraisal	80% against 85% target
Are we engaged with cultural change?	Summary of results from 4 ward Programme	42% participation 28% net culture	Checkpoint 5 launched February 2019 with results due in April.		Results of Checkpoint 5 due out in April 2019.	Improving response rate and net culture score
How many of our staff are taking time off sick?	Sickness absence rates measured against National average on NHS Model Hospital (4.27% as at Oct 2018; when our Trust reported 4.20%)	4.20% cumulative	Cumulative sickness for the 12 month period has increased by 0.01% to 4.20% compared to 4.18% last year. The Trust was better than Model Hospital average of 4.27% on the latest benchmark which is October 2018.		Sickness absence to continue to be managed through Divisions with support from HR business partners.	4.0%

Key to rag rating: Green - target met; Amber – on track or close to target: Red - target missed

Month 12 2018-19 Skilled Workforce Summary

Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	What are we aiming for in Apr?
Do we have enough staff?	Vacancies against funded establishment compared to the local target of 7%	9.30%	Vacancy rate has reduced by 0.45% from 9.75% to 9.30% which is due to increased recruitment activity and reduced establishment. Our contracted staff in post increased by 17.98 wte this month.	 Implementation of Allocate suite of solutions will give greater transparency of vacancy position. Business case for centralised recruitment to improve governance and timelines was approved in Mar-19.	9%
How much are we spending on temporary staff?	Agency spend as a percentage of total substantive and temporary pay spend	12.12%	Agency spend increased in March and was 12.12% of the total pay costs. Agency spend was above forecast as the forecast assumed agency costs would represent 4.67% of total pay costs.	 The FRP plan is to improve quality and safety through recruitment of substantive clinical staff.	4.67% (Forecast)
Are we spending too much on temporary staff?	NHSI set the Trust an annual agency expenditure ceiling of £17.3m	(£1611k)	Agency staffing costs of £3,051k in month is an increase of £597k on last month and is £1611k above the monthly NHSI agency ceiling. Agency costs are above the Trusts internal plan.	 Pay panel in place. Governance oversight of temporary workforce spend strengthened.	Need to reduce run-rate
Are our staff doing the necessary training?	All staff are required to undertake Mandatory training at the appropriate level assigned by leads in 11 mandatory training topics (33 topic levels)	84%	Compliance has remained at 84% across all levels this month. Only 5 of the 33 topic levels have declined (with 2 of these 5 remaining within 1% or above target)	 Divisions being held to account for their staff compliance. Fortnightly reports sent out to Divisions as well as visibility and automated emails To Managers and Staff via ESR self service	85%
Do our consultants have up-to-date job plans?	All consultants are required to have an annual job plan review	76%	Compliance has **improved by 12%** to 76% partly due to the exercise being led by HR around team job planning as part of the Allocate suite of rostering solutions. Target of 85% was achieved on 11 April 2019.	 Early Implementers have uploaded job plans to Health Medics rostering system. Targets for completion for 90% of all specialities by 30th April 2019 which will be challenging.	90%

Key to rag rating: Green - target met; Amber – on track or close to target: Red - target missed

People & Culture Committee Assurance Report

Accountable Non-Executive Director	Presented By	Author
Mark Yates - Non-Executive Director	Mark Yates - Non-Executive Director	Kimara Sharpe - Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	10 11

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

The Committee met on 23rd April 2019. The items discussed were as follows:-

New starters: Three new starters attended the meeting to discuss their experiences of the recruitment and induction processes. By and large, all three were complimentary about the selection process and the local induction provided. It was felt that the administration of reference chasing and the trust induction could be improved. The Committee was assured that the new post of Recruitment Manager and Learning and Development Manager have these areas under control and the new induction process will be in place by May 2019 and the centralised recruitment, one function of which is to have better administration of references, will be in place by September 2019. The Director of People and Culture will also be introducing focus groups to enable new staff to discuss their initial experiences of the trust.

Board Assurance Framework: The Committee were pleased to see the gap analysis to enable the better ranking of risks. The Committee approved the updates to the BAF risks 10 and 11.

People and Culture Strategy update: The report provided assurance against a range of actions which directly mapped to BAF risk 11. The key lines of enquiry relating to the well led domain were presented and actions identified which will give more progress in these areas.

The areas for focus this year, 2019/20 in supporting the workforce agenda, are as follows:

- Staff engagement
- Leadership and management development
- Retention and recruitment
- Workforce planning
- Education, learning and development
- Effective workforce systems
- Flexible working

There was evidence that work is progressing in these areas. Limited assurance.

Developing Our Communications Strategy: The Committee continues to give feedback on the draft strategy. It is on track for presentation in September to the board. **Limited assurance.**

People & Culture Committee Assurance Report

Accountable Director	Presented By	Author
Mark Yates - Non-Executive Director	Mark Yates - Non-Executive Director	Kimara Sharpe - Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	10 11

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary (cont.)

4ward steering group: This report set out the results of the most recent checkpoint. The participation rate and the net culture score were both lower than in the previous checkpoint. There is currently a refocus of 4ward to embed the four step process. There will also be a change to the clusters to be team based. The Committee is also recommending that every Committee and Board meeting has an item at the end to reflect on how the 4ward behaviours were demonstrated during the meeting. Concern was expressed about how people who were not exhibiting 4ward behaviours were held to account and this area will be discussed at our next meeting.

Leadership/Management Development: The Committee were pleased to receive a report which outlined the considerable work that is being undertaken in this area. The triumvirate programme has just completed the third module. Leadership development for senior and middle managers will commence in May and the programme for first line managers commenced in March with another cohort starting in May. The bespoke nurse and AHP development programme continues. Mentoring for medical staff, in conjunction with the Royal Wolverhampton NHS Trust has commenced.

Report on Nursing and Midwifery staffing Levels – January and February 2019: This item is also on the board agenda. No moderate harm was reported during the period and there were a reduced number of red flag incidents. The Trust has formally offered 50 overseas nurses positions. The timeline is unclear as yet for the commencement of the posts due to the external requirements. **Limited assurance.**

Recruitment and retention – medical workforce: This excellent report showed the amount of progress being made with medical recruitment. Work is being undertaken with the Royal Wolverhampton NHS Trust on the appointment of clinical fellows in August to reduce the reliance on locum staff. Job planning is now at 85% - it will reach 90% in May. There is a 90% compliance rate for appraisals. **Limited assurance.**

Education, Learning and development: This report provided an overview of the development of the academy. The medical faculty has met and the nursing faculty is meeting in May. The Committee were concerned that only 53% of departments have returned training plans for 2019/20. This is a key role for the HR business partners to work with all departments to ensure that plans are completed. **Limited assurance.**

Flexible working: The Committee received an update on the work that is on-going to provide flexible working arrangements. We are working with Timewise, a social enterprise, to ensure that we exploit all the avenues for staff to be able to work flexibly. This work is in its early stages. **Limited assurance.**

People & Culture Committee Assurance Report

Accountable Director	Presented By	Author
Mark Yates - Non-Executive Director	Mark Yates - Non-Executive Director	Kimara Sharpe - Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	10 11

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary (cont.)

Biannual patients' Acuity and dependency Winter Study: The Committee were informed that the Trust board has to endorse a statement as follows:

as part of the safe staffing review, the director of nursing and medical director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

The Committee were satisfied that the board are able to endorse such a statement for nursing staff but not for medical staff. and this will be found in the papers later on the agenda. The only anomaly is that there are no safe staffing levels for AHP staff and the CNO has raised this issue nationally.

Other reports received:

- Freedom to Speak up Annual Report
- People and Culture risk register
- JNCC minutes
- Work plan

Background

The People and Culture Committee is set up to assure the Board with respect to the People and Culture agenda.

Issues and options

None.

Recommendations

The Trust Board is requested to

- Note the report for assurance
- Agree to an item on each committee/board meeting to reflect whether the meeting demonstrated the 4ward behaviours.

Appendices

- TB IPR Dashboard M11 and M12 2018-19

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire Acute Hospitals NHS Trust

Reporting Period: February 2019

SAFE

Area	Indicator Type		Indicator	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Current YTD	Prev Year	2018/19 Tolerances			SRO	Data Quality Kitemark
																			On Target	Of Concern	Action Required		
Incidents	Local	QPS3.3	Number of overdue SIs	1	1	4	0	0	0	0	0	0	0	0	0	2			0	-	>0	CMO	
Falls	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	1	2	2	0	1	0	2	3	2	3	1	0	2	16	24	<=1	-	>=2	CNO	
VTE	National	QPS11.2	VTE Risk Assessment (as recorded in OASIS only)	91.98%	90.97%	93.74%	95.13%	94.35%	95.51%	94.67%	94.07%	95.14%	95.33%	92.70%	93.89%	93.99%			>=95%	94% - 94.9%	<94%	CMO	
Never Events	National	QPS4.1	Never Events	0	0	0	0	0	0	0	0	0	1	0	0	0	1	2	0	-	>0	CMO	
Pressure Ulcers	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	2	2	2	1	1	0	1	0	0	0	2	1	2	11	17	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	1	1	0	0	-	>=1	CNO	
Infection Control	National	QPS12.1	*Clostridium Difficile* Infection (Trust Attributable)	1	3	3	2	3	6	1	4	4	2	4	5	5	43	33	17/18 Threshold < = 32 18/19 Threshold < = 31			CNO	
	Contractual	QPS12.15	MSSA Bacteremia Cases (Trust Attributable)	0	0	5	1	1	3	3	1	0	2	3	2	0	24	17	0	1	>1	CNO	
	Contractual	QPS12.14	Ecoli Bacteremia Cases (Trust Attributable)	3	4	5	5	7	6	7	3	5	6	12	4	9	72	62	18/19 Threshold < = 47			CNO	
	National	QPS12.4	MRSA Bacteremia Cases (Trust Attributable)	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	-	>0	CNO	
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective	98.75%	97.26%	96.80%	95.50%	95.60%	97.70%	97.80%	96.50%	95.48%	93.90%	97.37%	96.91%	96.59%	96.64%		>=95	-	<95%	CNO	
C-Sections	Contractual	MCS1.2	Emergency Caesareans	18.90%	15.40%	12.60%	14.10%	12.10%	14.00%	16.20%	15.70%	19.80%	17.00%	16.20%	14.90%	16.80%	15.46%	16.14%	<=15.2%		>15.2%	CNO	
Sepsis 6	National	QEF3.4	% of patients receiving all elements of the sepsis 6 bundle within 1 hour			59.62%	47.06%	67.27%	48.33%	55.56%	52.63%	60.23%	39.39%	54.26%	43.88%	43.00%			>=80%	-	< 80%	CNO	
Hand Hygeine	Local	QEF3.5	Hand Hygiene Compliance to Practice	77.38%	88.58%	86.59%	85.55%	91.29%	89.96%	91.48%	95.02%	95.66%	96.79%	96.79%	97.35%	96.55%			>=95%		<95%	CNO	
	Local	QEF3.6	Hand Hygiene Audit Participation	0.79%	6.30%	11.57%	14.05%	12.40%	14.88%	12.40%	35.54%	57.02%	70.00%	65.83%	76.67%	75.83%			100%		<100%	CNO	

EFFECTIVE

Mortality	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months (HED)	104.52	104.15	106.34	107.50	108.90	109.61	109.83	110.64	111.49	112.70	112.52	111.39		-	-	<=100	-	-	DPS	
	National	QPS9.1	Mortality - SHMI - inc. deaths 30 days post discharge - rolling 12 months (NHS Digital)		1.0584			1.0921			1.1132						-	-	-	-	-	DPS	
	National	QPS9.23	% Primary Mortality Reviews returned within 30 days of issue (from month assigned)	52.59%	45.11%	34.16%	58.62%	51.46%	57.24%	58.18%	52.17%	59.89%	40.00%	39.51%	20.68%				>=60%	-	<60%	DPS	
	National	QPS9.26	% Completed PMRs (includes > 30 day completion)	77.44%	77.29%	78.68%	80.78%	81.10%	81.77%	82.18%	82.59%	82.51%	82.20%	80.51%	78.77%				-	-	-	DPS	
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	39	32	55	62	62	55	45	55	50	52	54	50	34	619	487	0	-	>0	CNO	
NOF	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	80.65%	81.48%	75.86%	79.10%	68.52%	76.56%	86.54%	66.18%	73.53%	86.67%	86.27%	93.65%	82.76%		81.4%	>=85%	-	<85%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Pts	94.34%	89.80%	86.27%	84.13%	84.09%	87.50%	93.75%	70.31%	80.65%	88.14%	91.67%	98.33%	100.00%		91.9%	>=85%	-	<85%	CMO	
Audits	Local	QR1.9	% Of NICE assessments completed within 12 weeks following publication	84.0%	85.5%														>95%	20% - 94%	<20%	CNO	
	Local	QR1.16	% of NICE assessments completed within 10 weeks (8 weeks wef 1/9/18, 6 weeks wef 1/4/19)			46.2%	74.6%	81.7%	79.4%	80.0%	84.0%	89.0%	90.0%	89.73%	90.42%	92.48%			>=85%	84%- 75%	<75%	CMO	
	Local	QR1.13	Complete an annual programme of local clinical audit			0.0%	1.0%	2.0%	5.0%	9.0%	19.0%	22.0%	28.0%	32.0%	41.0%	50.0%			>=60%	59%- 50%	<50%	CMO	
	Local	QR1.14	Participate in all relevant national clinical audits that the trust is eligible to participate in.			94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.00%	95.00%	95.00%			>=94%	93-90%	<90%	CMO	

* NCEPOD - currently not active as no reports are due

PATIENT EXPERIENCE

Friends & Family	National	QEX2.1a	Friends & Family - A&E (% Recommend)	73.60%	73.75%	80.13%	80.35%	81.46%	73.93%	78.68%	81.35%	81.70%	83.52%	78.27%	82.02%	85.71%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.2	Friends & Family - A&E (Response Rate %)	6.10%	3.59%	6.64%	5.72%	6.00%	4.86%	5.67%	4.12%	6.30%	6.83%	5.19%	5.87%	7.42%	-	-	>=20%	-	<20%	CNO	
	National	QEX2.61a	Friends & Family - Acute Wards (% Recommend)	94.84%	93.58%	96.27%	94.45%	94.49%	94.14%	93.65%	92.90%	93.16%	95.47%	95.30%	94.09%	94.60%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.62	Friends & Family - Acute Wards (Response Rate %)	9.30%	5.65%	7.51%	8.69%	17.46%	19.33%	18.26%	16.99%	18.29%	20.30%	16.40%	18.63%	19.62%	-	-	>=30%	-	<30%	CNO	
	National	QEX2.7a	Friends & Family - Maternity (% Recommend) (exc. Community)	97.51%	98.73%	98.68%	98.26%	97.25%	98.60%	95.98%	97.13%	97.88%	99.18%	98.59%	99.20%	97.42%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.8	Friends & Family - Maternity (Response Rate %) (exc. Community)	34.93%	19.14%	30.18%	26.56%	22.38%	27.99%	35.97%	21.76%	29.42%	29.37%	25.09%	29.64%	32.89%	-	-	>=30%	-	<30%	CNO	
	National	QEX2.10a	Friends & Family - Outpatients (% Recommend)	92.17%	92.39%	92.46%	92.51%	90.79%	92.17%	91.40%	91.01%	92.36%	93.32%	92.48%	92.34%	92.99%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.11	Friends & Family - Outpatients (Response Rate %)	5.69%	4.13%	4.72%	3.76%	3.65%	3.80%	4.60%	4.21%	5.11%	5.48%	5.04%	5.39%	5.80%	-	-	>=10%	-	<10%	CNO	
Complaint Management	Local	QEX1.24	Formal Complaints - Received In Month	52	56	55	61	44	58	50	49	56	47	45	45	52	562	607	-	-	-	CNO	
	Local	QEX1.37	Formal Complaints - % responded within 25 days (closed in month)	54.24%	73.21%	76.36%	81.33%	82.00%	86.67%	90.77%	88.57%	76.09%	71.43%	81.08%	75.60%	77.27%			>=80%	70-79%	<=69%	CNO	
	Local	QEX1.41	Formal Complaints - % of further concerns received	4.0%	0.0%	0.0%	3.0%	0.0%	0.0%	8.0%	0.0%	2.6%	2.1%	0.0%	0.0%	0.0%			<10%	-	>=10%	CNO	

Although some March data is available, it has been excluded from this dashboard until it has been through the agreed governance processes.

* A new electronic mortality review system was introduced at the end on May - this means previous months are not comparable. PMR reporting is based on the month assigned and reported a month in arrears.

** There has been a change in methodology for FFT - the 'score' now represents % recommended (where the response was either extremely likely or likely)

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

Data Quality Kite Mark Descriptions

Green - Reviewed in last 6 months and confidence level high.

Amber - Potential issue to be investigated

Red - DQ issue identified - significant and urgent review required.

Blue - Unknown - will be scheduled for review.

