Agenda (public) 0320

Trust Board
There will be a meeting of the Trust Board on Thursday 12 March 2020 at 10:00 in Alexandra Hospital Board Room, Redditch.

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	**Volunteer Story**		
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest** *To note any additional declarations of interest and to note that the declaration of interests is on the website.*		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **13 February 2020** as a true and accurate record of discussions.*	*For approval*	**Enc A**
6	**Action Log**	*For noting*	**Enc B**
7	**Chairman's Report**		**Verbal**
8	**Chief Executive's Report** Chief Executive	*For noting*	**Enc C**
9	**Strategy**		
9.1	**Annual Plan 2020/21** Director of Strategy and Planning	*For approval*	**Enc D1** ***To follow***
9.2	**Board Assurance Framework** • **2019/20 update and closure** • **2020/21** Chief Executive	*For approval*	**Enc D2**
9.3	**#WeAreVolunteering** Chief Nurse	*For approval*	**Enc D3**
9.4	**COVID-19 –** preparations Chief Nurse	*For information*	**Enc D4**
12	**Performance**		

12.1	**Home First Worcestershire Report** Chief Executive	*For assurance*	**Enc E1**
12.2	**Integrated Performance Report**		**Enc E2**
12.2.1	**Executive Summary** Chief Executive	*For assurance*	
12.2.2	**Section 1 – Finance and Operational Performance Report** Chief Operating Officer		
12.2.3	**Finance and Performance Committee Assurance Report** Finance and Performance Committee Vice Chairman		
12.2.4	**Section 2 – Quality Performance Report** Chief Nurse/Chief Medical Officer		
12.2.5	**Quality Governance Committee Assurance report** Quality Governance Committee Chairman		
12.2.6	**Section 3 – People and Culture Performance Report** Director of People and Culture		
13	**Governance**		
13.1	**Report on nursing and midwifery staffing levels** Chief Nurse	*For assurance*	**Enc F1**
13.2	**Local Maternity and Neonatal Service update** Chief Nurse	*For assurance*	**Enc F2**
13.3	**Learning from Deaths** Chief Medical Officer	*For assurance*	**Enc F3**
13.4	**Communications update** Director of Communications and Engagement	*For assurance*	**Enc F4**
13.5	**Staff Survey** Director of People and Culture	*For assurance*	**Enc F5**
13.6	**Trust Management Executive Report** Chief Executive	*For assurance*	**Enc F6**
13.7	**Going Concern** Chief Finance Officer	*For approval*	**Enc F7**
14	**Assurance Reports**		
14.1	**Audit and Assurance Committee Report** Audit and Assurance Committee Chairman	*For assurance*	**Enc G1**
14.2	**Remuneration Committee Report** Chairman	*For assurance*	**Enc G2**
14.3	**Terms of reference – all committees** Company Secretary	*For approval*	**Enc G3**

Any Other Business *as previously notified*

Date of Next Meeting
The next public Trust Board meeting will be held on 23 April 2020 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).

Enc A

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON
THURSDAY 13 FEBRUARY 2020 AT 10:00 hours
KIDDERMINSTER HOSPITAL & TREATMENT CENTRE EDUCATION CENTRE

Present:

Chairman:	Sir David Nicholson	
Board members: (voting)	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Dame Julie Moore	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Robert Toole	Chief Finance Officer
	Bill Tunnicliffe	Non-Executive Director
	Stephen Williams	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications & Engagement
	Colin Horwath	Associate Non-Executive Director
	Richard Oosterom	Associate Non-Executive Director
	Tina Ricketts	Director of People and Culture
	Kimara Sharpe	Company Secretary
	Sarah Smith	Director of Strategy and Planning
In attendance	Fleur Blakeman	NHS I Improvement Director
	Jackie Edwards	Deputy CNO (Quality) *items 160/19 & 161/19 only*
Public Gallery:	Press	1
	Public	2

160/19 **WELCOME**

Sir David welcomed all to the meeting, especially Mrs Lewis who was attending her first Board meeting.