White - No data available to assign DQ kite mark

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire Acute Hospitals NHS Trust

Reporting Period: March 2019

Area	Indicator Type		Indicator	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Current YTD	Prev Year	Tolerance Type	2018/19 Tolerances			SRO	Data Quality Kitemark
																					On Target	Of Concern	Action Required		
Waits	National	PW1.1.3	Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	96.20%	92.63%	89.89%	89.69%	86.51%	88.13%	91.52%	94.68%	94.81%	91.89%	90.13%	91.88%	92.40%			National	>=99%	-	<99%	COO	
	National	CW3.0	RTT - Patients on an incomplete pathway (within 18 weeks)	83.24%	84.15%	84.76%	83.86%	82.87%	81.45%	81.01%	81.36%	81.47%	80.14%	80.17%	80.14%	80.77%			National	>=92%	-	<92%	COO	
	National	CW4.0	RTT - Patients waiting 52 weeks or more for treatment	4	3	2	1	0	0	0	0	0	0	0	0	0			National	0	-	>=1	COO	
	National	CW4.2	RTT - Patients waiting 40 weeks or more for treatment	405	430	453	422	410	477	458	337	339	427	420	395	357								
A & E	National	CAE1.1	4 Hour Waits (%) - Trust (exc. H&CT, MIUs)	64.61%	69.44%	73.07%	73.94%	71.81%	70.22%	72.13%	68.83%	69.28%	65.01%	65.30%	67.50%	72.44%	69.70%	73.89%	National	>=95%	-	<95%	COO	
A & E	National	CAE1.1a	4 Hour Waits (%) - Trust (inc. H&CT, MIUs)	71.28%	75.34%	78.78%	79.80%	78.01%	76.37%	77.76%	75.02%	74.97%	71.04%	71.57%	73.48%	77.67%	75.80%	78.91%	National	>=95%	-	<95%	COO	
	Local	CAE2.1	12 hour trolley breaches	75	44	28	3	2	10	19	25	34	99	170	85	16	535	140	Local	0		0	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile	59	68	47	40	51	68	73	94	65	102	183	145	71	87	-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment for All Patients (Mins) - 95th Percentile	49	64	55	64	66	69	68	68	57	60	105	86	60	67	-	National	<=15mins	-	>15mins	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	28.60%	33.30%	36.70%	53.60%	51.00%	46.50%	43.90%	39.20%	43.80%	36.20%	28.70%	32.40%	42.30%	40.70%	46.30%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	71.40%	73.80%	78.80%	85.70%	83.40%	80.30%	79.20%	76.20%	81.60%	71.50%	63.10%	70.10%	82.70%	77.20%	81.20%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes - WMAS data	335	251	174	123	210	315	287	415	270	544	799	522	227	4137	1,992	Local	0		>0	COO	
Cancer	National	CCAN1.0	2WW: All Cancer Two Week Wait (Suspected cancer)	77.75%	70.48%	77.49%	65.62%	75.00%	80.58%	88.90%	93.96%	93.37%	95.58%	93.34%	94.05%	92.18%	85.09%	80.63%	National	>=93%	-	<93%	COO	
	National	CCAN2.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	55.65%	45.96%	51.76%	27.66%	55.68%	87.01%	94.20%	97.81%	93.02%	97.04%	91.72%	96.00%	84.80%	76.41%	71.79%	National	>=93%	-	<93%	COO	
	National	CCAN3.0	31 Days: Wait For First Treatment: All Cancers	98.11%	97.39%	97.32%	98.80%	97.82%	98.15%	97.35%	96.73%	96.99%	98.30%	94.07%	98.91%	98.11%	97.47%	97.63%	National	>=96%	-	<96%	COO	
	National	CCAN7.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	82.93%	79.11%	76.01%	72.14%	73.30%	77.96%	70.26%	68.38%	77.97%	70.13%	62.36%	66.67%	70.70%	72.02%	72.65%	National	>=85%	-	<85%	COO	
	Local	CCAN7.2	62 Days: Wait For First Treatment From Urgent GP Referral: Breast*	86.44%	87.50%	85.20%	86.70%	93.50%	89.70%	65.50%	91.50%	82.60%	94.60%	68.00%	81.00%	92.00%	84.40%	88.59%	National	>=85%	-	<85%	COO	
	Local	CCAN7.3	62 Days: Wait For First Treatment From Urgent GP Referral: Gynae*	100.00%	81.80%	55.00%	60.00%	69.20%	90.00%	44.40%	84.20%	85.00%	37.50%	45.50%	61.10%	94.10%	69.90%	74.12%	National	>=85%	-	<85%	COO	
	Local	CCAN7.4	62 Days: Wait For First Treatment From Urgent GP Referral: Haemotological*	76.00%	71.40%	70.00%	75.00%	92.90%	77.80%	100.00%	83.30%	33.30%	66.70%	60.00%	57.10%	63.60%	73.70%	78.71%	National	>=85%	-	<85%	COO	
	Local	CCAN7.5	62 Days: Wait For First Treatment From Urgent GP Referral: Head & Neck*	28.57%	100.00%	71.40%	10.00%	50.00%	20.00%	50.00%	0.00%	75.00%	25.00%	13.30%	50.00%	60.00%	40.60%	28.79%	National	>=85%	-	<85%	COO	
	Local	CCAN7.6	62 Days: Wait For First Treatment From Urgent GP Referral: Lower Gastro*	80.00%	71.40%	70.00%	73.90%	76.20%	80.50%	89.70%	70.00%	82.10%	72.70%	81.00%	82.60%	93.30%	77.50%	52.19%	National	>=85%	-	<85%	COO	
	Local	CCAN7.7	62 Days: Wait For First Treatment From Urgent GP Referral: Lung*	50.00%	57.10%	75.00%	75.00%	56.00%	66.70%	35.70%	52.20%	70.00%	45.50%	30.80%	14.30%	40.00%	52.10%	56.08%	National	>=85%	-	<85%	COO	
	Local	CCAN7.8	62 Days: Wait For First Treatment From Urgent GP Referral: Skin*	97.30%	96.90%	100.00%	100.00%	87.10%	92.70%	83.30%	77.50%	94.40%	91.40%	87.40%	89.80%	100.00%	91.00%	94.99%	National	>=85%	-	<85%	COO	
	Local	CCAN7.9	62 Days: Wait For First Treatment From Urgent GP Referral: Upper Gastro*	90.91%	57.10%	90.50%	53.80%	68.40%	85.70%	92.90%	52.90%	86.70%	60.00%	59.50%	82.40%	80.00%	72.60%	67.03%	National	>=85%	-	<85%	COO	
	Local	CCAN7.10	62 Days: Wait For First Treatment From Urgent GP Referral: Urological*	83.33%	77.10%	59.70%	53.20%	56.90%	67.50%	57.90%	59.60%	59.80%	62.50%	42.90%	43.00%	37.50%	56.30%	65.16%	National	>=85%	-	<85%	COO	
	Local	CCAN7.11	62 Days: Wait For First Treatment From Urgent GP Referral: Other*	-	33.33%	100.00%	100.00%	0.00%	100.00%	100.00%	-	50.00%	-	-	-	-	68.18%	56.10%	National	-	-	-	COO	
	National	CCAN8.0	62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers (Small numbers)	71.43%	85.19%	85.19%	90.00%	90.70%	76.60%	73.21%	65.38%	82.61%	93.55%	63.41%	86.96%	88.89%	80.54%	87.73%	National	>=90%	-	<90%	COO	
	Local	CCAN12.0	62 Days waits: 62 day treatments waiting over 62 days	78	83	93	107	113	135	133	87	102	129	135	108	104							COO	
	Local	CCAN10.0	104 Day waits : 62 day treatments waiting over 104 days	24	15	21	17	20	38	32	25	23	30	32	25	24							COO	
	Local	CCAN11.0	Cancer Long Waiters (104+ Days) - treated in month	12.0	7.5	9.5	9.5	12.5	9.5	17.5	18.5	9.5	12.5	18.5	21.5	14.0	160.5	127.0	-	-	-	-	COO	
Stroke**	Local	CST1.1	80% of Patients spend 90% of time on a Stroke Ward	60.70%	64.30%	62.00%	73.10%	64.30%	78.50%	65.50%	84.30%	74.60%	64.10%	77.30%	72.70%		70.40%	1	Local	>=80%	-	<80%	COO	
	Local	CST2.1	Direct Admission (via A&E) to a Stroke Ward	27.30%	17.60%	24.40%	42.50%	33.30%	31.60%	38.70%	41.50%	35.70%	31.70%	25.50%	39.40%		33.00%	0	Local	>=90%	-	<90%	COO	
	Local	CST3.1	TIA clinic within 24 hours	85.00%	68.60%	77.60%	77.90%	44.20%	14.10%	45.20%	66.70%	29.90%	55.70%	66.70%	77.80%		56.20%	0	Local	>=60%	-	<60%	COO	
	Local	CST4.0	CT scan within 60 minutes of arrival	23.60%	36.40%	42.20%	38.30%	38.30%	41.60%	51.90%	47.80%	39.70%	40.60%	37.70%	56.40%		43.00%	34.90%	Local	>=80%	-	<80%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH	99.91%	99.84%	99.83%	98.76%	100.33%	98.25%	96.27%	98.39%	97.30%	97.95%	99.65%	99.60%	98.54%	98.7%	97.4%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX	91.68%	87.24%	87.20%	87.34%	88.12%	87.78%	89.51%	91.37%	92.09%	93.59%	96.84%	95.16%	90.95%	90.6%	86.8%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN2.3	Beds Occupied by NEL Stranded Patients (>7 days) - last week of month	45.12%	40.20%	38.41%	41.18%	39.19%	37.41%	35.18%	41.04%	38.08%	43.91%	41.25%	40.84%	40.68%			Local	<=45%	-	>45%	COO	
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute	25	36	35	40	25	31	27	23	39	28	26	38	26			Local	<30	-	>=30	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute	923	830	803	713	617	840	622	523	885	575	607	639	671	8325		-	-	-	-	COO	
Elective	National	PEL3.1	Number of patients - 28 Day Breaches (cancelled operations) | Quarterly	59			72			57			52				181	150	TBC	-	-	-	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	1	0	1	1	3	2	1	0	2	1	0	0	0	11	7	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	4.9	5.3	4.6	4.6	4.4	4.5	4.5	4.3	4.3	4.5	4.6	4.6	4.5	4.6	5.0	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	7.1	7.7	6.9	6.9	6.6	6.6	6.6	6.4	6.6	6.8	7.0	6.9	6.9	6.8	7.2	-	-	-	-	COO	
Dementia	National	QEF1.1	Dementia: Find, Assess, Investigate and Refer (Pt 1 - Find)	88.10%	89.94%	88.11%	85.50%	93.58%	94.93%	86.80%	97.92%	93.44%	96.80%	96.47%	94.90%	96.10%	93.04%	94.10%	National	>=90%	-	<90%	CMO	
	National	QEF1.2	Dementia: Find, Assess, Investigate and Refer (Pt 2 - Investigate)	92.20%	93.38%	94.33%	90.53%	93.72%	93.09%	89.47%	93.33%	93.91%	94.90%	90.84%	95.50%	91.40%	93.16%	92.40%	National	>=90%	-	<90%	CMO	
	National	QEF1.3	Dementia: Find, Assess, Investigate and Refer (Pt 3 - Refer)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	National	>=90%	-	<90%	CMO	

** Cancer - this involves small numbers that can impact the variance of the percentages substantially.*

*** Stroke metrics are not reported for the current month due to coding timeliness.*

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.

PEOPLE AND CULTURE ENGAGEMENT SCORECARD FOR TRUST BOARD
AS AT 31 MARCH 2019

Worcestershire Acute Hospitals NHS Trust

DATA FROM OLM AND ESR- run 8 April 2019													
		Last 3 years performance				Last 3 months performance							Projection for 31 March 2020
Metric	Description	31/03/2016	31/03/2017	31/03/2018	Trend for Previous 3 years	31/01/2019	28/02/2019	31/03/2019	Trend for last 3 months	Trend from last month		Target	
Establishment	Trustwide establishment					5,974.00	5,932.80	5923.08		-9.72			
Staff In Post (SIP)	Contracted SIP (FTE)	5,080.09	5,104.18	5,199.57		5,292.09	5,354.26	5372.24		17.98		5923.08	
Vacancy Rate	**TOTAL SUBSTANTIVE VACANCIES**					681.91	578.54	550.84		-27.70		7%	
	Overall Vacancy Rate			7%		11.41%	9.75%	9.30%		-0.45%		7%	8.50%
Staff FFT - Recommend Trust as a place to Work	**Description**	**31/03/2016**	**31/03/2017**	**31/03/2018**	**Trend for Previous 3 years**	**31/01/2019**	**28/02/2019**	**31/03/2019**	**Trend for last 3 months**	**Trend from last month**		**Target**	**Projection for 31 March 2020**
	SFFT/Staff opinion survey results	51%	48%	50%		61%	52%	51.50%		-1%		62.6% national average Q3 SOS	55%
Appraisal/PDR Compliance	Medical	82%	82%	89%		85%	90%	89%		-1%		85%	90%
	Non Medical OVERALL PDR	**80%**	71%	**66%**		**77%**	76%	77%		1%		85%	
	Registered Nursing and Midwives	79%	75%	68%		76%	77%	79%		2%		85%	85%
	HCA's and Helpers (Additional Clinical Services)	78%	69%	63%		77%	76%	78%		2%		85%	85%
	Allied Health Professionals (Physios, OT's etc)	89%	80%	76%		85%	82%	84%		2%		85%	85%
	Professional, Scientific and Technical	78%	81%	72%		57%	56%	63%		7%		85%	85%
	Healthcare Scientists	90%	69%	74%		84%	83%	84%		1%		85%	85%
	Estates and Ancillary	89%	78%	72%		77%	73%	70%		-3%		85%	85%
	Admin and Clerical	77%	60%	58%		77%	76%	72%		-4%		85%	85%
Up to date Job Plans	Consultants	68%	65%	72%		53%	63%	76%		13%		100%	100%
	SAS Doctors	31%	35%	41%		34%	38%	64%		26%		100%	80%
	All Medical staff	68%	61%	67%		50%	59%	74%		15%		100%	90%
OVERALL Mandatory Training Compliance	**Description**	**31/03/2016**	**31/03/2017**	**31/03/2018**	**Trend for Previous 3 years**	**31/01/2019**	**28/02/2019**	**31/03/2019**	**Trend for last 3 months**	**Trend from last month**		**Target**	**Projection for 31 March 2020**
	Overall Training Compliance at Base Level	88%	82%	89%		85%	85%	84%		-0.5%		90%	90%
	Overall Training Compliance at **ALL** levels			74%		83%	84%	84%		0.3%		90%	90%
Mandatory Training Compliance by Staff Group	Medical and Dental					66%	67%	71%		4%		90%	85%
	Registered Nursing and Midwives					86%	87%	87%		0%		90%	90%
	HCA's and Helpers (Additional Clinical Services)					82%	83%	84%		1%		90%	90%
	Allied Health Professionals (Physios, OT's etc)					87%	88%	89%		1%		90%	90%
	Healthcare Scientists					91%	91%	92%		1%		90%	95%
	Professional, Scientific and Technical					82%	83%	83%		0%		90%	90%
	Admin and Clerical					88%	89%	87%		-2%		90%	90%
	Estates and Ancillary					77%	77%	75%		-2%		90%	90%

	Description	31/03/2016	31/03/2017	31/03/2018	Trend for Previous 3 years	31/01/2019	28/02/2019	31/03/2019	Trend for last 3 months	Trend from last month	Target	Projection for 31 March 2020
Mandatory Training Compliance By Topic	Information Governance	87%	90%	94%		84%	85%	85%		0%	95%	95%
	Fire	85%	82%	81%		82%	82%	82%		0%	90%	90%
	Health & Safety	75%	85%	84%		89%	89%	90%		1%	90%	90%
	Conflict Resolution	81%	87%	88%		90%	89%	90%		1%	90%	90%
	Equality & Diversity	74%	69%	69%		78%	79%	80%		1%	90%	90%
	Infection Control L1	85%	77%	89%		90%	89%	87%		-2%	90%	90%
	Infection Control L2			67%		78%	79%	79%		0%	90%	90%
	Moving & Handling L1	90%	88%	88%		87%	86%	82%		-4%	90%	90%
	Moving and Handling L2			77%		79%	80%	82%		2%	90%	90%
	Safeguarding Children L1	88%	80%	99%		97%	97%	96%		-1%	90%	97%
	Safeguarding Children L2			63%		79%	81%	83%		2%	90%	90%
	Safeguarding Children L3			59%		82%	84%	87%		3%	90%	90%
	Safeguarding Children L4			100%		100%	75%	75%		0%	90%	100%
	Safeguarding Children L5			0%		100%	100%	100%		0%	90%	100%
	Safeguarding Adults L1	96%	96%	87%		91%	90%	89%		-1%	90%	90%
	Safeguarding Adults L2			59%		82%	82%	83%		1%	90%	90%
	Safeguarding Adults L3			1%		36%	42%	49%		7%	90%	85%
	Safeguarding Adults L4			100%		100%	100%	100%		0%	90%	100%
	Safeguarding Adults L5			33%		100%	100%	100%		0%	90%	100%
	Resuscitation L1			72%		89%	90%	90%		0%	90%	90%
	Resuscitation L2 Basic Life Support	85%	85%	86%		80%	79%	80%		1%	90%	90%
	NLS L4 Newborn Life Support			58%		100%	100%	100%		0%	90%	100%
	EPLS L4			74%		86%	86%	91%		5%	90%	90%
	ALS L4 Advanced Life Support			63%		82%	84%	81%		-3%	90%	90%

	Description	31/03/2016	31/03/2017	31/03/2018	Trend for Previous 3 years	31/01/2019	28/02/2019	31/03/2019	Trend for last 3 months	Trend from last month	Target	Projection for 31 March 2020
Mandatory Training Compliance By Topic	Preventing Radicalisation L1			86%		94%	94%	94%		0%	85%	95%
	Preventing Radicalisation L2			89%		85%	86%	89%		3%	85%	90%
	Preventing Radicalisation L3 (WRAP)			52%		83%	85%	86%		1%	85%	90%
	Preventing Radicalisation L4 (WRAP)			100%		100%	100%	100%		0%	85%	100%
	Preventing Radicalisation L5 (WRAP)			100%		100%	100%	100%		0%	85%	100%
	MCA and DoLS L1			64%		79%	80%	84%		4%	90%	90%
	MCA and DoLS L2			47%		72%	75%	75%		0%	90%	90%
	MCA and DoLS L3			0%		80%	82%	84%		2%	90%	90%
	MCA and DoLS L4			0%		100%	100%	100%		0%	90%	100%

	Description	31/03/2016	31/03/2017	31/03/2018	Trend for Previous 3 years	31/01/2019	28/02/2019	31/03/2019	Trend for last 3 months	Trend from last month	Target	Projection for 31 March 2020
Turnover	Monthly Turnover			1.02%		0.85%	0.77%	1.04%		0.27%	MHB Aug 18 Peers 0.86%	0.85%
	Annual Turnover (FTE)	12.97%	12.57%	11.04%		12.46%	12.33%	12.30%		-0.03%	local target 10-12%	11.50%
	Annual Turnover (FTE) for Consultants	7.84%	8.24%	7.89%		8.84%	8.98%	9.49%		0.51%	local target 10-12%	8.50%
	Other Medical and Dental staff	13.53%	12.82%	11.22%		2.38%	4.56%	8.90%		4.34%	local target 10-12%	7.00%
	Professional, Scientific and Technical	12.50%	10.30%	13.95%		11.41%	10.62%	9.96%		-0.66%	local target 10-12%	10.00%
	HCA's and Helpers (Additional Clinical Services)	13.35%	15.60%	13.08%		16.24%	15.68%	15.57%		-0.11%	local target 10-12%	14.00%
	Admin and Clerical	11.89%	9.27%	11.41%		9.62%	9.02%	9.57%		0.55%	local target 10-12%	10.00%
	Allied Health Professionals (Physios, OT's etc)	13.56%	13.87%	12.64%		17.98%	17.77%	18.04%		0.27%	local target 10-12%	16.00%
	Estates and Ancillary	13.70%	12.11%	9.50%		10.05%	9.61%	8.90%		-0.71%	local target 10-12%	10.00%
	Healthcare Scientists	10.46%	15.10%	7.62%		11.87%	13.70%	11.06%		-2.64%	local target 10-12%	10.00%
	Registered Nursing and Midwives	14.15%	13.29%	10.47%		12.18%	12.33%	12.22%		-0.11%	local target 10-12%	11.50%
	Students	12.50%	0.00%	0.00%		5.56%	6.45%	6.45%		0.00%	0.00%	0.00%

Staff Retirement Profile - Percentage Staff age **61** and over by staff group (FTE)

Description	31/03/2016	31/03/2017	31/03/2018	Trend for Previous 3 years	31/01/2019	28/02/2019	31/03/2019	Trend for last 3 months	Trend from last month	Target	Retirement Profile for 31 March 2020
Medical and Dental - Consultants	5.47%	6.83%	7.09%		6.21%	6.22%	6.03%		-0.19%	7% (provisional)	7.52%
Medical and Dental - Middle Grades	0.88%	0.73%	1.36%		0.98%	0.96%	0.96%		0.00%	7% (provisional)	0.96%
Professional, Scientific and Technical	2.10%	1.95%	2.47%		2.96%	2.99%	2.96%		-0.03%	7% (provisional)	2.99%
HCA's and Helpers (Additional Clinical Services)	4.39%	3.80%	4.92%		5.66%	5.62%	5.84%		0.22%	7% (provisional)	6.96%
Admin and Clerical	6.49%	7.26%	7.77%		8.38%	8.39%	8.37%		-0.02%	7% (provisional)	10.45%
Allied Health Professionals (Physios, OT's etc)	1.90%	2.37%	2.55%		2.60%	2.44%	2.31%		-0.13%	7% (provisional)	4.01%
Estates and Ancillary	15.58%	14.77%	15.24%		16.12%	15.86%	16.73%		0.87%	7% (provisional)	18.64%
Healthcare Scientists	2.47%	1.83%	2.12%		2.83%	2.57%	2.58%		0.01%	7% (provisional)	3.12%
Registered Nursing and Midwives	2.86%	3.38%	3.68%		3.75%	3.72%	3.78%		0.06%	7% (provisional)	4.71%

The percentage of staff age 61 and over increases by March 2020 particularly for Estates and Ancillary and Admin and Clerical staff. Divisions need to develop plans for potential gaps in services.

Retention Rate/Stability Index

Description	31/03/2016	31/03/2017	31/03/2018	Trend for Previous 3 years	31/01/2019	28/02/2019	31/03/2019	Trend for last 3 months	Trend from last month	Target	Projection for 31 March 2020
Trust Retention Rate/Stability Index	88.97%	88.91%	90.08%		88.70%	88.34%	88.89%		0.55%	MHB Nov 18 85.9%	89.00%
Consultants retention rate	93.78%	93.92%	92.38%		92.70%	93.28%	92.26%		-1.02%	92.47% (Model Hospital Mar 18)	93.00%
Other Medical and Dental staff	98.49%	93.23%	102.04%		96.57%	97.84%	93.35%		-4.49%	92.47% (Model Hospital Mar 18)	97.00%
Professional, Scientific and Technical	89.28%	87.75	89.93%		100.08%	95.36%	94.66%		-0.70%		98.00%
HCA's and Helpers (Additional Clinical Services)	85.95%	84.17%	88.06%		84.53%	84.01%	84.49%		0.48%	MHB Dec 18 83.3%	85.00%
Admin and Clerical	93.31%	93.61	91.70%		91.84%	92.11%	93.28%		1.17%		92.00%
Allied Health Professionals (Physios, OT's etc)	87.63%	83.81%	88.23%		81.41%	82.22%	82.53%		0.31%	MHB Dec 18 86%	84.00%
Estates and Ancillary	86.12%	88.65	91.51%		91.40%	91.95%	93.79%		1.84%		91.00%
Healthcare Scientists	92.74%	91.32	92.44%		90.26%	88.50%	90.88%		2.38%		90.00%
Registered Nursing and Midwives	87.49%	88.41%	89.76%		88.88%	88.31%	88.73%		0.42%	MHB Dec 18 87.4%	89.00%
Students	113.33%	164.71%	82.14%		56.52%	40.91%	40.91%		0.00%		

Sickness Absence

Description	31/03/2016	31/03/2017	31/03/2018	Trend for Previous 3	31/01/2019	28/02/2019	31/03/2019	Trend for last 3 months	Trend from last month	Target	Projection for 31 March 2020
Monthly sickness absence	4.30%	4.00%	3.93%		4.93%	4.49%	4.14%		-0.35%	MHB Oct 18 4.27%	4.00%
Cumulative Sickness over 12 months	4.35%	4.27%	4.17%		4.16%	4.19%	4.20%		0.01%	MHB Oct 18 4.27%	4.00%
Model Hospital Benchmark Sickness as at Oct 2018					4.00%	4.00%	4.00%		0.00%	MHB Oct 18 4.27%	4.00%

NOTES:

No exclusions for sickness, maternity or career break are made to Mandatory Training figures; New starters in last 12 month are excluded from PDR %

KEY TO COLUMN H	
	TARGET MET
	WITHIN 3% OF TARGET
	TARGET NOT MET
	GREY BOXES ARE NOT APPLICABLE OR NOT AVAILABLE

KEY TO COLUMN J					
	PERFORMANCE IMPROVED				
	PERFORMANCE DETERIORATED				
	PERFORMANCE UNCHANGED				
	0				ARROW DEPICTS DIRECTION OF TRAVEL

V2 Feb 2019

Meeting	Trust board
Date of meeting	9 May 2019
Paper number	G1

Urgent Care – Home First Worcestershire Plan

For approval:		For discussion:		For assurance:	x	To note:	x

Accountable Director	Paul Brennan – Deputy Chief Executive / Chief Operating Officer		
Presented by	Paul Brennan	**Author /s**	Robin Snead – Deputy Chief Operating Officer

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care		Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	x	Continuously improve our services to secure our reputation as the local provider of choice			

Alignment to the Trust's goals							
Timely access to our services	x	Better quality patient care	x	More productive services	x	Well-Led	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	4,5

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☒ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Trust Board is asked to - Note and gain assurance from the steps being taken to improve patient flow across the acute hospital sites.

Meeting	Trust board
Date of meeting	9 May 2019
Paper number	G1

Executive Summary

The urgent care home first Worcestershire plan has been launched week commencing 8th April 2019.

The aim of the programme is to alleviate the significant pressures currently (and for a number of years) felt along the emergency care pathway, in part due to the exit block experienced by both acute medicine and the emergency department (ED). Ultimately the aim will be to remove corridor waits from ED, ensure ambulance handovers happen in a timely way, in line with national standards and the emergency access standard is attained.

The programme is made up of six elements which are;

1. The SAFER patient flow bundle and Red2Green days – designed to improve in-patient flow and earlier in the day discharges. Undertaking this successfully will significantly decongest ED and help to remove exit block. The aim should be for bed availability on wards to meet the demand for admissions from ED.
2. Streaming – ensuring patients are directed to the most appropriate place for treatment, from their first contact with the hospital.
3. Clinical site management – making sure the site management model follows best practice to ensure timely, safe use of the available bed stock.
4. Internal professional standards - Internal professional standards ensure specialty response times within the trust are reasonable so that patients are seen in as timely a way as possible.
5. Long length of stay reviews - A systematic review of patients with a Long length of stay designed to unpick, unblock and escalate issues preventing progress of the patient plan.
6. Trust workshop outcomes – several strands of work which came from a workshop held with consultants

The above six elements have specific actions attached (appendix 1), with action owners and deliverable dates.

The delivery of this plan is supported by senior Emergency Care Intensive Support Team (ECIST) members to ensure national best practice principles are applied.

Background

The inpatient flow through the Worcestershire Acute Hospitals has been compromised for the past 5 years due to circa 100% bed occupancy and inefficient clinical practice. This has restricted performance against Key Performance Indicators (KPIs) including Emergency Access Standard; Referral To Treatment Times and Cancer 62 days and 2 week wait standards.

A co-ordinated plan to implement sustained change to patient flow across the acute hospitals in required.

Issues and options

The Trust and the local system continue to develop an improvement plan in response to the operational plan submitted by the Trust on 4 April 2019.

This includes support from ECIST to support the delivery of sustained change to clinical

practice and patient flow.

The acute trust require continued support from systemwide partners, in health and social care, to reduce the number of stranded and super stranded (long length of stay) patients in order to deliver required reduction in bed occupancy.

Adequate staffing levels with correct skill mix need to be maintained in order to deliver the improved services in line with the proposed plan.

Recommendations

The Trust Board is asked to

- Note and gain assurance from the steps being taken to improve patient flow across the acute hospital sites.

Appendices

Appendix 1 – Urgent Care – Home First Worcestershire Plan

Project Reference / Number	01	Individual Project Plan	Project Start Date	08/04/2019
Project Name	SAFER patient flow bundle and Red2Green bed days		Project End Date	
Project Description	Processes which empower clinicians to advocate on behalf of patients to ensure that todays work is completed today. The process will identify key constraints and themes which require resolution. The net effect is an improvement in flow, a reduction of length of stay, earlier in the day discharge		Project Lead	Vicky Morris, Chief Nurse. Suneil Kapadia, Medical Director

			Quantity		0	0	0	6		
			Percentage %		n/a	n/a	n/a			
			Original		BRAG STATUS					
Item No	Summary of Action	Action Owner	Start Date	End Date	Overdue/ Mtg action	Some Risk	Work in Progress	Action Complete	Completion Date	Comments
1	Identify wards taking part in first phase roll out (WRH)	Divisional Directors	08/04/2019	12/04/2019				4		
2	Sign off and agree roll out	PB	08/04/2019	12/04/2019				4		
2	Meet with Leadership teams to agree process/ ownership	AA/WJH/JW	08/04/2019	03/05/2019				4		
3	Engage/ 1 - 1's with key consultants	Clinical Directors	08/04/2019	03/05/2019						
4	Training for executive team	ECIST	08/04/2019	19/04/2019				4		
5	Training/ awareness/ comms for key ward staff	ECIST	08/04/2019	26/04/2019				4		
6	Draft Internal Trust Communication Plan	RH	08/04/2019	10/05/2019			`			
7	Agree consultant engagement plan for each ward	Clinical Directors	08/04/2019	03/05/2019						
8	Confirm metrics with informatics	BH/ AA/ ECIST	08/04/2019	10/05/2019						
9	Agree resources required to ensure programme is sustainable	Divisions /Finance	08/04/2019	03/05/2019						
10	Draft Governance Process	WJH/JW	08/04/2019	12/04/2019				4		
11	Sign Governance Process	PB	08/04/2019	03/05/2019						
12	Grab pack agreed and printed/ bound	PH/WJH/AA	08/04/2019	03/05/2019						
13	Agree social movement plan (inclusive of social media training)	RH	08/04/2019	03/05/2019						
14	Agree a 'knowing how your doing' board	BH	08/04/2019	03/05/2019						
15	Sufficient training is provided for mental capacity assessments to allow this to be expedited rapidly	Vicky Morris	08/04/2019	08/06/2019						
16	Commence roll out to first phase wards (7 wards)	Ward Managers/ Medics	29/04/2019	24/05/2019						
17	Agree second phase wards (6 wards Alex)	WJH/SB	23/04/2019	26/05/2019						
18	Sign off and agree roll out to phase 2 wards	PB	29/04/2019	03/05/2019						
19	Commence roll out to second phase wards (Alex Hospital)	Ward Managers/ Medics	27/05/2019	21/06/2019						
20	Meet with Leadership teams to agree process/ ownership	AA/WJH/JW	13/05/2019	17/05/2019						
21	Engage/ 1 - 1's with key consultants	Clinical Directors	13/05/2019	24/05/2019						
22	Training/ awareness/ comms for key ward staff	ECIST	13/05/2019	24/05/2019						
23	Agree resources required for Phase 2	Divisions /Finance	13/05/2019	17/05/2019						
24	Agree a 'knowing how your doing' board	BH	22/04/2019	03/05/2019						
25	Agree third phase wards (6 wards WRH)	WJH/SB	17/05/2019	01/06/2019						
26	Commence roll out to third phase wards (WRH)	Ward Managers/ Medics	03/06/2019	07/06/2019						

Project Reference / Number	02	Individual Project Plan			Project Start Date					08/04/2019
Project Name	Streaming				Project End Date					
Project Description	Streaming of patients appropriate for a primary care clinician, to the appropriate place				Project Lead					Sarah Smith
			Quantity		0	0	0	1		
			Percentage %		n/a	n/a	n/a			
			Original		BRAG STATUS					
Item No	Summary of Action	Action Owner	Start Date	End Date	Overdue/ Mtg action	Some Risk	Work in Progress	Action Complete	Completion Date	Comments
1	Understand current contractual arrangements for the three processes (Care UK, GP Federation)	JF/WJH	08/04/2019	10/05/2019						
2	Agree and document the criteria and standard operating procedure/ protocol for primary care streaming	JF/WJH	08/04/2019	17/05/2019						
3	Process map streaming requirements	WJH/JK/ECIST	08/04/2019	17/05/2019						
4	Undertake a demand and capacity review for primary care	James France/ Abdul Jalil	08/04/2019	03/05/2019				4		
6	Identify opportunities for pre-hospital streaming and review access to alternative ED dispositions	ECIST/WJH/Jenny Sears Brown	08/04/2019	17/05/2019						
7	Agree the streaming process given the capacity and demand work already undertaken	WJH/ JW	08/04/2019	17/05/2019						
8	Ensure the commisioned GP capacity matches the demand	MG	08/04/2019	31/05/2019						
9	Develop training package for streaming staff to ensure consistency of service	JK	08/04/2019	31/05/2019						
10	Agree and document the governance arrangements to ensure shared learning, undertsand what hasn't worked and continued development of the service	WJH/JW	08/04/2019	31/05/2019						
11	Establish close links with primary care streaming and speciality pathway groups	WJH/JW	08/04/2019	31/05/2019						
12	Ensure a clear escalation plan is in place to deal with increasing operational pressures	RS	08/04/2019	31/05/2019						
13	Commence testing new model	JK/JF/AJ	23/04/2019	ongoing						
14	Test model of Community Matron in WMAS Hub to identify other pathways for patients avoiding ED	ECIST	29/04/2019	ongoing						This is to be trialled in Stoke with significant success in avoiding ED

Project Reference / Number	03	Individual Project Plan	Project Start Date	08/04/2019
Project Name	Clinical Site Management		Project End Date	
Project Description	A pro-active site management team ensure available beds are utilised effectively to place the right patient in the right place with an overview of site safety and risk		Project Lead	Robin Snead, Deputy Chief Operating Office

			Quantity	0	0	0	1		
			Percentage %	n/a	n/a	n/a			
			Original	BRAG STATUS					
Item No	Summary of Action	Action Owner	Start Date	End Date	Overdue/ Mtg action	Some Risk	Work in Progress	Action Complete	Completion Date	Comments
1	Recruit to new role of Director o Capacity	PB	01/04/2019	05/04/2019				4	01/04/2019	
2	Review function and resource of the bed management and clinical site management role	RS	08/04/2019	01/06/2019						
3	Identify roles/ responsibilities/ job descriptions for new roles	RS	08/04/2019	17/06/2019						
4	Document team structure/ standard operating procedures for new ways of working	RS	08/04/2019	01/07/2019						
5	provide training for new processes	ECIST/ AA/ SS	22/04/2019	01/08/2019						
6	Revise site meeting purpose, times, frequency, agenda, attendee's and comms	AA/SS	22/04/2019	31/07/2019						
7	Update ED and hospital escalation protocols	RS	08/04/2019	01/08/2019						
8	Implement new process	RS	29/04/2019	ongoing						
9	Identify core data sources to be completed 'live' to endorse real time management of available Trust capacity	RS	08/04/2019	01/08/2019						
10	Implement new on-call escalation and on call escalation process	RS	26/04/2019	Ongoing						

Project Reference / Number	04	Individual Project Plan	Project Start Date	08/04/2019
Project Name	Long Length of Stay Reviews		Project End Date	
Project Description	A systematic review of patients with a Long length of stay designed to unpick, unblock and escalate issues preventing progress of the patient plan. All Wards to be included in process		Project Lead	Vicky Morris

		Quantity	0	0	0	1	
		Percentage %	n/a	n/a	n/a		
		Original	BRAG STATUS				

Item No	Summary of Action	Action Owner	Start Date	End Date	Overdue/ Mtg action	Some Risk	Work in Progress	Action Complete	Completion Date	Comments
1	Identify key staff who will undertake long length of stay reviews in line with guidance from best practice document, guide to reducing long hospital stays p. 29	VM	04/03/2019	08/03/2019				4	06/03/2019	
2	Provide training to key staff on national best practice model	ECIST	04/03/2019	19/04/2019				4	19/04/2019	Training completed for both sites (07/03/2019 WRH/ 16/04/2019 AH
3	Long Stay List produced and distributed in advance of escalation meetings - all wards	BH	27/03/2019	Ongoing						
4	Review process takes place each week at a regular time	VM	01/04/2019	Ongoing						
5	Clear Governance process agreed with actions from each meeting	VM	08/04/2019	17/05/2019						
6	Ensure a consistent repetitive approach is adopted for the weekly reviews	VM	08/04/2019	Ongoing						
7	Ensure resource is protected so that reviews can be undertaken at the same time each week. This includes a consistent team undertaking reviews.	VM	08/04/2019	Ongoing						
8	Develop metrics utilising statistical process control charts to measure success	VM	08/04/2019	10/05/2019						Utilise ECIST guidance

Project Reference / Number	05	Individual Project Plan	Project Start Date	08/04/2019
Project Name	Trust Professional Standards		Project End Date	
Project Description	Internal professional standards ensure speciality response times to the emergency department are reasonable so that patients are seen as quickly as possible to provide the best experience.		Project Lead	Suneil Kapadia, Medical Director