161/19 **Carer story**

Sir David invited Mrs Morris to introduce this month's story. Mrs Morris explained that Mrs Edwards would present the story which showed learning from listening to a carer. N had experience of the Trust in relation to care of her mother and stepfather.

Mrs Morris stated that N, a retired midwife who used to work at the Trust, approached her to express concern about the lack of engagement with carers and not using the carer documentation appropriately, *This is Me*. She also expressed concern about dignity issues and nutrition and hydration in relation to her stepfather.

Mrs Morris discussed the issues with the band 7 development group. N presented to the group. This was very powerful – particularly when she showed pictures of her step father pre and post admission.

Mrs Morris commissioned the deputy CNOs to discuss issues with all ward managers to determine whether issues raised were systemic.

She asked Mrs Edwards to continue the story.

Mrs Edwards then outlined the work that she and Mrs Miruszenko had undertaken. It was one of the most rewarding pieces of work she has undertaken. The impact on the nurses of the story that N told was profound. The importance of informal carers cannot be underestimated, particularly for people with dementia.

When the deputy CNOs undertook the audit, they did not find major deficits in care. There were elements to improve and they saw excellent demonstrations of good care. She outlined the nail care undertaken on Ward 4 where there were also ward games.

She has triangulated the information she obtained and has concluded that some areas of activities of daily living have not had the focus that they should have. There are also some myths in place such as not being able to undertake nail care as this could cause harm.

In conclusion, she is working with the ward managers to improve documentation for the basics of care. The fundamentals of care programme has been launched to put patients first. She also confirmed that dementia care would feature in the next three year quality strategy.

Mr Horwath joined the meeting.

In conclusion, Mrs Morris stated that she would feedback to N that her story and consequences were discussed at a Trust Board meeting.

Mr Oosterom welcomed the story but wondered whether there was time to implement the recommendations. Mrs Edwards stated that fundamentals of care needed to be a key priority. There needed to be further understanding of the barriers to giving the care needed. Mrs Morris stated that she was confident that fundamentals of care would be given the priority needed as the band 7s now owned the issues. The matrons and Divisional Directors of Nursing also were involved.

Ms Day was concerned that *This is Me* was not being used appropriately. Mrs Morris stated that she has discussed this with nurses and often the documentation is not brought into the Trust on admission. She was working to see how the document could be summarised to ensure that the key elements were observed.

Mr Yates asked whether Mrs Edwards has had discussion with the university about the lack of the basic skills. Mrs Edwards confirmed that she has but she was also aware that the current student nurses have a different perspective on nursing as they are now paying for their course. There is a trend to want to undertake more technical aspects, not necessarily the basic care.

Dr Tunnicliffe asked how the work dovetailed with the Path to Platinum. Mrs Edwards confirmed that this was the platform for launching the work and the Quality Assurance Matron would have a key role to play. She stated that this would be part of the ward accreditation.

Sir David thanked Mrs Edwards for her presentation. He asked her to consider whether this approach would ensure that the Trust became outstanding for caring, rather than

good.

162/19 **ANY OTHER BUSINESS**
There were no items of any other business.

163/19 **DECLARATIONS OF INTERESTS**
There were no additional declarations of interest.

164/19 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 16 JANUARY 2020**

RESOLVED THAT the minutes of the meeting held on 16 January 2020 be confirmed as a correct record and signed by the Chair subject to the following amendment:

Within the Q&A section: Add in *backlog maintenance and expansion of the hospitals* to the answer to the question raised by Mr Pinfield.

165/19 **MATTERS ARISING/ACTION SCHEDULE**
Mrs Sharpe confirmed that all matters arising were either not yet due or completed.

166/19 **INTEGRATED PERFORMANCE REPORT (IPR)**

166/19/1 **Executive summary**
Sir David invited Mr Hopkins to speak in relation to the CQC report and the coronavirus prior to introducing the IPR. He confirmed that the response why the report was not on the agenda was because the Trust was not aware of the publication date when the trust board papers had been published. He confirmed that the Trust response would be published as soon as practicable.

ACTION: Mr Haynes to publish the CQC response as soon as practicable

Mr Hopkins stated that the CQC report related to the unannounced inspection of the EDs on 16 December, as part of the CQC winter inspection regime. He was disappointed with the findings compared to those found at the planned inspection in May/June 2019. He was now reviewing to see whether Home First Worcestershire was sufficient to drive the changes needed. Key was to ensure flow is more effective and better for patients. Empty beds were needed on both sites in the morning to ensure flow. He confirmed that a lot of work was being undertaken in respect of the enforcement actions.

Mr Hopkins then turned to the state of readiness as county for coronavirus. He praised Mrs Morris' leadership on this issue but was disappointed with the poor response from partners in what should be a mainly community response to screening the public who may have symptoms.

Mrs Morris stated that there were a number of immediate actions that had to take place as a result of the CQC report. The Trust has been reporting fortnightly on the 12 enforcement actions which included 10 main areas. Staff numbers were increased immediately to increase the response times for GRAT assessments. There was also immediate work undertaken in respect of resus and clinical need. There had been daily calls with NHS E/I to ensure implementation. These have now been stood down. There is a daily call between the EDs at 2pm.

Additional quality assurance visits have taken place (including from the patient forum) and any patient waiting in the department for more than 6 hours has a review of documentation to ensure that their care needs are being met.

Mrs Morris is supporting the ED team. They are very resilient – she stated it was important to recognise that the report confirmed that there was care and compassion being given to patients.

Dame Julie asked about the response from partners. She wondered what the oversight was from NHS E/I. Ms Blakeman confirmed that a System Improvement Board had been established which is chaired by the Regional Director. The A&E Delivery Board is also well established. Ms Smith stated that she was of the opinion that the current escalation was not operating as effectively as it should be. Mrs Morris agreed that there needed to be a review of the escalation process and the current Deputy Director of Operations was reviewing the process and making this much clearer. Mr Hopkins confirmed that the first draft of the revised plan had been discussed the day before. The target date for completion was the end of March. Mr Oosterom challenged this and Mr Hopkins agreed to try to get agreement by the end of February. Sir David added that he would like it to be discussed at the Integrated Care System executive on 27 February.

ACTION: Revised escalation plan to be in place by end of February and discussed at the Integrated Care System executive on 27 February (Mr Brennan)

Mr Hopkins stated that once the patient flow is established, the Trust would apply to the CQC to have the conditions lifted.

Dr Tunnicliffe asked why the standards cannot be met at the Alexandra Hospital which is under less pressure than Worcestershire Royal. Ms Day stated that both hospitals needed to concentrate on flow and work was needed on longer term, sustainable plans.

Mr Williams wondered what lessons the Trust should learn from the CQC report, in particular from ward to board governance. Mrs Morris stated that there needed to be structured oversight of departments. Currently this takes place but is not a formalised as she would wish. She was pleased that QGC would now review the effectiveness of Home First Worcestershire in relation to quality and safety. She stated that the ward to board process was more robust and formal for other areas within the hospitals.

Mr Hopkins reiterated that it was essential to concentrate on the support the whole hospitals were giving the EDs. Support was needed from the community and system partners to ensure more there were discharges than admissions. He asked for Board support for this message. The Board supported this stance.

Sir David then turned to coronavirus and asked Mrs Morris to update the Board. Mrs Morris confirmed that nationally the NHS was on a level 4 incident. There have been nine positive cases nationally and the key message is to contact NHS 111 if anyone has symptoms. Any expenditure made by the Trust would be reimbursed by the government.

She went onto explain that a ‘pod’ for swabbing has been set up at the Working Well Centres. She then described access to this pod and its working. It is now operational 24 hours a day, 7 days a week. The Health and Care trust/CCG staff the pod Monday-Thursday and the Acute Trust the rest of the week and weekend. It is being staffed through volunteers and bank and agency.

Mrs Morris explained that she has been chairing a system wide planning group whilst internally; Mrs Cooper has been taking charge. The new emergency planning officer would be working full time on this to ensure robust business continuity plans.