			Quantity		0	0	0	0		
			Percentage %		n/a	n/a	n/a			
			Original		BRAG STATUS					
Item No	Summary of Action	Action Owner	Start Date	End Date	Overdue/ Mtg action	Some Risk	Work in Progress	Action Complete	Completion Date	Comments
1	Review current Trust professional standards to ascertain whether compliant with national best practice	SK	08/04/2019	17/05/2019						
2	Identify gaps where standards are not in place	SK	12/04/2019	17/05/2019						
3	Understand reasons why TPS have not been complied with previously	SK	08/04/2019	17/05/2019						
4	Agree with each speciality a time for each individual standard and document accordingly	SK	12/04/2019	31/05/2019						
5	Ensure governance measures are in place to monitor adherence to standards on a daily basis	SK	08/04/2019	31/05/2019						
6	Ensure peer reviews are part of the governance process	SK	08/04/2019	31/05/2019						
7	Commence process and monitoring	SK	29/04/2019	Ongoing						
8	Assess whether direct access pathways exist for GP referred and streamed patients to key specialities i.e. surgery, medicine, acute medicine, gynaecology, orthopaedics	JW	08/04/2019	17/05/2019						
9	Identify scope for granting admission rights for Emergency Medics	JW	08/04/2019	24/05/2019						
10	Agree final process for pathway diversion from ED	Divisional Medical Directors	19/04/2019	31/05/2019						
11	For those areas where this is not in place safe, direct access pathways should be developed to avoid GP referred patients attending ED unless clinically necessary. This should include escalation measures for each speciality so that patients do not default to ED when the speciality is full	Divisional Medical Directors	08/04/2019	28/06/2019						

Project Reference / Number	06	Individual Project Plan							Project Start Date	08/04/2019
Project Name	Trust Workshop Outcomes								Project End Date	31/08/2019
Project Description	A Divisional team workshop was held on Tuesday 12th Fenruary 2019. The key outputs from the workshop fom Project 7								Project Lead	Jasper Trevellyan
			Quantity		0	0	0	0		
			Percentage %		n/a	n/a	n/a			
			Original		BRAG STATUS					

Item No	Summary of Action	Action Owner	Start Date	End Date	Overdue/ Mtg action	Some Risk	Work in Progress	Action Complete	Completion Date	Comments
1	Review existing deployment of therapy staff to ensure presence at all Board rounds in line with SAFER and Red2Green project	CL	08/04/2019	17/05/2019						
2	Ring fence AEC to prevent use as inpatient surge area.	RS	08/04/2019	Ongoing						
3	Implement weekend resident Pharmacy service at Worcester Royal site	RM	01/08/2019	Ongoing						
4	A lack of organisation and coordination in ED was discussed when specialities arrive to see patients. This requires exploring further with a resolution developed	JF/ CB	08/04/2019	10/05/2019						
5	Access potential demand, by core specialties, for urgent (hot) outpatient slots to avoid admission and set out a clear plan to deliver the required capacity	JK	08/04/2019	17/05/2019						
6	Review appropriatness of defined 'high care' areas with the objective of moving to level 1 (acute), 2 (high dependency) and 3 (critical) designation of inpatient areas	SK	01/05/2019	01/07/2019						
7	Integrate elements of the patient flow function wth clinical site management service (link to project 03)	RS	01/05/2019	01/07/2019						
8	Patients must not be moved between inpatient wards unless clinically indicated and patient step down from ITU/HDU to occur within 24 hours of decision to transfer to a level 1 bed	RS	01/07/2019	29/07/2019						
9	Review existing inpatient bed allocation to specialty to align capacity with demand (link to projects 05 and 03) to ward cover to oversee high potential morning discharges	RS	01/05/2019	01/07/2019						
10	Redeploy Consultant time from ED morning review and bed meeting (Link to projects 05 and 03) to ward cover to oversee high potential morning discharges	JT	08/04/2019	10/05/2019						
11	GP Expected patients to go direct to specialty assessment/ward area rather than ED, unless clinically required	Clinical Directors	08/04/2019	28/06/2019						
12	Undertake weekly review of all failed discharges (within 6 hours of plan) to identify points of failure	RS	08/04/2019	10/05/2019						
13	Ringfence discharge lounge to prevent use as an inpatient surge area.	RS	01/07/2019	ongoing						

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
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Paper number	Enc G2

Report on Nursing and Midwifery Staffing Levels – January and February 2019

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Vicky Morris, Chief Nursing Officer		
Presented by	Vicky Morris Chief Nursing Officer	**Author /s**	Louise Pearson: Lead for Nursing and Midwifery Workforce

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	x	Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients		Continuously improve our services to secure our reputation as the local provider of choice			

Alignment to the Trust's goals							
Timely access to our services	x	Better quality patient care	x	More productive services		Well-Led	

Report previously reviewed by		
Committee/Group	Date	Outcome
People and Culture	April 2019	Received for assurance

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	11

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☒ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is requested to note: • That staffing levels were safe in January and February 2019 following mitigating actions • That work continues to reduce the qualified nursing and healthcare assistant vacancies across the Trust with good progress being made in the first 3 months of 2019 • From April, in line with the revised workforce standard the Chief Nursing Officer must confirm a statement to the Trust Board that she is satisfied with the outcome of the annual assessment that staffing is safe, effective and sustainable. This will be provided for the bi-annual winter review.

NHS
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Executive Summary

This paper provides assurance to the Committee of the nursing and midwifery staffing levels for January and February 2019. It confirms that following mitigation staffing levels were safe.

- This is evidenced by the fill rates of shifts which was over 90% on days and 95% on night shifts.

Safe staffing levels and Care Hours per Patient Day (CHPPD) are monitored three times a day per ward and the data for the reporting period is contained in Appendix 1.

This table demonstrated that there were 12 wards which flagged as below fill rates and mitigations were put in place contemporaneously. The area of particular concern was Ward 16, elective orthopaedics (Alexandra Hospital) where there is a vacancy rate of over 25% which has affected both day and night shifts.

The mitigations that have been put in place to ensure patient quality and safety were:

- The moving of staff where risks were identified by ward managers and matrons, booking proactively bank and agency where vacancies were known and also short term booking where there was sickness or where increased patient acuity and demand requires increased nursing presence.
- The use of block booking of agency nurses through a project managed approach with the external agency ID medical on adult wards has and remains very successful in filling shifts.

Risks and incidents:
There were no moderate harm incidents reported for the reporting period. There has been a reduction in the number of red flag incidents in this period compared to the previous month. This is due to the use of the managed agency service known as project nightingale. The project has supported the trust with 100 WTE nurses over a sustained period of time.

Vacancies:
The current qualified nursing vacancy factor trust wide is 257 whole time equivalents (WTE). There is stability in the number of Registered Nurses (RN) and Health Care Assistants (HCA) vacancies. In January and February 2019 we had 40 registered nurses commence in ward areas. In March we have a further 20 registered nurses joining the trust. We do not have any Registered Midwives (RM) vacancies.

The new Head of Midwifery is due to commence in April 2019. Staffing levels in Jan and Feb were safe. A review of staffing establishment will be undertaken in line with a new Birthrate+ review in June 2019

There remain 46 HCA vacancies, which are being actively recruited to. This number is as a result of the requirements from opening new wards. There were 50 HCA's who joined the trust in January and February 2019 with a further 30 to join in March. The vacancy rate has reduced by 1.66%.

Wards that have over 25% vacancy rate are being monitored and a monthly support meeting convened by the Nursing Lead for Workforce and respective Ward Manager. These wards are: 8 in specialised medicine, 5 in Surgery and 3 in urgent care. Action taken has been to focus on

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recruitment initiatives and book block agency bookings.

Number of Nursing staff cleared each month (unconditional offers made)

	2018												2019		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Registered Nurses	15	18	12	14	12	17	22	31	29	18	13	13	34	29	21
Unregistered Nursing	7	14	12	7	10	17	4	6	13	20	23	22	29	20	33
Total Cleared	**22**	**32**	**24**	**21**	**22**	**34**	**26**	**37**	**42**	**38**	**36**	**35**	**63**	**49**	**54**

Recruitment:

A proactive recruitment plan is in place and key actions in month have been:

- Working With Health Education England to secure International Nurses via skype interviews which will take place from 8th April 2019
- An external recruitment event in London on 13th April
- An active social media campaign
- Fortnightly staffing meetings to discuss rosters, vacancies and bank usage
- Working with the university to guaranteed posts on qualification for students known as the 'Golden Ticket'
- Support for internal and external recruitment events by the Practice Development Team
- The rollout of the first Nursing Associates who join the NMC register and our workforce in April 2019.
- Strategic date – formerly known as UNIFY

Background

We are required to submit monthly data to NHS Strategic Data Collection Service (SDCS). This information provides the detail per ward of the nursing and midwifery staffing fill rates and bed days. This information is displayed on our website.

From September 2018, NHSI have published Care Hours Per Patient Day (CHPPD) on MY NHS and NHS choices. This measure is used alongside clinical quality and safety outcome measures to reduce unwarranted variation and support delivery of high quality, efficient patient care. This is through ward deployment of staff to care for the right patients at the right time with the right skill set to meet patients' needs..

Fill rates are calculated from the expected level of staffing against what was actually provided. This data is produced from the safer staffing app and submitted to SDCS in response to Lord Carter's recommendations. SDCS data is provided at Appendix 1.

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Issues

Fill rates of staffing shifts
For January and February 2019 wards that have triggered red have the explanation and mitigation detailed within Appendix 1.

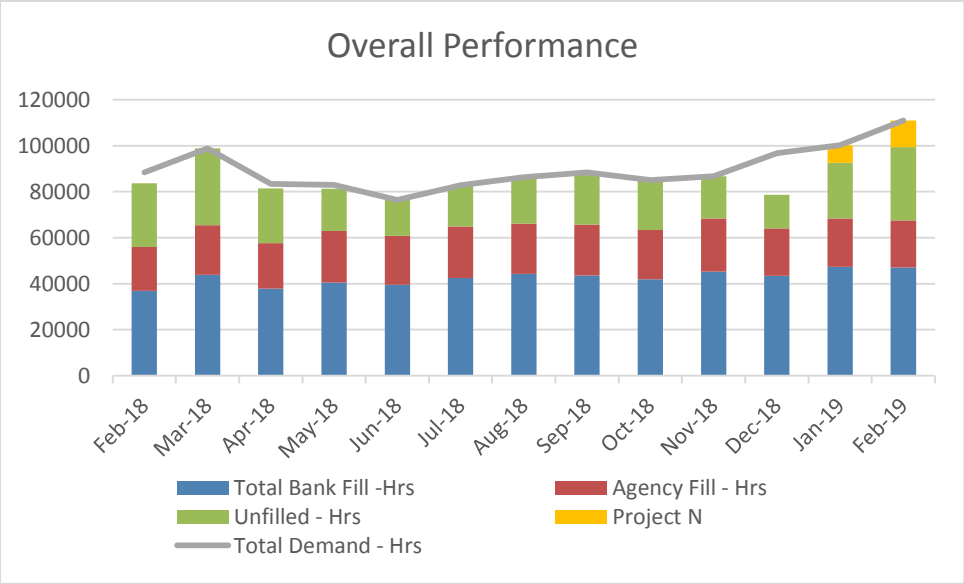
Staffing has been reviewed by the Matrons and Divisional Directors of Nursing three times a day and by the matrons on call overnight. Mitigation processes have been activated in real time when temporary staffing measures were not achieved. These have included:

- Reviews of the acuity and dependency of patients on wards to ensure needs are being met with reduced staffing numbers.
- The cancelling of training
- The use of non-ward based nursing staff. Restrictions in opening extra capacity beds
- The role out of Allocate safe care module which allows full visibility across both substantive and temporary workers to enable real time redeployment of staff if required

Temporary staffing
The fill rates from bank and agency in January and February were 44 and 47% respectively for bank and 51 and 45% for agency with 8% of requested shifts unfilled. Table 1 below provides a breakdown of this data. The key messages are:

- Demand in Adult ward areas has increased; this is particularly driven by surge capacity required.
- The use of project nightingale (project managed approach for opening of winter adult wards) has supported the increase in demand.

Table 1. Bank and agency performance



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Winter planning

Ward 4 and Ward 1 at the Alexandra Hospital have reported specific concerns with high agency requirements which has required oversight by the Matron and Divisional Nurse Director. The Chief Nursing Officer and Deputy chief nurses have provided additional oversight and regular visits to these areas. Identified the need to fast track ATRs to acquire permanent staff. Permanent ward leadership role. Continued oversight by matron.

Incident reports and red flags

There were 47 and 45 incidents reported respectively with the specific category of nurse/midwifery staffing. The number of reported incidents that fell within the red flag criteria had reduced from the previous reporting period.

Table 4 provides a breakdown of red flag shifts reported.

Table 4 Incident reported with category nurse/midwifery staffing

	No Harm	Minor Harm	Moderate Harm
January	40	7	0
February	44	1	0

There was no moderate harm incidents reported for the reporting period. There were 8 incidents that reported minor harm. All 8 were related to situations where there has been decreased staffing and are related to staffing in ED on the WRH site. In all incidents, mitigations have been put into place through the use of either bank or agency, moving staff from neighbouring wards to ensure patients' needs were met.

Staffing levels/Vacancies

The data below in Table 1 highlights the funded and in post rates within the nursing workforce as of the dashboard for February 2019.

Table 1

Vacancy for in patient wards areas & non ward areas	February 2019
Qualified	210.56
Unqualified	46.65
Total	257.21

From January through to the end of February 2019 there were approximately 40 registered nurses who commence in post into vacancies on ward areas and 50 Healthcare Assistants.

In March there are approximately 20 registered nurses and 30 healthcare assistants scheduled to join the trust. The Divisions continue to actively recruit to support the additional wards at the

Alexandra Hospital site (Ward 4 and Ward 1) and the winter ward on the Worcester Royal Hospital site.

The recruitment event in January at the Alexandra Hospital had over 80 applicants for Healthcare Assistant positions which will support the additional 2 medical wards due to open in April 2019. The team ran a further targeted campaign for the WRH site in March which yielded a further 60 applicants.

Table 2 below provides a summary of the vacancy rates across the Divisions.

Division	RN vacancy wte	HCA vacancy wte	Hot spot Areas
Speciality Medicine*	54.92	(2.71)	Wards with vacancies greater than 25% of their establishment are ASU, Avon 3, Avon 4, Evergreen, Ward 2, 6, 11 and 12
Urgent Care	63.32	1.50	The ward with a vacancy factor of greater than 25% is Medical Assessment Unit WRH, MSSU, MAU Alexandra
Surgery	38.08	2.21	Wards with a vacancy factor greater than 25% of their establishment is Beech A, B SCDU Trauma and Orthopaedics
SCSD	42.42	11.84	TAU
Women & Children	2.21	9.34	No areas above 25%

These figures exclude the additional winter wards

Actions that will be taken by the workforce team and divisional nurse directors to support proactive recruitment in March/April are:

- Increased profiling of high vacancy areas for medicine, surgery and urgent care in forth coming local recruitment events and adverts. We are undertaking an external recruitment event with the RCN in March 19 which allows up to 10 external vacancy adverts onto the RCN bulletin, Divisional directors of nursing have provided adverts. This included targeted recruitment for specialty wards/ units rather than generic recruitment adverts. The use of social media was found to be very successful for HCAs in January and February and will be rolled forward, however this requires additional capacity within the communications team and a post is being requested to provide support.
- The DDN's with wards with vacancies greater than 25% were required to prioritise block booking of bank and agency to ensure safe cover;
- A specialised managed agency project – "Project Nightingale" has been in place since December 2018 to support safe staffing of the winter wards. This has been provided through an external company supporting the Trust to fill substantive vacancies with the

same agency staff from December until the end of March. This project has been extended into April to support the additional wards on both sites.

- A weekly staffing meeting involving Divisional Directors of Nursing (DDNs) and Workforce Leads/ Deputy CNO was in place to provide oversight of planned staffing and actual staffing numbers and actions in place for escalation.
- Wards with >25% vacancies had a monthly workforce review meeting.(these wards are provided in Table2).

Proactive Recruitment in place

- Social media continues to be actively used to raise the trust's profile regarding nurse vacancies and opportunities being offered through targeted advertising the use of this for the recent recruitment drive Endoscopy used the targeted advertising and this resulted a 50% reduction in their vacancy rate.
- Fortnightly meetings with strategic partners is in place to ensure agency partners and HR, are addressing the agency staff being used appropriately.
- The reintroduction of the Nursing and Midwifery Action Group (NWAG) and NMAG has been recommenced with the initial meeting taking place in January with a task and finish group to complete the recruitment strategy made up from all divisions
- The Lead for Nursing Workforce will work with HR in raising profile of nursing in local schools for Worcestershire- with the use of the SIM lab and the team going out to careers days. What can we do going forward – offer week long work experience placements for 16 year old students looking for a job within the NHS.
- The Professional Development Team is supporting internal and external recruitment events planned for 2019.
- The rollout of the first cohort of Nursing Associates will be in the workforce by April 2019 with 18 qualifying and taking their place on the NMC register
- Flexible working.

Recommendations	The Committee is requested to note: • That staffing levels were safe in January and February 2019 following mitigating actions • That work continues to reduce the qualified nursing and healthcare assistant vacancies across the Trust with good progress being made in the first 3 months of 2019 • From April, in line with the revised workforce standard the Chief Nursing Officer must confirm a statement to the Trust Board that she is satisfied with the outcome of the annual assessment that staffing is safe, effective and sustainable. This will be provided for the bi-annual winter review.

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Appendices

Appendix 1 – Unify Data – January and February 2019

APPENDIX 1 January 2019

Jan-19						Care Hours Per Patient Day (CHPPD)					
	Day		Night			Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Registered allied health professionals	Non-registered allied health professionals	Overall
WARD	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Narrative for each red Shift						
Acute Stroke Unit	87.1%	96.9%	89.0%	125.9%		925	4.1	3.7	0.0	0.0	7.8
Avon 2	96.8%	92.7%	87.1%	106.5%		666	3.1	3.3	0.0	0.0	6.3
Avon 3	98.9%	99.2%	87.1%	108.1%		584	3.6	3.9	0.0	0.0	7.5
Avon 4	94.1%	118.1%	98.4%	115.3%		709	2.5	5.5	0.0	0.0	8.0

Beech A	100.0%	91.4%	68.8%	100.0%	1 trained under per shift but no escalation required	642	2.9	2.7	0.0	0.0	5.7
Beech B	131.5%	132.6%	130.4%	78.3%		271	5.3	2.1	0.0	0.0	7.5
Beech C	83.9%	84.9%	101.6%	109.7%		512	3.3	3.4	0.0	0.0	6.8
Coronary Care	100.0%	-	100.0%	-		111	13.4	0.0	0.0	0.0	13.4
Critical Care	82.3%	74.2%	81.2%	-	Staffing levels set for patient acuity County wide service 2 WTE vacancies in the establishment but these aren't put out to NHSP	136	26.8	2.1	0.0	0.0	28.9
Critical Care	99.2%	80.6%	100.3%	-		328	22.6	0.9	0.0	0.0	23.5
EGAU/ANW Gynaecology	87.1%	70.2%	80.6%	66.1%	Staff utilised for high acuity areas which has had no impact on patient care in this area.	349	3.6	2.9	0.0	0.0	6.5
Evergreen	85.9%	119.8%	77.4%	161.3%	Due to poor RN Fill additional HCA to cover staffing	769	2.8	4.7	0.0	0.0	7.4
Head and Neck	93.6%	93.5%	106.5%	48.4%	1 HCA under per shift	355	4.4	3.0	0.0	0.0	7.4
Laurel 1	100.5%	125.8%	116.1%	125.8%		558	3.6	2.1	0.0	0.0	5.7
Laurel 2	102.4%	99.2%	101.6%	100.0%		652	4.7	3.4	0.0	0.0	8.1
Laurel 3	84.7%	73.1%	91.1%	100.0%	Working 1 under due to patient acuity	545	4.8	2.2	0.0	0.0	7.0
Laurel CCU	99.2%	-	99.2%	-		228	12.9	0.0	0.0	0.0	12.9
Lavender Suites	91.9%	86.3%	91.2%	99.6%		1003	15.5	5.4	0.0	0.0	20.9

Medical Assessment Unit - ALX	78.2%	77.7%	81.2%	75.8%	The area has been reduced to 28 beds. Safer staffing still set to 34 beds which has resulted in <90% fill rate	713	5.0	4.8	0.0	0.0	9.8
Medical Assessment Unit - WRH	90.3%	106.5%	103.2%	98.9%		716	5.0	3.2	0.0	0.0	8.2
Medical Short Stay Unit	94.8%	73.6%	94.7%	98.2%	HCA staff on the ward came in and filled gaps, shifts filled by agency.	754	4.3	3.8	0.0	0.0	8.1
Neonatal TCU	113.0%	97.8%	73.9%	126.1%	TCU was offset by NNU as staff were deployed between wards.	273	1.9	2.3	0.0	0.0	4.2
Neonatal Unit	142.6%	95.7%	142.6%	95.7%		464	8.5	1.1	0.0	0.0	9.6
Riverbank	96.8%	87.1%	106.7%	106.7%		549	10.1	1.9	0.0	0.0	12.0
SCDU	94.6%	106.5%	112.9%	203.2%		506	3.7	3.1	0.0	0.0	6.8
Silver Oncology	114.0%	87.9%	96.8%	96.8%		604	3.9	4.0	0.0	0.0	7.8
Surgical High Care Unit	107.1%	89.1%	107.1%	126.1%		234	9.3	2.5	0.0	0.0	11.9

Trauma And Orthopaedics	131.7%	110.5%	150.0%	125.2%		1071	3.2	3.3	0.0	0.0	6.6
Vascular Unit	81.6%	66.7%	97.6%	62.9%	Establishment is 2 HCAs on days and 1 on nights as opposed to funding of 3 on Long days and 2 on nights which has resulted in triggering red shifts.	549	5.4	2.2	0.0	0.0	7.6
Ward 1	103.2%	114.5%	100.0%	-		141	10.7	3.1	0.0	0.0	13.8
Ward 10	103.8%	80.6%	101.6%	98.4%		591	3.2	2.8	0.0	0.0	6.0
Ward 11	80.3%	97.6%	140.3%	208.1%		843	3.0	3.6	0.0	0.0	6.6
Ward 12	112.9%	108.5%	144.1%	125.0%		1025	3.2	3.4	0.0	0.0	6.6
Ward 14	91.9%	97.8%	104.8%	95.2%		576	3.1	3.1	0.0	0.0	6.3
Ward 16	66.1%	69.1%	73.1%	66.1%	Elective orthopaedics vacancy factor >25% staffing adjusted to workload as 6-12 beds can be utilised for Surge capacity	428	4.2	3.3	0.0	0.0	7.5
Ward 17	116.1%	101.6%	116.1%	97.6%		965	3.1	3.1	0.0	0.0	6.2
Ward 18	86.4%	88.5%	96.8%	146.8%		799	3.2	2.8	0.0	0.0	6.0
Ward 2	97.8%	91.4%	81.7%	156.5%		699	2.9	3.1	0.0	0.0	6.0
Ward 4 ALX	208.7%	203.3%	189.1%	193.5%		693	3.2	3.2	0.0	0.0	6.3
Ward 5	78.7%	91.9%	76.8%	111.3%	Working 1 under trained per shift due to vacancy factor and agency was moved to area dependent on patient acuity.	686	4.2	2.7	0.0	0.0	6.9
Ward 6	83.3%	104.5%	109.7%	130.6%		684	2.6	2.8	0.0	0.0	5.4

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APPENDIX 1 February 2019

Feb-19						Care Hours Per Patient Day (CHPPD)					
	Day		Night								
WARD	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	SUPPORTING NARRATIVE	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Registered allied health professionals	Non-registered allied health professionals	Overall
Acute Stroke Unit	86.4%	108.3%	81.1%	116.3%		847	3.9	3.7	0.0	0.0	7.6
Avon 2	100.0%	89.3%	76.2%	121.4%	Work 1 trained under per shift due to patient acuity and dependency	601	3.0	3.4	0.0	0.0	6.3
Avon 3	103.6%	95.5%	89.3%	103.6%		556	3.5	3.6	0.0	0.0	7.1
Avon 4	98.8%	114.6%	101.8%	124.1%		658	2.6	5.5	0.0	0.0	8.0
Beech A	100.6%	93.5%	66.7%	100.0%	3RN's on nights in establishment - currently staffing with 2RN's given ↓ vacancy factor.	572	2.9	2.8	0.0	0.0	5.8
Beech B	132.5%	152.5%	130.0%	70.0%	2HCAs funded on establishment currently staffing 1	245	5.1	2.2	0.0	0.0	7.3

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					HCA						
Beech C	88.1%	86.9%	101.8%	119.6%		456	3.4	3.7	0.0	0.0	7.1
Coronary Care	100.0%	-	100.0%	-		93	14.5	0.3	0.0	0.0	14.7
Critical Care	80.4%	64.3%	84.5%	-	County wide service 2 WTE vacancies in the establishment but these aren't put out to NHSP	121	27.5	1.8	0.0	0.0	29.3
Critical Care	98.9%	82.1%	98.9%	-		289	23.0	1.0	0.0	0.0	24.0
EGAU/ANW Gynaecology	89.3%	76.8%	83.9%	62.5%	Dependency on EGAU allowed. HCAs moved to more acute areas to support patient dependency and acuity	276	4.2	3.4	0.0	0.0	7.6
Evergreen	75.9%	108.5%	75.0%	154.8%	Established for 4 RNS working at 3 due to bank and agency fill additional HCA used to support area	700	2.5	4.3	0.0	0.0	6.8
Head and Neck	88.3%	94.6%	103.6%	50.0%	1 HCA under per shift – no impact on patient care.	313	4.4	3.1	0.0	0.0	7.5
Laurel 1	101.2%	122.6%	108.9%	117.9%		537	3.3	1.9	0.0	0.0	5.2
Laurel 2	105.4%	96.4%	100.9%	101.8%		586	4.7	3.4	0.0	0.0	8.1
Laurel 3	83.0%	73.8%	92.0%	117.9%	Working 1 under due to assessment of patient acuity.	476	4.9	2.4	0.0	0.0	7.3
Laurel CCU	96.9%	-	96.4%	-		213	12.2	0.0	0.0	0.0	12.2

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Lavender Suites	85.6%	87.3%	90.9%	98.6%		822	16.4	6.0	0.0	0.0	22.4
Medical Assessment Unit - ALX	76.5%	75.6%	79.8%	69.6%	The areas has been reduced to 28 beds safer staffing still set to 34 beds and has resulted in < 90% fill rate. No impact on patient care.	628	5.0	4.7	0.0	0.0	9.7
Medical Assessment Unit - WRH	94.3%	115.5%	100.7%	92.9%		638	5.1	3.3	0.0	0.0	8.4
Medical Short Stay Unit	90.7%	73.1%	83.3%	93.0%	HCA staff on the ward came in and filled gaps and other shifts were filled by agency.	671	4.1	3.8	0.0	0.0	7.8
Neonatal TCU	95.0%	115.0%	65.0%	140.0%	TCU will be offset by NNU as staff were deployed between wards. No impact on patient care.	196	2.0	3.1	0.0	0.0	5.1
Neonatal Unit	116.3%	115.0%	130.0%	110.0%		392	9.0	1.4	0.0	0.0	10.4
Riverbank	88.1%	95.5%	100.0%	100.0%		565	8.3	1.7	0.0	0.0	10.0
SCDU	94.6%	103.6%	125.0%	210.7%	↑rate of HCA on ward as part of pilot for increased assessment trolleys/chairs	452	4.0	3.1	0.0	0.0	7.1
Silver Oncology	113.1%	91.1%	94.0%	107.1%		566	3.7	4.1	0.0	0.0	7.8

Surgical High Care Unit	109.2%	112.5%	109.2%	135.0%		210	9.5	2.8	0.0	0.0	12.3
Trauma And Orthopaedics	127.0%	107.5%	141.3%	124.0%		926	3.1	3.3	0.0	0.0	6.4
Vascular Unit	82.1%	64.3%	96.4%	58.9%	Establishment is 2 HCAs on days and 1 on nights as opposed to funding of 3 on Long days and 2 on nights. No impact on patient care reported.	493	5.4	2.1	0.0	0.0	7.5
Ward 1	100.9%	103.6%	100.0%	-		123	11.0	2.8	0.0	0.0	13.8
Ward 10	99.4%	90.5%	101.8%	100.0%		522	3.2	3.0	0.0	0.0	6.3
Ward 11	76.4%	87.9%	155.4%	169.6%	Established for 4 RNs Ward Manager works in the numbers to support safe staffing	742	3.1	3.1	0.0	0.0	6.3
Ward 12	107.6%	113.4%	141.7%	125.0%		920	3.1	3.5	0.0	0.0	6.6
Ward 14	86.9%	98.2%	100.0%	94.6%		507	3.1	3.2	0.0	0.0	6.3
Ward 16	73.7%	80.1%	76.2%	85.7%	Elective orthopaedics vacancy factor >25% staffing adjusted to workload as 6-12 beds can be utilised for Surge capacity	453	3.9	3.4	0.0	0.0	7.2
Ward 17	104.9%	93.8%	106.0%	94.6%		760	3.3	3.3	0.0	0.0	6.6

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	Enc G2

Ward 18	87.3%	91.8%	101.2%	148.2%	Additional staffing on night shifts particularly over the weekends for additional capacity opened	709	3.3	2.9	0.0	0.0	6.2
Ward 2	95.8%	88.1%	71.4%	146.4%		619	2.7	3.0	0.0	0.0	5.7
Ward 5	78.6%	105.4%	82.1%	121.4%		619	4.4	3.0	0.0	0.0	7.4
Ward 6	88.1%	104.3%	100.0%	114.3%		613	2.5	2.7	0.0	0.0	5.2

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	G3

Bi-annual Patients' Acuity and Dependency Winter Study

For approval:		For assurance:		To note:	x

Accountable Director	Vicky Morris : Chief Nursing Officer		
Presented by	Vicky Morris Chief Nursing Officer	**Author /s**	Lyn Hinton, Nursing Workforce Adviser Jackie Edwards, Deputy Chief Nurse Officer Louise Pearson Nurse Lead Nursing Workforce

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	X	Design healthcare around the needs of our patients, with our partners	X	Invest and realise the full potential of our staff to provide compassionate and personalised care	X
Ensure the Trust is financially viable and makes the best use of resources for our patients	X	Continuously improve our services to secure our reputation as the local provider of choice	X		

Alignment to the Trust's goals							
Timely access to our services		Better quality patient care		More productive services	X	Well-Led	

Report previously reviewed by		
Committee/Group	Date	Outcome
People and Culture	April 2019	Received for assurance

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	2

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☒ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The board is asked to note that the chief nurse is satisfied that staffing is safe, effective and sustainable.

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	G3

Executive Summary

This paper provides the evidence gathered from the Bi annual staffing review in October 2018 and Jan-February 2019. The study does not include the 3 new winter wards (Ward 1 and 4 Alexandra Hospital and Avon 5 At Worcestershire Royal) which have opened 2018/19 these will be included in June 2019 study, because these wards were in development at the time of the review.

The emergency departments, outpatients and theatres are not part of the bi annual study, however arrangements are in place to review these areas with the support of NHSI workforce team colleagues in June 2019.

Method

The reviews focused on the number of nursing and midwifery staff and the range of skills required to meet the needs of the people who have used our service. This was achieved using two components:

1. We have employed an evidenced based tool: The Safer Nursing Care Tool (SNCT) endorsed by NICE and The National Quality Board 'Safe sustainable productive staffing' guidance (2016/ reviewed 2018).The tool measured the acuity and dependency of patients in adult in-patient areas. The neonatal unit was not included at this time as a separate assessment of staffing is underway against BaPPAM standards. Areas for further development and assessment by the workforce team are theatres, outpatients ITU, maternity and the emergency departments.

2. Professional judgement was also a key component of the review. Wards with a bed base of less than 15 beds the SNCT is not sensitive enough to be able to have a true reflection of staffing so the tool is used as a base and a discussion with the ward managers, matron, divisional nurse directors, and lead for nursing and midwifery workforce, Deputy Chief Nurse and Chief Nursing Officer to review the data and make a decision based on all known factors. To note we have ward areas with less than 15 beds are Ward 1 (Kidderminster), Beech B, Head and Neck and Vascular (Surgery) WRH.

We have completed 2 studies during the winter period of 2018/19.

- Part A. was completed in October 2018. The evidence at this time showed that the trust wide nursing establishment was 57.43 whole time equivalents (wte) more than that required for patient acuity and dependency (A&D).
- Part B was completed between mid-January to mid-February 2019. The evidence at this time reflected there to be 15.08 WTE more than that required for patient A&D but we have wards where there is an under establishment and wards where there is an over establishment.

The results of the combined reviews demonstrate that the nursing workforce plan going forward should reflect the current establishment of WTE equivalents, but a realignment of staff across areas is required.

No movement of staff will occur until a full review of risk has been undertaken and mitigated. A Quality Impact Assessment (QIA) is planned to be carried out in each division in Quarter 1

(2019/20).

The transferring of staff in areas will be achieved within and across division to ensure right numbers of staff, with the right skills are in place to meet patient acuity through vacancy management.

Following on from the September 2017 review of midwifery staffing, the data showing we are 2.3 WTE over established. Midwifery will commence 6 monthly desktop reviews using Birth rate plus the nationally recognised tool which is endorsed by NICE. Results of these reviews will be reported alongside the acuity and dependency reviews.

Background

The Trust has routinely undertaken 6 monthly nurse staffing reviews based on the assessment of patient acuity & dependency. There have been gaps in the A&D process historically therefore based on concerns, the process was reviewed in the summer of 2018 and the Chief nursing officer commissioned the support from the NHSI workforce team. This is in line with The National Quality Board 'Safe sustainable productive staffing' guidance (2016/ reviewed 2018). The trust is asked to publish these on the website along with the monthly staffing paper. This is in progress and will be completed by April 2019. A declaration is required From April pertaining to the safe effective and sustainability of staffing by the CNO and the CMO.

The following actions were undertaken:

1. Critique of current A&D process the recommendations which followed were:

- A facilitated workshop with matrons and ward managers. This workshop included a theory element and then a practical session assessing patients, an inter-reliability assessment and feeding back the results. The training was well attended.
- Purchase of the licence to enable use of the updated evidenced based tool (SNCT).
- A process of carrying out the review with each ward was established to ensure robustness and trust wide validity.

2. The NHSI Clinical Workforce Lead confirmed that funding decisions for wards should not be considered until 2 studies have taken place in order to control for seasonal variation and hence a more reliable data set to base the annual establishment recommendations upon which we have now completed

3. The data has been subject to a review with ward managers, matrons and DDN's where professional judgement was applied.

- We undertook a patient, carers and staff engagement event in November 2018. The event identified that staffing was a key quality priority for them. Improvement of permanent staffing has already been considered through our recruitment and retention campaign.

The SNCT is aligned to evidence based staffing resources to allow nursing establishments to be based on a patient's needs. There is a specific tool for general inpatient areas, assessment units and children and young people. The trust is asked to publish the A&D

results on the website along with the monthly staffing paper. This is in progress and will be completed by April 2019.

A declaration is required from April 2019 pertaining to the safe effective and sustainability of staffing by the CNO and the CMO.

Findings

The results are based on the midnight occupancy summary which is set at an occupancy level for the hospital of 97.9% our bed occupancy from January – February was 98.87%

Key findings per division

- **Speciality Medicine:** The data shows an overall uplift of 34.98 wte is required; however there is a significant shift in skill mix needed with an increase of 58.95 wte in the qualified element of the workforce against a decrease of 24.95 wte in non-qualified nursing staff. The skill mix review will take place by June 2019.

- **Urgent Care Medicine:** The data shows the Ward assessment areas (MAU/MSSU) are over established by 38.76 wte. This study does not cover the Emergency Departments these areas will be undertaken in June 2019 with support from NHSi secured by the Nursing workforce lead at NHSI (Ann Casey).

- **Women and Children:** The data shows that the children's ward requires an additional 9.45 wte. However given this area has had only 1 validated assessment of Acuity and Dependency nursing tool. No action will be taken until after the June review.

- **SCSD:** The data shows that the division is 1.60 wte above the required staffing. It is noted that NHSI confirm that wards with under 15 beds cannot be included as the tool cannot provide a safe rota; there is one ward with 12 beds in this division. Ward 1 (Kidderminster) is a 12 bed unit but also covers the day unit and recovery.

- **Surgery:** The data shows that the division has 19.15 wte above the required staffing. There are 3 wards with under 12 beds in the division, this is being reviewed and will be addressed as part of the Aconbury moves scheduled during 2019. However a cross divisional resource requirement.

Findings by Ward
Table 1 (page 5) shows the results from the part B winter acuity study.