Sir David asked for clarification on the local chain of command. It was established that Dale Bywater was the overall officer in charge. The CNO and CMO for the region were also key players. Mrs Morris stated that the ambulance service was the lead for NHS 111. Public health are giving advice.

Mr Hopkins reminded members that whilst the Trust has by default led the response, it was time for the community and system partners to take the lead as this is a community based virus. Mrs Morris added that the model would be based on pandemic flu where there is screening in patients' homes.

Dr Tunnicliffe thanked Mrs Morris for her leadership at this time. He echoed Mr Hopkins and stated that the community needed to take the lead as soon as possible.

Sir David also thanked Mrs Morris and confirmed that he would speak to Dale Bywater.

ACTION: Sir David to speak to Dale Bywater in respect of coronavirus

Mr Yates asked what arrangements were for any hospitalisation of people with coronavirus. Mrs Morris confirmed that preparations had been made. Avon 3 has been identified also there are 10 new beds with negative pressure.

Post meeting note: Mr Brennan confirmed that the 10 beds were not negative pressure.

Sir David noted that internationally, there was efforts to try to contain the virus within China. He observed that the Trust probably had time to ensure the preparations were robust. Mr Hallissey reminded members that there was an opportunity to use the new capacity as an ITU.

Mr Hopkins then turned to the IPR. He asked colleagues to concentrate on the following areas:

- Home First Worcestershire
- Sepsis
- Infection control and in particular the year end trajectories.

Mr Haynes left the meeting

166/19/3 **Financial and Operational Performance/Finance and Performance Committee Assurance Report**

Mr Brennan spoke initially about Home First Worcestershire (HFW). He referred members to pages 44 and 45 of the papers which outlines the key metrics, ambulance handovers, 12 hour trolley waits and long length of stay. Key highlights including ambulance handovers increasing. 12 hour trolley waits have reduced from 137 to 101 and long lengths of stay have been declining with the Trust meeting the national target for March already.

He went onto report that the previous outlined ward moves have been completed. He was pleased that all stroke patients were now being admitted to the stroke ward. With the increase in respiratory beds, the number of medical outliers has decreased with the aim of for zero by the end of March. The onward care team (OCT) has now commenced and there has been some good initial feedback.

Mr Haynes returned to the meeting.

Mr Brennan stated that 33 beds would open on 17 February. Once these have opened,

the Trust will have opened 107 beds. He reminded members that the capacity modelling showed a gap of 109 beds. The new beds will be for renal (23) and general medicine (10).

Extra consultants are now in place within the ED from 10am to 9pm seven days a week. They will also support the extra 10 general medicine beds. He was pleased that all patients were now being seen by consultant by the end of the shift.

HFW was now focussing on stopping the use of the discharge lounge for inpatient care and the relaunch of MAU as an assessment unit with a maximum of 12-14 hour stay.

He then stated that if everything is delivered, then this should result in 90% occupancy on day to day basis. Success will be demonstrated by having empty beds at the start of the day.

Mr Brennan then turned to other metrics. He apologise that there was a mistake with the figure being 23 for patients waiting over 40 weeks. He was confident that this will be reduced to zero by 31 March. The target for 20/21 would be ensuring no one waits over 34 weeks. The incomplete list was within 500 of the NHS target.

Sir David asked Mr Oosterom, Chair of the Finance and Performance Committee to report on the discussions held at the meeting on HFW. Mr Oosterom was clear that a number of issues had been addressed. However he stated that there should be more a sense of urgency across the Trust in the delivery of HFW. He was still not clear what was being achieved and when. Sir David asked for a report to the Integrated Care System executive who clarifies the actions and expectations for all health care organisations to deliver the results required.

ACTION: Draft a report for the ICS executive on the roles and expectations of partners in respect of HFW (Mr Brennan/Ms Smith).

Dr Tunnicliffe was pleased with the improvement in the elective workload. He highlighted that we are the best performing non specialist trust for elective flows in the region. He pointed to slides 51 and 52 which showed the winter interventions and the Trust's dependence on actions by other organisations. He asked what the accountability was for the Health and Care Trust when they had not delivered the additional capacity.

Mr Brennan stated that the Chief Operating Officer at the Health and Care Trust was working very effectively with him, particularly with the development and launch of the OCT. Dr Tunnicliffe ask why there was no home IV service. Mr Brennen admitted that there were about 8 patients at the Alexandra Hospital who could be managed at home with such a service. Mr Brennan stated that there are actions that the Trust could take for example the better working of the MAU. He wished to show that the Trust could deliver and do as we said we would before holding partners to account.

Mr Hallissey stated that a single point of access was essential i.e. GPs being able to bypass ED and refer patients straight into an assessment unit. He confirmed that work was ongoing on this.

Dame Julie stated that the Trust needed to develop metrics to show that partners were not delivering actions in support of patient flow. She stated that QGC would contribute to developing such metrics.

Mr Hopkins was confident that the A&E Delivery Board was already holding partners to account. Sir David added that the System Improvement Board would also support this.

Mr Hopkins stated that the Improvement Director would commence in post shortly and they would be reporting into the Integrated Care System. Line Management was through to the Clinical Commissioning Group Chief Officer. Sir David was clear that the Improvement Director would ensure that all partners were clear about their role in ensuring empty beds at the Trust.

Sir David then asked for assurance that the Trust was on track to deliver the agreed control total. Mr Oosterom stated that he was pleased that the Trust was on track. However he was concerned about the exit run rate and the productivity and efficiency plans for 2020/21.

Mr Toole asked for approval of the award for secondary VAT. This was approved.

RESOLVED THAT the report be received for assurance and the contract award for secondary VAT service was approved.

166/19/2 **Quality Performance/Quality Governance Committee Assurance Report**

Mr Hallissey reported that four out of the five divisions met the target for antibiotic delivery within one hour. Bar codes are now on the sepsis documents. He was confident that the Trust was on the right trajectory.

Mrs Morris described the actions being taken with respect to infection prevention and control indicators. Antimicrobial prescribing was being overseen by Mr Hallissey and actions were being taken.

Dr Tunnicliffe was pleased with the progress being made in key areas and was looking forward to having a focus on the HFW metrics.

RESOLVED THAT the report be received for assurance.

166/19/4 **People and Culture Performance/People and Culture Assurance Report**

Ms Ricketts reported that she was expecting to see improvement in the rate of mandatory training and PDRs completed. There had been a baseline review at the recent committee meeting which discussed the priorities for 2020/21 and they can be seen on page 39 of the papers. The five main areas of work are:

- to continue our culture improvement journey,
- to further develop our employee offer,
- to finalise and implement our 5 year strategic workforce plan,
- to continue to provide a stable and substantive workforce leading to cost reductions and
- to strengthen our approach to employee health and wellbeing to mitigate sickness due to stress.

In response to a question from Ms Day, Ms Ricketts stated that the current flu jab uptake was 77.8%. She was confident that the Trust would meet the 80% target.

RESOLVED THAT the report be received for assurance.

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held on Thursday 12 March 2020 at 10:00 in the Alexandra Hospital Board room, Redditch.

The meeting closed at 11.40 hours.

Signed _____ Date
Sir David Nicholson, Chairman

Questions and answers

Mr Pinfield recognised that everyone was working very hard within the Trust. He offered support to the trust from HealthWatch, in particular to balance the recent negative reporting. He asked specifically about the tertiary cancer partner for the trust. He wanted to have an understanding as to whether the public's desire for a partner with good transport links from Worcestershire was being heard. He specifically asked that Birmingham be considered as the partner for services.

Mr Hopkins thanked Mr Pinfield for his support. He confirmed that the patient voice had been heard by the Trust in respect of specialised commissioning. Mr Haynes added that the opinion had come across loudly and clearly at the consultation events held for the Clinical Services Strategy last summer.