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	G3

SUMMARY of DATA COLLECTION

Jan/ Feb 2019

Jan/ Feb 2019

36 Wards

Ref / Days	Directorate/ Ward	Beds	Bed Occupancy (set) A.	Bed Occupancy (for ref period)	Bed Occupancy at Set Rate	Dependency Level Summary 0	1a	1b	2	3	Current Nursing Levels (WTE)	Acuity Proposed Nursing Levels (WTE) at set Occupancy Level of 98.87%	Staffing Increase/(Decrease) (WTE)	Trained (WTE)	Untrained (WTE)
Days	**Specialty Med**										**490.23**	**525.21**	**34.98**	**59.95**	**-24.97**
20	Acute Stroke Unit	31	98.9%	97.6%	98.9%	13.1%	15.9%	67.3%	3.8%	0.0%	52.25	48.48	-3.77	-0.12	-3.65
20	Avon 2	22	98.9%	99.3%	98.9%	12.4%	28.8%	58.8%	0.0%	0.0%	31.39	33.38	1.99	5.53	-3.54
20	Avon 3	20	98.9%	96.8%	98.9%	30.7%	26.1%	42.6%	0.5%	0.0%	33.29	27.89	-5.40	1.01	-6.41
20	Avon 4	24	98.9%	98.5%	97.9%	12.7%	22.4%	64.9%	0.0%	0.0%	37.04	36.86	-0.18	9.20	-9.38
20	Laurel 1 CCU	27	98.9%	98.7%	98.9%	5.6%	43.9%	24.0%	25.1%	1.3%	43.29	51.95	8.66	-1.83	10.49
19	Avon 6	26	98.9%	98.0%	98.9%	6.2%	7.6%	86.2%	0.0%	0.0%	38.52	42.40	3.88	6.80	-2.92
20	Laurel 2	21	98.9%	104.8%	98.9%	9.8%	30.7%	40.7%	18.9%	0.0%	41.88	33.11	-8.77	-2.60	-6.17
20	Ward 12 AGH	34	98.9%	99.0%	98.9%	6.4%	30.9%	62.7%	0.0%	0.0%	40.74	52.83	12.09	14.85	-2.76
20	Ward 2 AGH	22	98.9%	99.3%	98.9%	27.5%	2.5%	70.0%	0.0%	0.0%	27.97	32.87	4.90	5.20	-0.30
20	Ward 5 AGH	26	98.9%	97.9%	98.9%	1.4%	18.9%	72.3%	7.3%	0.0%	33.74	42.74	9.00	6.73	2.27
20	Ward 6 AGH	22	98.9%	100.0%	98.9%	34.8%	0.9%	64.3%	0.0%	0.0%	28.86	31.82	2.96	4.51	-1.55
20	Ward 11 AGH	28	98.9%	99.5%	98.9%	3.2%	0.0%	96.8%	0.0%	0.0%	40.30	46.97	6.67	10.28	-3.61
0	Ward 1 - ALX	19	98.9%	99.3%	98.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00	0.00	0.00	0.00	0.00
20	Ward 4 - ALX	22	98.9%	99.3%	98.9%	0.0%	28.8%	69.8%	1.4%	0.0%	29.12	35.42	6.30	7.14	-0.84
0	Avon 5	26	98.9%	0.0%	98.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00	0.00	0.00	0.00	0.00
20	CCU ALX	4	98.9%	93.8%	98.9%	9.3%	0.0%	12.0%	78.7%	0.0%	11.84	8.49	-3.35	-6.75	3.40
	Urgent Care Med										**159.55**	**120.79**	**-38.76**	**-1.40**	**-26.35**
20	MHC SSU	25	98.9%	96.6%	98.9%	17.0%	65.0%	12.2%	5.8%	0.0%	46.54	34.50	-12.04	-1.36	-10.68
19	MAU AGH	28	98.9%	91.4%	98.9%	44.4%	25.7%	29.6%	0.2%	0.0%	65.37	44.64	-20.73	-3.05	-17.68
20	MAU WRH	21	98.9%	104.5%	98.9%	0.7%	20.7%	68.1%	10.5%	0.0%	47.64	41.65	-5.99	3.01	2.01
	W & C										**56.95**	**66.40**	**9.45**	**-12.92**	**21.78**
20	Riverbank Paeds	31	98.9%	90.6%	98.9%	79.9%	1.4%	18.1%	0.4%	0.2%	56.95	61.38	4.43	-6.46	10.89
20	PAU - WRH	4	98.9%	298.8%	98.9%	100.0%	0.0%	0.0%	0.0%	0.0%	0.00	5.02	5.02	-6.46	10.89
	SCSD										**70.87**	**69.27**	**-1.60**	**0.35**	**-1.95**
20	Silver	20	98.9%	88.2%	98.9%	43.0%	1.0%	55.9%	0.0%	0.0%	32.15	30.50	-1.65	0.60	-2.25
20	Laurel 3	18	98.9%	0.0%	98.9%	0.0%	68.8%	21.1%	10.1%	0.0%	25.84	27.02	1.18	3.37	-2.19
20	KTC - Ward 1	12	98.9%	70.8%	98.9%	100.0%	0.0%	0.0%	0.0%	0.0%	12.88	11.75	-1.13	-3.62	2.49
	Surgery										**365.58**	**346.43**	**-19.15**	**6.24**	**-25.39**
20	Beech A	20	98.9%	103.3%	98.9%	37.3%	6.1%	56.7%	0.0%	0.0%	27.41	28.23	0.82	2.13	-1.31
20	Beech (B and C)	26	98.9%	99.6%	98.9%	64.9%	8.5%	26.4%	0.2%	0.0%	38.60	31.34	-7.26	-3.47	-3.79
20	Head & Neck	11	98.9%	105.5%	98.9%	53.9%	0.4%	44.4%	1.3%	0.0%	20.30	14.45	-5.85	-1.76	-4.09
20	SCDU	17	98.9%	97.9%	98.9%	61.3%	31.5%	6.6%	0.6%	0.0%	23.33	24.42	1.09	-1.57	2.66
20	SHCU	8	98.9%	99.4%	98.9%	21.4%	45.3%	23.9%	9.4%	0.0%	20.29	11.37	-8.92	-7.83	-1.09
20	T&O	36	98.9%	96.5%	98.9%	24.7%	1.3%	74.0%	0.0%	0.0%	50.52	54.64	4.12	10.68	-6.56
20	Vascular	14	98.9%	97.9%	98.9%	49.3%	4.7%	46.0%	0.0%	0.0%	23.13	18.61	-4.52	-2.38	-2.14
20	Vascular High Care	4	98.9%	97.9%	98.9%	11.3%	72.5%	16.3%	0.0%	0.0%	11.84	5.54	-6.30	-8.24	1.94
20	Ward 14 AGH	19	98.9%	98.9%	98.9%	57.2%	4.5%	38.3%	0.0%	0.0%	29.68	24.18	-5.50	-0.96	-4.54
20	Ward 10 AGH	21	98.9%	99.0%	98.9%	85.3%	4.6%	10.1%	0.0%	0.0%	24.88	22.47	-2.41	0.92	-3.33
20	Ward 16 AGH	28	98.9%	68.6%	98.9%	79.7%	2.1%	18.2%	0.0%	0.0%	30.27	31.32	1.05	2.60	-1.55
19	Ward 17 AGH T&O	28	98.9%	112.4%	98.9%	18.6%	0.8%	80.6%	0.0%	0.0%	37.56	43.79	6.23	9.70	-3.47
20	Ward 18 AGH	28	98.9%	98.8%	98.9%	54.6%	5.6%	39.8%	0.0%	0.0%	27.77	36.07	8.30	6.42	1.88
	TOTAL	**643**	**98.9%**	**103.8%**	**98.9%**	**31.1%**	**16.9%**	**48.7%**	**3.3%**	**0.1%**	**1143.18**	**1128.10**	**-15.08**	**52.22**	**-56.88**

WTE Decrease -1.3% Dec

NB: Total Bed Occupancy & Dependancy Levels and Staffing Increase/Decrease exclude zero values in their calculation

NB: Data Issue means returns % is less than the target set

Next Steps

Following a skill mix review a QIA will be carried out and reviewed with the CNO for sign off, before any change to ward establishments occur. This is in line with recommendations set out by NHSI (2018) Developing workforce safeguards).

Actions in each Division will be:

Medicine

- Avon 2 to undertake a skill mix review to review the ratio of trained to untrained staff
- Avon 3 for further review in June with the acuity results based on the environmental layout.
- Laurel 1 skill mix review with a view of increasing the HCAs following the June acuity study.
- Laurel 2 to review its establishment when moving into Aconbury, to monitor the number of patients requiring Non Invasive Positive Pressure Ventilation (NIPPV)
- Evergreen to use the enhanced observation policy to determine if the correct

numbers of HCAs are in the establishment.
- Wards 5 and 11 to undertake skill mix reviews.

Children's
- Review in June will take place to enable a triangulated view of the children's staffing levels to be agreed.

Urgent care
- Short stay ward on the Worcester site will undertake a skill mix review including review of shift patterns.
- Both MAU's will undertake a skill mix review.

Surgery
- Skill mix reviews will be undertaken to determine if the Nursing Associate role can support care in the Trauma and Orthopaedic and vascular wards. The Head and Neck Unit and ward 17 will undertake a skill mix review.

Recommendations

The board is asked to note that the chief nurse is satisfied that staffing is safe, effective and sustainable.

NHS
Worcestershire
Acute Hospitals
NHS Trust

V2 Feb 2019

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	G4

Trust Management Executive: Report to Trust Board

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Matthew Hopkins Chief Executive		
Presented by	Matthew Hopkins Chief Executive	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	X	Design healthcare around the needs of our patients, with our partners	X	Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients	X	Continuously improve our services to secure our reputation as the local provider of choice	X		

Alignment to the Trust's goals							
Timely access to our services	x	Better quality patient care	x	More productive services	*x*	Well-Led	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	All

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Trust Board is requested to receive this report for assurance.

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	G4

Executive Summary

Since the last report, the Trust Management Executive has met twice. This report details the discussions and decisions made at those meetings.

Meetings held on 20 March and 24 April

Communications Strategy: TME discussed the first draft of the strategy which has also been presented to the People and Culture Committee.

7 Day Services: the trust submitted an update to NHS I on 27 February. We are in the lower to mid quartile and in summary, we are meeting only one of four clinical standards and one out of three urgent network clinical services. An assurance framework is being developed for reviewing compliance. The action plan associated with the standards is being reviewed and rewritten and a further update will be presented to TME prior to the next submission to NHS I which is on 30 June.

International nurse recruitment: The business case was approved.

Obstetric scanning: The business case for provision of emergency obstetric scans was approved.

Mosaiq: The business case for electronic prescribing and medicines management system for chemotherapy was approved.

Infection control update: A monthly update is discussed at TME. The focus remains on reducing patient harm associated with Clostridium Difficile infections. NHS I reviewed the Trust in early March 2019 and we remain red rated with a further review in June 2019. NHS I have expressed confidence in the leadership and the actions being undertaken to reduce avoidable harm for patients.

Frailty: TME received a compelling presentation from Dr Maggie Keeble on frailty. This included information on Integrated care for older people (ICOPE). Networks were being set up and a launch held on 1 May.

BAF: TME approved the Board Assurance Framework (BAF).

Digital strategy: Members heard a presentation on the current draft of the Digital Strategy. It is evident that a significant amount of work is needed to ensure that we meet the deadline in the NHS long term plan that the whole NHS is digitised by 2024. The full strategy will be presented in May with the final version at the Board in June.

Items discussed and subsequently presented to either a subcommittee or Trust Board

- Mortality report
- Quality report
- Maternity and inpatient survey
- Operational plan update
- Annual governance statement
- Stroke services
- Harm reviews
- Getting is right first time update

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	G4

- Integrated Performance Report
- People and culture update
- Recruitment and Retention – medical workforce

Background

TME is the primary executive decision making body for the Trust. It is set up to drive the strategic agenda and the business objectives for the Trust. It ensures that the key risks are identified and mitigated as well as ensuring that the Trust achieves its financial and operational performance targets.

Issues and options

Recommendations

The Trust Board is requested to receive this report for assurance.

Appendices - none

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	G5

Communications and Engagement Update

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Richard Haynes, Director of Communications and Engagement		
Presented by	Richard Haynes	**Author**	Richard Haynes

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care		Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients		Continuously improve our services to secure our reputation as the local provider of choice	x		

Alignment to the Trust's goals							
Timely access to our services		Better quality patient care		More productive services		Well-Led	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	12

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☒ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is asked to note the report for assurance.

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	G5

Executive Summary

This report provided Board members with an update on the development of our Trust Communications Strategy as well as a forward look at some other key pieces of communications activity.

The report also summarises some recent achievements and issues in the Trust's efforts to engage effectively with key internal and external stakeholders.

Background

It is important that we are able to share the story of our Trust in a clear, consistent and compelling way with a wide range of key audiences, so that they are understanding, and are supportive of, what we are doing to achieve our objectives, in particular:

- Our plans to continuously improve the quality and safety of the care we provide
- Our plans to move to a sustainable position of financial balance
- Our plans to transform the culture of our organisation through 4ward

Issues and options

Developing our Communications Strategy

With a number of key strategies or plans now approved or in development – including the Clinical Services Strategy and medium term financial plan – we have an opportunity to also develop a Communications Strategy which sets out a clear vision for how a high quality communications service will actively promote and support the objectives of those other strategies – including 4ward

Our aims in developing the communications strategy are to:

- Further our efforts to focus the work of the communications team on the Trust's operational and strategic priorities
- Set out clear objectives and metrics which can be monitored through the appropriate governance structures and lines of accountability
- Provide additional assurance that the finite resources available for communications and engagement are being targeted in a way which offers the optimum return on investment and value for money for the Trust.

The current draft has been developed with input from the Trust Management Executive (TME) and People and Culture Committee and will be further discussed at those forums before coming to Trust Board in July.

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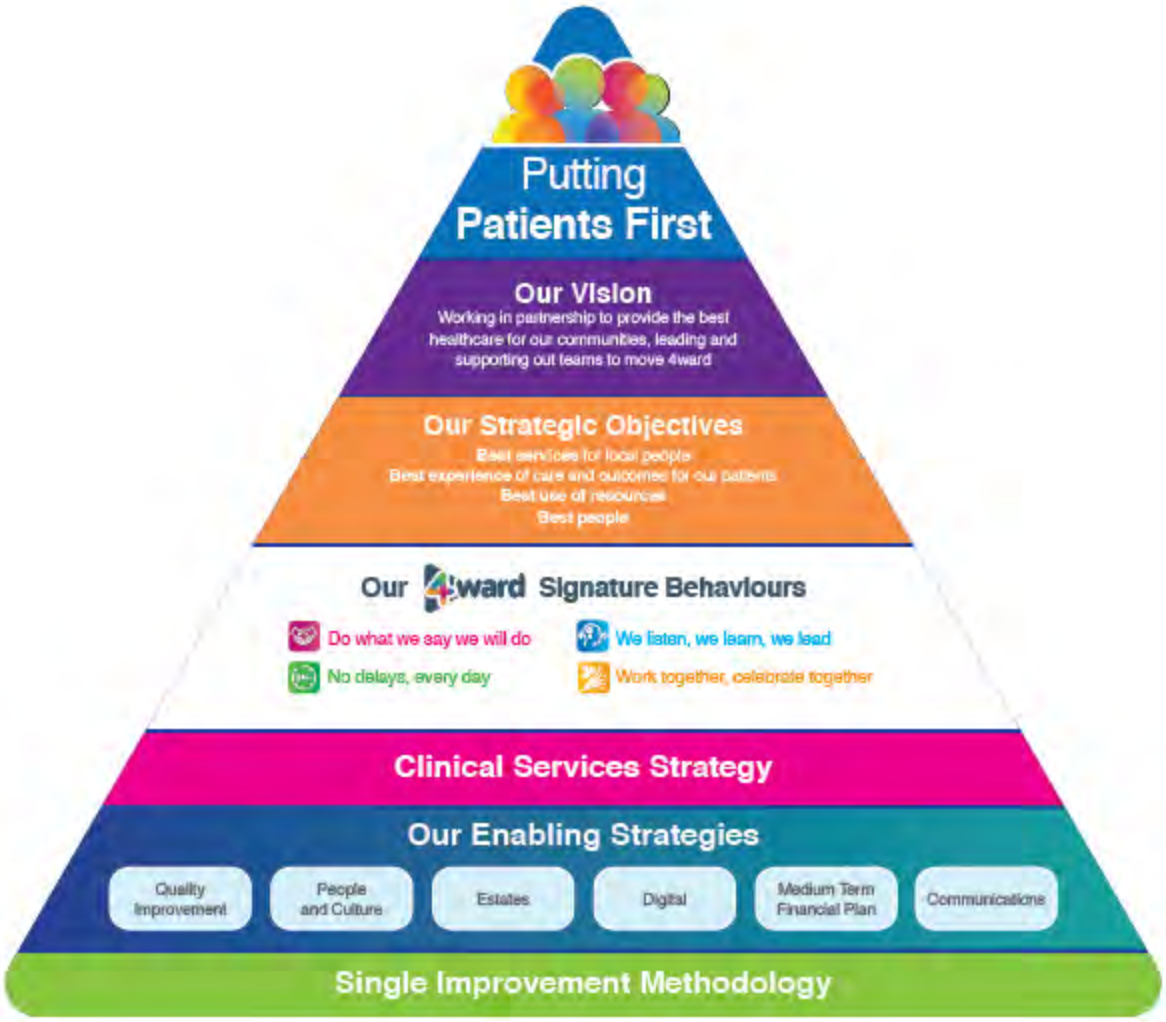
As this report was being written, work was also under way on:

- A series of live events and other communications activities to encourage wider conversations with staff around our Trust purpose of Putting Patients First – including display and promotional materials featuring the 'pyramid' graphic below and supporting video and social media content.

- A related communications plan to support the development of the Clinical Services Strategy



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Highlights of communications activity since the last update to Trust Board include:

Listening to our Colleagues: Two new face to face internal communications forums were launched with the support of Matthew Hopkins to coincide with his arrival as our new CEO in January.

- **'Meet the Chief'** sessions are informal, unscripted sessions held monthly at each of our three sites, open to all staff.

- A monthly **Senior Leaders Briefing** was also launched in January, with an invitation list of around 100 of the Trust's most senior clinical and corporate leaders. Initially held on a single site, since February briefings have been offered at both the Alexandra and WRH to facilitate attendance. The briefing includes a slide deck and additional document to support the cascade of information through team brief arrangements in each division.

4ward: Recent activities included a "Showcase Week" in February which saw daily celebrations of improvements made by colleagues across the Trust and two "Thank You Thursday" events. Monthly briefing and development sessions for our 4ward Advocates are now being held at each site.