Enc B

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – MARCH 2020

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
13-2-20	CEO report	166/19/1	Escalation process – discuss at ICS executive on 27 Feb	PB	Feb 2020	Mar 2020	Item on agenda for next meeting.	
13-2-20	IPR	166/19/3	Draft a report for the ICS executive on the roles and expectations of partners in respect of HFW	PB/ SS	Feb 2020	Mar 2020	Item on the agenda for the next meeting	
12-9-19	Patient Story	63/19	Arrange dementia training for Trust Board members.	CNO (VM)	Oct 2019		To be programmed into a Board seminar.	
16-01-20	Audit and Assurance Committee	143/19/1	Review responsiveness to internal audit with the executive team	RT	Mar 2020		Item discussed with executive team. On agenda for TME, March 2020. Action closed.	
13-2-20	CEO report	166/19/1	Publish the Trust response to the CQC report	RH	Feb 2020		Published. Action closed.	
13-2-20	CEO report	166/19/1	Speak to Dale Bywater re coronavirus	DN	Feb 2020		Telephone call taken place Action closed.	
13-2-20	Minutes of previous meeting	164/19	Amend the Q&A section	KS	Feb 2020		Amendment made. Action closed	

Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	C

Chief Executive's Report

For approval:		For discussion:		For assurance:		To note:	X

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

Alignment to the Trust's strategic objectives							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to • Note this report
Executive summary	This report is to brief the board on various local and national issues.

Risk								
Key Risks	N/A							
Assurance	N/A							
Assurance level	**Significant**		**Moderate**		**Limited**		**None**	
Financial Risk	N/A							

NHS
Worcestershire Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	C

Introduction/Background

This report gives members an update on various local, regional and national issues.

Issues and options

I should like to thank all staff for their continued work during the recent local flooding. In many cases staff have gone out of their way to keep our services running (both in our hospitals and in the community).

New wards opened: I am pleased that our new wards, Aconbury 2 and Aconbury 3 have opened on the Worcestershire Royal site. These give an additional 33 beds and for the first time, a dedicated renal ward on site. The impact of these wards on our performance will be covered in the IPR section of the Board agenda. I should like to thank all the staff involved in the preparation and opening of these wards.

Coronavirus (COVID-19): This is the subject of a separate paper on the agenda for today's meeting.

Staff Friends and Family Test is now available for all staff to complete. I would urge all Board members to participate in this short survey.

System Board to Board meeting: We had a system to board meeting on 16 January 2020. NHS E/I recognised the system commitment to work differently by all the system leaders. There was a focus on the development of a strong system improvement plan with collective ownership and leadership by all. We are looking to appoint a System Improvement Director to support this work. We spent time discussing the responses needed to improve patient experience within the urgent and emergency care pathway as well as the financial position. Currently there is no further meeting planned.

Mental Health services for Children in Worcestershire rated Outstanding: I should like to offer our congratulations to the Health and Care Trust whose children's mental health services in Worcestershire have been rated Outstanding in the latest CQC report, relating to a planned inspection in the Autumn last year. The CAMHS team provides a countywide service for children up to 18yrs and includes help for those with learning disabilities, a children's eating disorder team and a youth offending team.

Worcester Anaesthetist wins top national award: One of our Consultant Anaesthetists, Dr Satinder Dalay was awarded the highest honour by the Association of Anaesthetists at their 2020 meeting. Dr Dalay was nominated for the award after being recognised for the successes she achieved as an elected member of the Group of Anaesthetists in Training (GAT) Committee. Satinder - or Satty as she's known by her colleagues – also edited and produced the latest Group of Anaesthetists in Training Handbook, which all trainee anaesthetists in the UK use as guidance in their training.

Health Equity in England: The Marmot review 10 years on: This report highlights:

- stalling life expectancy for men and women in England since 2010
- the more deprived the area, the shorter the life expectancy
- among women in the poorest 10% of areas, life expectancy fell between 2010-12 and 2016-18
- people in poorer areas spend more of their lives in ill health than those in affluent

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areas
- the amount of time people spend in poor health has gone up across England since 2010
- cuts in funding in deprived areas and areas outside London were larger and affected those areas more

Organ donation – law set to change: From May 2020, all adults in England will be automatically enrolled as organ donors unless they choose to opt out. This is part of a bid to boost the number of transplants on the NHS. However, relatives will still be asked for their opinion which can lead to donations being blocked.

Recommendations

The Trust Board is requested to
- Note this report

Appendices - none

Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	D2

Board Assurance Framework

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

Alignment to the Trust's strategic objectives							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	19 Feb 2020	Approved
QGC (quality areas only)	Feb 2020	Approved
F&P (F&P areas only)	Feb 2020	Approved
P&C (P&C areas only)	Virtual (Feb 2020)	Approved
Audit and Assurance Committee	10 March 2020	Review of process only

Recommendations	Trust Board is requested to approve • The 2019/20 update and closure of the BAF • The 2020/21 BAF

Executive summary	The BAF for 2019/20 has been updated and is attached. The significant change is the increase in the current risk rating for risk 12, the Trust reputation due to the CQC report on the unannounced visit in December. As this is the last iteration of this BAF the future for each risk has been identified. The BAF for 2020/21 has been developed in conjunction with the executive leads. 11 strategic risks have been identified, and links to the BAF 2019/20 are shown. The gap analysis is shown on the cover sheet which shows the top three risks are the mismatch between demand and capacity, implementation of the Clinical Services Strategy and Home First Worcestershire. The rationale for the reduction in risk relating to culture is due to the results from the staff survey and the workforce metrics improving.

Risk									
Key Risks	*All strategic risks*								
Assurance	*As shown in the document*								
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**		
Financial Risk	*As shown within the document*								

Board Assurance Framework – Gap analysis

This analysis shows the difference between the target risk and the current risk rating.

no	risk	gap
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 potential 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 digital infrastructure, resulting in the lack of ability to deliver safe, effective and efficient care to patients	14
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 possible compromise to patient safety	11
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
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	9
8	If we do not have effective digital 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 we 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 and higher staffing costs	8
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 for putting patients first, resulting in lower quality care	7
5	If there is a lack of a county wide operational plan which balances demand and capacity across the county, then there will be delays to patient treatment, resulting in a significant impact on the trust's ability to deliver safe, effective and efficient care to patients	7
2	If we do not deliver the outcomes of the quality improvement strategy (incorporating the CQC 'must and should' dos), then we may fail to deliver sustained improvements, resulting in improvements not being delivered for patient care & reputational damage	6
1	If we do not have in place robust clinical governance, then we may fail to deliver high quality safe care, resulting in negative impact on patient experience and outcomes.	4

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS				CURRENT 29 Feb 2020			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	RISK RATING 30 JUNE 2019	RISK RATING 31 OCTOBER 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
1	3927 ------ 2017	IF we do not have in place robust clinical governance THEN we may fail to deliver high quality safe care RESULTING IN negative impact on patient experience and outcomes.	Chief Medical Officer	Quality Governance	12	16	16	12	3	4	12	⇔	Feb 2020	Risk carried over to risk 11 BAF 2020/21	7
2	3930 ------ 2018	IF we do not deliver the outcomes of the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained improvements RESULTING IN improvements not being delivered for patient care & reputational damage	Chief Nurse	Quality Governance	16	12	12	12	3	4	12	⇔	Feb 2020	Risk merged into risk 11 BAF 2020/21	9

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS				CURRENT 29 Feb 2020			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	RISK RATING 30 JUNE 2019	RISK RATING 31 OCTOBER 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
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	16	12	12	3	4	12	⇔	Feb 2020	Risk closed	11
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 possible compromise to patient safety	Chief Operating Officer	Finance and Performance	20	20	20	20	4	5	20	⇔	Feb 2020	Transferred to risk 4 BAF 2020/21	13

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS				CURRENT 29 Feb 2020			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	RISK RATING 30 JUNE 2019	RISK RATING 31 OCTOBER 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
5	3933 ------ 2018	IF there is a lack of a county wide operational plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a significant impact on the trust's ability to deliver safe, effective and efficient care to patients	Chief Operating Officer	Finance and Performance	20	15	16	16	4	4	16	⇔	Feb 2020	Transferred to risk 1 BAF 2020/21	14
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 potential inability to invest in services to meet the needs of our patients.	Chief Financial Officer	Finance and Performance	15	20	20	20	5	4	20	⇔	Feb 2020	Transferred to risk 6 BAF 2020/21	15
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 digital infrastructure RESULTING IN the lack of	Chief Financial Officer	Finance and Performance	15	16	20	20	5	4	20	⇔	Feb 2020	Transferred to risk 7 BAF 2020/21	17