Recruitment and Retention: The communications team continue to support the Trust's recruitment events and activities with display materials, press releases and social media activity

Nurse and Healthcare Assistant recruitment event (January)
From a budget of £500 our social media posts/content reached 54,100 people on Facebook – this resulted in 2,500 people viewing our event on Facebook and 2,375 visiting the designated webpage for this on the Trust website.

We then received 744 responses to the event on Facebook, with 654 declaring an interest in attending the event. On the day a total of 162 people attended which was a Trust record for attendance at any recruitment event we have hosted.

Social Media
- Our content is regularly being seen by over 100,000 different people every month on Facebook.
- April saw us reach over 14,000 'followers'' on Facebook. Our Page is the 12th most followed of any Acute Hospital Trust.
- Videos we've produced have been watched 103,874 times on our social media channels in 2019 alone (1 January - 29 April 2019).
- Our dedicated Staff Facebook Group to encourage staff to "work together, celebrate together" and share their own good news stories, which was set up a year ago, now has 3,076 members. This is the largest open Staff Facebook Group of any NHS organisation.
- Our Twitter page passed 5,500 followers in April. We are continuing to see increased engagement with members of the public/patients sharing their positive experiences of our care.

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- We are placing an increased focus on our Instagram and LinkedIn channels. Instagram is now the most popular social media for under-25s so we have placed an increased focus on appealing to this audience as it could be beneficial for recruitment/staff engagement. LinkedIn is useful to engage with a more professional audience and is ideal for helping to recruit to vacant posts.
- Our Instagram account now has 1,866 followers, with our posts receiving ever-greater engagement from colleagues and members of the public. Our LinkedIn page is also growing quickly with 2,500 followers regularly receiving updates from job opportunities to latest press releases.
- We continue to work with an increasing number of teams to set up their own Service/Department social media accounts. We now have individual service/department pages for over 25 of our services, which each helping colleagues engage with their own professional colleagues from other organisations and share useful information and self-care tips with the public.

Other activities of note include:

- Opening of WRH Aconbury link bridge by our local MPs (January)
- Visit by Matt Hancock, Secretary of State for Health (March)
- Support for Parliamentary Health Awards – seven services from across the Trust (Stoma Care, Bereavement Suite, Maternity Hubs, Bladder cancer support group, Capacity App, Intensive Care support group, BSL and Walking Football support group) were nominated by our MPs in time for the end of April deadline.
- The next scheduled briefing for our local MPs is on 7 June

Other topics generating significant levels of media coverage, or interest/requests for updates from stakeholders included:

- Appointment of Matthew Hopkins as our new Chief Executive (announced December 2018) – press release
- Claire Slater – from investment banker to midwife press release
- Head and neck cancer surgery changes
- CQC report on Emergency Departments (including local TV coverage)

And Finally – Recognition for the Communications Team

Following our shortlisting for a Chartered Institute of Public Relations (CIPR) Midlands Pride Award for our work on 4ward, in December the Communications Team won the national Comms 2.0 Award for Best Use of Social Media – for our staff Facebook Group.

As a result of these successes, Richard Haynes was asked to lead a breakout session on how communications adds value in the public sector at the Midlands CIPR/PRCA Conference in April. Communications team colleagues Rebecca Bourne and Pete Orton will have been invited to present at the Comms 2.0 Winners Masterclass on 9 May.

Recommendations
The Board is asked to note the report for assurance.
Appendices

NHS
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Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H1

Audit and Assurance Committee Assurance Report

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Steve Williams Audit and Assurance Chairman		
Presented by	Steve Williams Audit and Assurance Chairman	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	x	Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	x	Continuously improve our services to secure our reputation as the local provider of choice			

Alignment to the Trust's goals							
Timely access to our services		Better quality patient care		More productive services	*x*	Well-Led	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	All

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Trust Board is requested to note the report for assurance.

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Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H1

Executive Summary

The Committee met on 26 March and discussed the following items:

- **Evaluation of the Quality Governance Committee (QGC):** the Chair of QGC attended and presented a review of the working of the QGC. The Chairman felt that the away half day had contributed to the better working of the Committee. Refining of the data was the next stage of the Committee's development. The Chairman consciously tries to avoid becoming operational but some areas of concern need the detailed approach. Some metrics were not progressing as quickly as he wanted.
- **Data Quality audit**: The clinical lead for Data Quality, Dr Tom Martin and the Deputy Head of Information attended to present the latest audit into data quality. Their enthusiasm for the issues was evident and the Committee gained assurance from their presence. It was evident that we have excellent leaders in this area. Dr Martin explained how he has introduced a prize for junior doctors for the best record keeping. We were also told of the development of training manuals as well as the restructuring of the team to ensure better liaison with the front line staff.
- **Information Governance update**: The Data Protection and Security Toolkit was submitted on time with 57 outstanding actions, which will be completed by September. 85% of staff have completed their training.
- **External Audit update**: The external auditors reported that the audit was on time.
- **Internal Audit**: the draft head of internal audit opinion was received along with the draft annual report. Overall limited assurance was given, mainly due to the Trust remaining in special measures and the significant financial deficit. This opinion was disappointing to the Committee members. It was concerning to learn that staff do not prioritise the responding of emails from internal audit and we have asked for this to be rectified. We received two internal audit final reports, both were limited assurance – Governance arrangements – divisions and the Quality Governance Framework.
- **Internal audit plan**: We agreed to make explicit the links to the BAF. We will consider this at our meeting this month.
- **Annual governance statement**: We received an early draft of this document.
- **Annual self-assessment**: We have undertaken a short self-assessment of the working of the Committee. We will be taking some time at our July meeting to review the working of the Committee.

Other items that were considered were:

- European Working Time Directive - debts
- Counter fraud progress report
- Review of debt write off
- Work plan

Background

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. Membership is three non-executive directors.

Issues and options

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H1

Recommendations
The Trust Board is requested to note the report for assurance.
Appendices

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V2 Feb 2019

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H2

Remuneration Committee Report

For approval:		For discussion:		For assurance:		To note:	x

Accountable Director	Sir David Nicholson Chairman		
Presented by	Sir David Nicholson Chairman	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care		Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients		Continuously improve our services to secure our reputation as the local provider of choice			

Alignment to the Trust's goals							
Timely access to our services		Better quality patient care		More productive services		Well-Led	

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is requested to note the contents of this report.

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H2

Executive Summary

The Remuneration Committee has met twice (virtually) since the last Board report. This is the report from that meeting.

Background

The Remuneration Committee sets and reviews pay for staff not on agenda for change terms and conditions of service. It also ensures that there is a succession plan for senior members of staff including Board members.

Issues and options

March 2019
The Committee approved the arrangements for the Interim Chief Finance Officer and the departure of the Chief Finance Officer.

March 2019
The Committee considered the business case for a retention premium for a new member of staff. This was approved.

April 2019
The Committee approved the arrangements for the

- Interim Chief Medical Officer and the departure of the Chief Medical Officer.
- Appointment of the substantive Chief Finance Officer.
- Appointment of a Chief Digital Officer.

Recommendations

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

Appendices none

V2 Feb 2019

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H3

Conditions of Licence

For approval:	x	For discussion:		For assurance:		To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Matthew Hopkins CEO	**Author /s**	Kimara Sharpe Company Secretary Fleur Blakeman, NHS I Tina Ricketts

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	X	Design healthcare around the needs of our patients, with our partners	X	Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients	X	Continuously improve our services to secure our reputation as the local provider of choice	X		

Alignment to the Trust's goals							
Timely access to our services	X	Better quality patient care	X	More productive services	*x*	Well-Led	X

Report previously reviewed by		
Committee/Group	Date	Outcome
A&A Committee	8-5-19	Verbal feedback at meeting

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The Board is requested to approve the Trust's position with conditions FT4 and G6 of the provider licence.

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H3

Executive Summary

The executive team have considered the conditions required for compliance with provider conditions FT4 and G6. The Board needs to approve the Trust's position and the statements need to be placed on the website prior to 31 May 2019.

The Audit and Assurance Committee are considering the compliance statements at the meeting on 8 May 2019. Verbal feedback will be given that the Board meeting in relation to the discussion at the Committee.

The suggested compliance for condition FT4 and G6 are summarised below. The detailed assessment in relation to each element of the conditions shown in appendix 1 (attached).

Condition FT4

Element	Corporate Governance Statement	2019
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed**
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Confirmed**
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	**Confirmed** Confirmed Confirmed Confirmed
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate,	**Not confirmed** Not confirmed Not confirmed Not confirmed Not confirmed Not confirmed

	comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not confirmed Not confirmed Confirmed
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Not confirmed** Confirmed Confirmed Not confirmed Not confirmed Confirmed Confirmed
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Not confirmed**
Condition G6		
Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Not compliant**

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H3

Summary of factors influencing the current assessment

The period of assessment is 1 April 2018 to 31 March 2019. The Trust has remained in quality Special Measures throughout the year. There are currently no conditions in place. The two regulatory conditions in place on 31 March 2018, were lifted during the year.

The Board Committees have met and reported to each Board meeting. All terms of reference have been revised and approved by the Board during the year. The relevant risks within the Board Assurance Framework are reviewed by each Committee bimonthly and changes approved by the Board. The Audit and Assurance Committee reviews the processes for the management of the BAF.

The Trust continues to have significant challenges in delivering key national standards. These include the 4 hour Emergency Access Target, 18 weeks referral to treatment – incomplete pathways, 62 day cancer performance standard and the 6 week wait diagnostics standard.

The Trust reported a deficit of £73m against a control total of £58.63m

Background

NHS Trusts are required to make the following self-certified declarations:

1. Condition FT4: Providers must certify compliance with required governance standards and objectives.
2. Condition G6: Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (being considered by the Audit and Assurance Committee)

Whilst NHS Trusts are exempt from holding a provider licence, NHS Trusts are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate. This is then used as a basis for oversight. NHS Trusts therefore are legally subject to the equivalent of certain licence conditions and in light of this now have to self-certify each year.

There is no set process for assurance or how conditions are met which reflects the autonomy given to providers. Boards need to sign off on compliance and there are no returns or information submissions.

Issues and options

None.

Recommendations

The Board is requested to approve the Trust's position with conditions FT4 and G6 of the provider licence.

Appendices – summary of self-assessment

Meeting	Trust Board
Date of meeting	9 May 2019
Paper number	H3

Summary of self-assessment			
	Corporate Governance Statement FT4	**2019**	**Evidence (based on 2018/19)**
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed**	The Trust has remained in quality Special Measures throughout the year. The Trust has currently no conditions/warning notices in place. The Trust commissioned an independent external review of the Corporate Governance Board systems in October 2018 by Deloittes. An action plan has been put into place to address the recommendations identified in the review and monitored by a task and finish group consisting of non-executive and executive directors.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Confirmed**	NHSI guidance is reviewed by the Executive team and where appropriate bought to the attention of the Board. The Trust Management Executive also receives all guidance. A non-executive director has been identified to oversee and support governance development within the Trust.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	**Confirmed**	a&b. The Board Committees met regularly and report to each Board meeting. All terms of reference have been revised and approved by the Board during the year. The relevant risks within the Board Assurance Framework are reviewed by each Committee and changes approved by the Board. The Audit and Assurance Committee reviews the processes for the management of the BAF. The terms of reference for the Risk Management Group were revised during the year and meet monthly, chaired by the Chief Nurse. The Deloitte report reviewed Board and Board Committee governance arrangements and the Trust is currently acting upon the key findings and recommendations of this review. c. Governance below the level of Committees was reviewed by the Interim Director of Governance in 2017/18 and is currently under review by the Trust Improvement Director. Once this review has been undertaken, an action plan will be developed to address any identified gaps.

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4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:	**Not confirmed**	**Key issues in 2018/19**	**Trust response**
(a) (b)	To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	Not confirmed	• Effective financial forecasting • Contract management • Pay spend (bank and agency)	a&b. The Trust Management Executive (TME) (January 2019) meets monthly to oversee the operational business of the Trust. The Board Committees meet monthly (Finance and Performance, Quality Governance) and People and Culture meets bimonthly. The Board meets monthly (not August) and has a forward plan for business. At each meeting reports are given on quality, financial and workforce strategy and performance management. We remain in quality special measures and in enhanced oversight for finance. We are subject to monthly NHSI led quality system-wide oversight meetings and monthly NHSI led performance review meetings. We have a confirmed CQC inspection in quarter 1 of 2019/20. This will include an inspection of a number of core services, well led and use of resources. Action plans will be developed to address any 'must' and 'should do's' arising from this inspection.
c)	To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	Not confirmed	• Timeliness of financial reporting • Identification of drivers of the deficit • Establishment control overview	c. Whilst we are currently not compliant with all relevant standards, the Quality Governance Committee and Finance and Performance Committee and the TME meet monthly and receive detailed quality, performance and financial information including compliance with relevant standards. We have recently agreed the business objectives for 2019/20 and these have been reflected in the personal objectives of Executive Directors for which they will be held to account for delivering by the Remuneration Committee. The Trust holds monthly performance review meetings with all clinical divisions. A non-executive director has been identified to support recovery of the urgent and elective performance. Launch of the Quality improvement Strategy – monitoring of must and should do's

				through the RAIT process.
(d)	For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	Not confirmed	• Remain in quality special measures • Overall inadequate CQC rating	d. The Finance and Performance Committee meets monthly to receive assurance on financial performance and reports back to each Board meeting. The Trust Management Executive also meets monthly to review financial performance and monitor performance of the cost improvement programme. The revised control total was negotiated in-year (2018/19), in recognition of a deteriorating financial situation and was subsequently not achieved. The Trust remains subject to enhanced financial oversight.
(e)	To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	Not confirmed	• Timeliness of financial reporting • Identification of drivers of the deficit • Establishment of control overview	e. The Trust has achieved improvements in the accuracy, capture and flow of information. The staff have access real time information through locally developed systems (WREN and SQUID). The Trust is currently developing a Digital Strategy (to be approved by the Board in June 2019), to further strengthen data quality and information reporting and achieve the NHS long term plan ambition of paperless by 2024. A comprehensive action plan to facilitate implementation of the strategy will be developed and a Chief Digital Officer is currently being recruited to. The Quality Governance Committee uses performance data to inform its decision-making process. The Finance and Performance Committee scrutinise the performance dashboards and financial performance reports monthly. The People and Culture Committee has a bespoke dashboard which is reviewed at every meeting.
(f)	To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Not confirmed	• No Digital Strategy • No medium term financial plan • Business cycle not established • Gaps in control and key organisational risks not been fully mitigated	f. The Board Assurance Framework (BAF) was reviewed during the year and is considered four times a year by the Board. We have recently reviewed the risk appetite for the organisation and this will be cascaded throughout the organisation during 2019/20. The relevant risks are considered by Board Committees at each meeting. The BAF is being revised in the first quarter, 2019/20 to be aligned to the

				Trust Strategy.
(g)	To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	Not confirmed	• Business plan in development • Business planning cycle in development	g. Whilst we have a business case process in place, we are seeking to strengthen this in 2019/20 particularly in relation to the quality impact assessments. Annual business cycle under review to strengthen linked to service reviews. Clinical services strategy in development.
(h)	To ensure compliance with all applicable legal requirements.	Confirmed		h. The Trust was registered with the CQC during the year 2018/19.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:	**Not confirmed**		
(a)	That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	Confirmed		a. The Quality Governance Committee (QGC) oversees all aspects of quality within the trust. This meets monthly and escalates via a written report to each Board meeting. The Chief Nurse and Chief Medical Officer are the executive directors accountable for quality within the organisation and both posts were filled substantively throughout the year. A non-executive director has been identified to provide leadership with respect to learning from deaths. He is also the Chair of the Quality Governance Committee.
(b)	That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	Confirmed		b. The Board has an annual plan of business which incorporates regular updates on quality and performance and the statutory annual reports are presented to the Board (e.g. safeguarding, quality account, annual report, local security management service). We have suitable standing financial instructions (including scheme of delegation) and standing orders which govern decision making of the Board. Quality Impact Assessments are undertaken for all changes in

				services and are signed off by the Chief Nurse and Chief Medical Officer and are reported to the TME and a six monthly assurance report is provided to QGC. Any QIAs not signed off are escalated immediately to the QGC and then to Trust board.
(c)	The collection of accurate, comprehensive, timely and up to date information on quality of care;	Not confirmed	• Under investment in IT systems	c. The majority of information is collected electronically within the Trust with only small number of data collection remaining paper based. We have built real time information systems for staff to utilise in their day to day activities (WREN and SQUID) to support operational and performance management. The Digital Strategy (due for Board approval in June 2019) will seek to further improve data quality and strengthen information reporting and achieve the NHS long term plan ambition of paperless by 2024. A comprehensive action plan to facilitate implementation of the strategy will be developed and a Chief Digital Officer is currently being recruited to. Monthly performance review meetings with divisions.
(d)	That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	Not confirmed	• Triangulation of data with workforce and finance	d. QGC considers quality performance data at each of its meetings. This is then reported to the Board via the written report from QGC and the integrated performance report. The Board considers the integrated performance report at each meeting. The implementation of the Digital Strategy will further improve all aspects of quality information presented to the board.
(e)	That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	Confirmed		e. The Board receives a patient story or equivalent at each Board meeting and receives updates via the QGC report on the Quality Improvement Strategy and associated plans (including the Patient, Carer and Community Plan) which were approved at its March 2018 meeting and are currently being refreshed. Patient representatives attend the QGC meeting and participate in ward visits. HealthWatch also attends QGC. A Youth Forum is currently being set up. We regularly attend the Health Overview and Scrutiny Committee. The Quality

				Oversight Group is attended by the HealthWatch and Clinical Governance Group.
(f)	That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed		f. The Chief Nurse is the executive director responsible for quality and is very visible and accessible to staff members. This was recently endorsed by an external report undertaken as part of the preparations for the Well Led inspection. Through the performance review meetings the divisions are held to account for the quality of care within the Trust. Each division reports monthly to the Clinical Governance Group which in turn provides a report to the Trust Management Executive and for assurance, to the Quality Governance Committee which reports to the Board at every meeting.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Not confirmed**	• Succession planning • Stability of executive team and Board • Lack of strategic workforce plan	The Board had one vacancy (Chief Finance Officer) as at 31 March 2019 which was filled with an interim position. The substantive post is currently being recruited to. All Board members have undertaken the Fit and Proper Person Test. We are reliant on bank and agency staff to maintain safe staffing levels and whilst we are able to recruit to permanent positions, we need to improve the retention of staff. We have recently implemented a suite of HR modules via Allocate which will improve the management of our rotas and annual leave. We continue to work with Health Education England in respect of doctors in training and the development of our strategy will improve recruitment to consultant posts. We are also exploring the appointment of clinical fellowships. These initiatives are being overseen by the People and Culture Committee through the monitoring of the People and Culture Strategy.

NHS
Worcestershire Acute Hospitals NHS Trust

V2 Feb 2019

Meeting	Trust board
Date of meeting	9 May 2019
Paper number	H4

Statement of Undertakings

For approval:		For discussion:	x	For assurance:		To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Matthew Hopkins CEO	**Author /s**	-

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care		Design healthcare around the needs of our patients, with our partners		Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients		Continuously improve our services to secure our reputation as the local provider of choice			

Alignment to the Trust's goals							
Timely access to our services		Better quality patient care		More productive services		Well-Led	

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☐ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	The board is requested to discuss the attached document as per the covering letter from NHS Improvement.

From the office of Julie Grant
Acting Director of Strategic Transformation West Midlands

St Chad's Court
213 Hagley Road
Birmingham
B16 9RG

T: [redacted]

VIA EMAIL ONLY

19 April 2019

Matthew Hopkins
Chief Executive
Worcestershire Acute Hospitals NHS Trust
Charles Hastings Way
Worcester WR5 1DD

Dear Matthew

Worcestershire Acute Hospitals NHS Trust (the trust) – Notification of formal enforcement action

As previously discussed, I am writing to provide you with an update on our regulatory approach with the Trust.

As the Trust is in Quality Special Measures and enhanced financial oversight, we have reasonable grounds to suspect that the trust has provided, or is providing, a health care service for the purposes of the NHS in breach of conditions equivalent to the provider licence. As a result, we have decided that the trust requires mandated support.

I therefore enclose a copy of the Enforcement Undertakings that we have accepted from the trust.

The Trust Board are requested to discuss and sign the undertakings and return them to me within a month. We will review progress quarterly against the undertakings and agree key milestones with you.

If you have any questions in relation to the matters set out in this letter, please contact me on [redacted] or by email at [redacted]

Yours sincerely

Julie Grant

Julie Grant
Acting Director of Strategic Transformation, West Midlands Locality

Enclosed: copy of Enforcement Undertakings

Cc Sir David Nicholson, Chairman

ENFORCEMENT UNDERTAKINGS

NHS TRUST:

Worcestershire Acute Hospitals NHS Trust ("the Trust")
Charles Hastings Way
Worcester
WR5 1DD

DECISION:

On the basis of the grounds set out below and pursuant to the powers exercisable by NHS Improvement under or by virtue of the National Health Service Act 2006 and the TDA Directions, NHS Improvement has decided to accept undertakings from the Trust.

These undertakings include the actions which have been agreed in consequence of the trust being in special measures for quality.

DEFINITIONS:

In this document:

"the conditions of the Licence" means the conditions of the licence issued by Monitor under Chapter 3 of Part 3 of the Health and Social Care Act 2012 in respect of which NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions, pursuant to paragraph 6(c) of the TDA Directions;

"NHS Improvement" means the National Health Service Trust Development Authority;

"TDA Directions" means the National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016.

GROUNDS:

1. The Trust

The trust is an NHS trust all or most of whose hospitals, facilities and establishments are situated in England.

2. Issues and need for action

2.1. NHS Improvement has reasonable grounds to suspect that the trust has provided and is providing health services for the purposes of the health service in England while failing to comply with the following conditions of the Licence: FT4(5)(a) to (d), (f) and FT4(6)(a) to(f) and FT4(7).

2.2. In particular:

Quality

2.2.1. An inspection of the trust by the CQC during January and March 2018 resulted in the trust being given an overall rating by the CQC of 'Inadequate' with the safe and responsive domains also being rated inadequate.

2.2.2. The overall concerns were focused on the trust's Worcestershire Royal Hospital site which was rated inadequate in Urgent and Emergency Care, Surgery, and Outpatients overall. The Alexandra site was rated inadequate for safe, responsive and well led domains overall and inadequate for Surgery and Outpatients overall. Further details are contained the CQC's report dated 5th June 2018 ('the CQC Report').

Operational performance

2.2.3. The trust has not achieved the A&E 4 hour waiting time since September 2014 and did not deliver its recovery trajectory in 2017/18. 2018/19 YTD performance is 79.8% at December 2018.

2.2.4. The trust did not achieve the 62 Day Cancer standard during 2017/18 and did not deliver its recovery trajectory. 2018/19 performance has not demonstrated recovery against the agreed trajectory, and a robust recovery plan has not been developed.

Performance YTD

	2018/19 Q1	2018/19 Q2
Cancer 62 day	75.5%	73.8%
Cancer 104 days	26	40

2.2.5. The trust has breached the Diagnostic performance (DM01) standard having not achieved the <1% standard since February 2016 and, to date, no recovery plan has been developed or delivered

Financial Performance

2.2.6. For 2017/18 the trust delivered a significant negative variance against its control total plan. The control total for 2017/18 was a deficit of £42.7m, excluding STF. The trust outturn position for 2017/18 was a deficit of £57.9m, excluding STF.

2.2.7. For 2018/19 the trust's financial plan is to deliver the control total of a deficit of £41.5m excluding PSF. However, the trust has indicated that it will revise its Forecast Outturn (FOT) and have identified that the most likely outturn will be a deficit of £72.5m excluding PSF. excluding the reported issue in relation to emergency costs

2.2.8. Workforce and Use of Agency: The Trust has an agency ceiling of £17.291m. As at month 9 the Trust has spent £15.710m on agency staffing and is forecasting expenditure of £22.9192m, £4.901m above cap. This variance is in the main due to additional unplanned winter capacity in order to meet demand. In addition to this the Trust has had a number of workforce CIPs such as rota grip and control and leave management. These were expected to reduce agency spend but they have not delivered.

2.3. Failures and need for action

These failings by the trust demonstrate a failure of governance arrangements and financial management including, in particular:

2.3.1. failure to establish and effectively implement systems or processes:

2.3.1.1. to ensure compliance with the trust's duty to operate efficiently, economically and effectively;
2.3.1.2. for timely and effective scrutiny and oversight by the Board of the trust's operations;
2.3.1.3. to ensure compliance with healthcare standards binding on the trust;
2.3.1.4. to ensure that the trust's services are safe and of sufficient quality.

2.3.2. failure to establish and effectively implement or apply systems, standards and/or processes:

2.3.2.1. of corporate and financial management suitable for a provider of NHS services and which provide reasonable safeguards against the risk of being unable to carry on as a going concern; and
2.3.2.2. for effective financial decision-making, management and control.

2.4. Need for action:

NHS Improvement believes that the action which the trust has undertaken to take pursuant to these undertakings, is action required to secure that the failures to comply with the relevant requirements of the conditions of the Licence do not continue or recur.

UNDERTAKINGS

NHS Improvement has agreed to accept and the trust has agreed to give the following undertakings:

1. <u>Quality Improvement Strategy and Regulatory Requirements Milestone Plans</u>

1.1. The trust will take all reasonable steps to address the concerns identified in, but not limited to, the CQC Report, including carrying out the actions set out in the CQC Report in accordance with timescales as determined by the CQC such that, upon re-inspection by the CQC within 12 months of the date of the CQC Report (or such other date as CQC may determine), the trust will no longer be found to be 'inadequate' in any of the CQC domains.

1.2. The trust will refresh the existing Quality Improvement Plans (QIPs) for emergency access (EAS) following completion of the current baseline assessment of the QIPs and their information reporting systems.

1.3. The trust will continue to provide updates on progress with achievement of the existing Quality Improvement Strategy (QIS) and the associated milestones of the QIPs.

1.4. The trust will continue to cooperate with arrangements for oversight of the achievement of the QIS and the individual regulatory requirements via the single system Quality Improvement Review Group (QIRG), led by NHS Improvement. The QIRG comprises NHS Improvement, CQC, NHS England, the CCG and Health Watch, and is established to provide system support to the trust. The trust will

modify the QIPs if required to do so by NHS Improvement in response to feedback from the QIRG.

1.5. The trust will demonstrate that it is able to deliver all the QIPs including demonstrating that it has sufficient capacity at both executive and other levels of management to enable delivery of these.

1.6. The trust will keep the QIPs and their delivery under review. Where matters are identified which materially affect the trust's ability to deliver the QIPs, whether identified by the trust or another party, the trust will notify NHS Improvement as soon as practicable and update and resubmit the QIPs within a timeframe to be agreed by NHS Improvement.

1.7. The trust will ensure that the delivery of the QIPs, and other measures to improve quality and operational performance do not compromise its overall financial position. The trust will keep the financial cost of its quality improvements under close review and will notify NHS Improvement as soon as practicable of any matters which are identified as potentially having a material impact on the trust's overall financial position.

2. Operational Performance

2.1. The trust will take all reasonable steps to recover operational performance to meet national standards, including but not limited to those set out in paragraphs 2.2 to 2.5, below.

Demand and capacity planning

2.2. The trust will ensure it has in place a robust demand and capacity plan for 2019/20 by the end of March 2019, alongside implementing a rolling process of reviewing run-rate demand and capacity and producing detailed forward demand and capacity plans for 1 and 2 months, with this detailed process having a regular feedback loop into the 2019/20 plan.

Emergency Care

2.3. The trust will take all reasonable steps to recover operational performance to meet its projected performance and achieve sustainable compliance with the 4 hour A&E standard in 2019/20. The trust will submit a revised trajectory and recovery plan as part of the planning process for 2019/20 See section 1.2 with regard to a significant refresh of the emergency access quality improvement plan.

Diagnostics

2.4 The trust will take all reasonable steps to recover overall diagnostics performance (DM01) to <1 % in 2019/2020 . The trust will submit a recovery plan and revised trajectory to NHS Improvement by 12th April 2019.

Cancer

2.5 The trust will take all reasonable steps to recover cancer performance; 62 day, in line with the agreed trajectories by June 2019. The draft recovery plan needs to be strengthened following feedback and to be submitted to NHS Improvement by 12th April 2019.

The Operational Plan

2.6 The trust will ensure that there is a robust and board approved operational plan in place for 2019/20 (Operational Plan) to meet national planning guidance and the requirements of paragraph 2.1 and will agree the Operational Plan with NHS Improvement in line with national timescales.

2.7 The Operational Plan will, in particular:

2.7.1 include the actions required to meet the requirements of paragraph 2.1, with appropriate timescales, key performance indicators and resourcing including financial impact;
2.7.2 describe the key risks to meeting the requirements of paragraph 2.1 and mitigating actions being taken;
2.7.3 be based on realistic assumptions; the trust is discussing with commissioners activity and bed capacity and how this will be commissioned for 2019/20
2.7.4 reflect collaborative working with key system partners and other stakeholders;
2.7.5 set out the key performance indicators which the trust will use to measure progress;
2.7.6 be consistent with the trust's other key plans, including but not limited to those plans described elsewhere in these undertakings and the Sustainability and Transformation Plan; and
2.7.7 support the trust in delivering their agreed financial plan for 2019/20

2.8 The trust will keep the Operational Plan and its delivery under review and provide appropriate assurance to its Board regarding progress towards meeting the requirements of paragraph 2.1, such assurance to be provided to NHS Improvement on request. Where matters are identified which materially affect the trust's ability to meet the requirements of paragraph 2.1, whether identified by the trust or another party, the trust will notify NHS Improvement as soon as practicable and take mitigating actions and a revised recovery plan and resubmit within a timeframe to be agreed with NHS Improvement.

3 <u>Finance</u>

Understanding the drivers of the deficit

3.1 The trust will rapidly identify and set out in writing and submit for agreement to NHS Improvement, by 31st March 2019:

3.1.1 a robust understanding of the underlying causes of the trust's financial position vs. appropriate peers to include the identification of:
3.1.2 drivers which are out of the trust's control ('Structural'); and
3.1.3 drivers that the trust has some control over but will require the input of other STP stakeholders to address ('Strategic'); and
3.1.4 drivers that are wholly within trust control ('Operational').
3.1.5 an overview of the evidence underpinning the rationale for the driver and range of values/value identified; and to include analysis of service line contribution.

3.2 Medium term financial strategy (MTFS)

The MTFS will be informed by the work the trust is undertaking on the clinical and workforce strategies, which, together with the financial strategy and a refresh of the Trust's vision, purpose and ambition will form the Trust's overall strategic plan.

The trust will identify, set out in writing and submit for agreement to NHS Improvement a 3 year medium-term financial strategy (MTFS). The drivers of deficit analysis will inform the actions to be set out within the MTFS. The MTFS will set out how and when the trust will return to financial balance (excluding structural deficit), given the exit position and run rate for 2018/19. The date for submission will be agreed between the Trust and NHS Improvement.

The scope and detailed content of the MTFS will be as agreed with NHS Improvement but will include:

3.2.1 Key assumptions: description of key assumptions and drivers of future financial flows around income (including contracting) taking into account the current STP medium term planning , expenditure, workforce, activity, and capacity;
3.2.2 Enabling strategies: building upon and including appropriate references to, the trust's strategic plans across all key areas, to include: quality; clinical; workforce; operational; estates and capital; digital and IT;
3.2.3 Efficiencies: clear articulation of the efficiency requirement over the period with a detailed plan for 2019/20 and themes for future years as a minimum, including demonstrating how the trust is addressing Model Hospital efficiency opportunities;
3.2.4 Delivery milestones and actions: actions to address the key issues identified through the work on the drivers of the deficit and to deliver the MTFS, including a high-level milestone plan for delivery of the trust's key schemes to deliver the MTFS;
3.2.5 Financial model to breakeven: a fully populated Long Term Financial Model with a credible trajectory to the break-even position which shows improvement in the monthly run rate from year 1; supported by bridging analysis to show key changes;
3.2.6 Service level reviews: a trajectory at individual service level for returning low/no contribution and loss-making services identified to a break-even position or to an agreed alternative delivery solution (to include consideration of services that are a clinical sustainability risk);
3.2.7 Sensitivities: pressure testing of key assumptions to identify the factors that most influence/impact delivery of the MTFS;
3.2.8 Risks and mitigations: potential risks to delivery of the MTFS and how the trust would mitigate these;
3.2.9 Financial support: analysis to show the revenue and capital cash support that will be needed over the period;
3.2.10 Resourcing: details of both the level of resourcing needed to deliver the MTFS and how the trust will deploy sufficient resources to ensure its implementation;
3.2.11 Assurance: the governance, assurance and programme management arrangements to support delivery of the identified efficiencies and overall operational delivery plan (including the trust's internal assurance approach); and
3.2.12 Oversight: details of the trust governance arrangements for approval and delivery of the MTFS.

3.3 The Operational Plan will form the base year for the MTFS.

3.4 The trust will ensure that the MTFS is robust, quality-assured and agreed by the trust's Board and that it links through to the overall trust strategy and supporting strategies (e.g. Workforce, Clinical Services, Estates).

3.5 When developing the MTFS, the trust will engage effectively with key stakeholders, including commissioners, and will reflect their views appropriately in the MTFS.

3.6 The trust will, if deemed necessary by NHS Improvement, commission external support and/or assurance to assist it in developing the MTFS. The provider and scope of the support and/or assurance will be agreed with NHS Improvement.

3.7 The trust will take all reasonable steps to secure that it is able to deliver the MTFS once approved by NHS Improvement.

MTFS delivery

3.8 The trust will demonstrate to NHS Improvement a period of successful implementation of the MTFS through achievement of the Operational Plan and assurance of continued focus, capability and capacity to sustainably maintain financial recovery and deliver the MTFS.

3.9 The trust will, if deemed necessary by NHS Improvement, appoint a Turnaround Director to support it in the delivery of their Financial Plan for 2019/20. .

4. Funding conditions and spending approvals

4.1. Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the trust under Schedule 5 to the National Health Service Act 2006, the trust will comply with any terms and conditions which attach to the financing.
4.2. Where the trust receives payments from the Provider Sustainability Fund, the trust will comply with any terms or conditions which attach to the payments.
4.3. The trust will comply with any spending approvals processes that are deemed necessary by NHS Improvement.

5. Workforce and Governance

5.1. The trust will develop a comprehensive workforce plan to address key workforce risks. The workforce plan should be supported by detailed underlying work programmes with key metrics and milestones to measure impact of actions and submit to NHS Improvement by a date to be agreed with NHS Improvement.
5.2. The workforce plan should include a specific improvement plan related to reduction of agency spend with a credible and ambitious trajectory to reduce spend in line with the agency ceiling in a reasonable timeframe to be agreed with NHS Improvement.

6. Improvement Director

6.1 The trust will co-operate and work with the Improvement Director appointed by NHS Improvement to oversee and provide independent assurance to NHS Improvement on the trust's delivery of the quality plans and improvement of quality of care the trust provides.

7. Buddy trust and other partner organisations

7.1. The trust will co-operate and work with any partner organisations (this may include one or more 'Buddy trusts') who may be appointed by NHS Improvement to:

7.1.1. support and provide expertise to the trust; and
7.1.2. assist the trust with the delivery of the quality plans and the improvement of the quality of care the trust provides.

7.2. The trust will work with any such partner organisation on such terms as may be specified by NHS Improvement.

7.3. The Trust will be engaging with system partners to build a coalition in order to support the delivery of the improvements that are required

8. Programme Management

8.1. The trust will maintain sufficient programme management and governance arrangements to enable delivery of these undertakings.

8.2. Such programme management and governance arrangements must enable the board to:

8.2.1. obtain clear oversight over the process in delivering these undertakings;
8.2.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and
8.2.3. hold individuals to account for the delivery of the undertakings.

9. Access

9.1. The trust will provide to NHS Improvement direct access to its advisors, programme leads, and the trust's board members as needed in relation to the matters covered by these undertakings. Access will be co-ordinated through the Executive Assistant to the Chief Executive at the trust.

10. Meetings and reports

10.1. The trust will attend meetings or, if NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS Improvement.

10.2. The trust will provide such reports in relation to the matters covered by these undertakings as NHS Improvement may require.

10.3. Meetings and reports referred to above will be requested and co-ordinated through the Executive Assistant to the Chief Executive at the trust.

Any failure to comply with the above undertakings may result in NHS Improvement taking further regulatory action. This could include giving formal directions to the trust under section 8 of the National Health Service Act 2006 and paragraph 6 of the TDA Directions.

THE TRUST

Signed

(Chair or Chief Executive of trust)
Dated

NHS IMPROVEMENT

Signed

Delivery and Improvement Director Midlands and East and member of the Regional Provider Support Group (Midlands and East)
Dated