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS				CURRENT 29 Feb 2020			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	RISK RATING 30 JUNE 2019	RISK RATING 31 OCTOBER 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
		ability to deliver safe, effective and efficient care to patients													
8	3936 ------ 2018	IF we do not have effective digital 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 Digital Officer/Chief Medical Officer	Finance and Performance/ Quality Governance Committee	16	16	16	16	4	4	16	⇔	Feb 2020	Transferred to risk 5 BAF 2020/21	18
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	16	12	3	4	12	⇔	Feb 2020	Risk closed	20
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 for putting patients first RESULTING IN lower quality care	Director of People and Culture	People and Culture	15	15	15	15	3	5	15	⇔	Feb 2020	Transferred to risk 9 BAF 2020/21	21

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS				CURRENT 29 Feb 2020			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	RISK RATING 30 JUNE 2019	RISK RATING 31 OCTOBER 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
11	3939 ------ 2018	IF we 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 and higher staffing costs	Director of People and Culture	People and Culture	16	16	16	16	4	4	16	⇔	Feb 2020	Transferred to risk 8 BAF 2020/21	23
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	16	12	4	4	16	⇧	Feb 2020	Transferred to risk 10 BAF 2020/21	25

Summary of risks on Corporate Risk Register (Oct 2019) & Glossary – page 24

BAF RISK REFERENCE *Summary for Datix entry*	1 Lack of robust clinical governance	**DATE OF REVIEW**	Feb 2020
DATIX REF	3927 (Linked to corporate risks 3483, 4009)	**NEXT REVIEW DATE**	

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we do not have in place robust clinical governance THEN we may fail to deliver what high quality safe care RESULTING IN negative impact on patient experience and outcomes.	**INITIAL**	4	5		⇨
	TARGET Dec 19	2	4		
	PREVIOUS	3	4		
	CURRENT	3	4		

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and outcomes for our patients
GOAL (S)	Quality and Improvement
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	Framework for governance including (not exhaustive) • Learning from deaths – external review • Better outcomes • Serious incident management – improving performance • Divisional governance leads – in place for 2 divisions • Outcomes • Complaints – improving performance • Learning	Clinical Governance Committee (CGG) report to Trust Management Executive (TME) and Quality Governance Committee (QGC) (monthly) and Trust Board (bimonthly) monitoring via Integrated Performance Report and Learning from Deaths	2
2	Quality Improvement Strategy and associated plans	CGG report to TME	1
3	Risk Management Strategy	Reviewed by TME, QGC, Audit and Assurance Committee & Trust Board	2
4	Performance Review Meetings	TME	0

REF	CONTROL	ASSURANCE	LEVEL
5	Medical annual appraisals	NHS E/Trust Board/People and Culture	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Framework for clinical governance	Development of a framework	Sep 2020	
2		Interim report on the development of a framework	April 2020	
	Effectiveness of medical appraisals	Review appraisals	Dec 2019	Medical appraisal rate improved. Methodology now robust. Action completed.
4	Alignment of resources	Review of clinical governance staff	Apr 2020	

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**	Feb 2020
DATIX REF	3930 (linked to corporate risks)	**NEXT REVIEW DATE**	

RISK DETAILS

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

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and outcomes for our patients
GOAL	Quality and Improvement
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	Reporting from the CGG to the Quality Governance Committee	TME and Quality Governance Committee – bimonthly	2
2	Year 2 Quality Improvement Plans developed for Divisions	CGG – monthly	1
3	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)	CGG report to TME and Quality Governance Committee monthly	2
4	On-going quality audits	Report to CGG	1
5	Board members undertaking safety walk abouts	Report to TME, Quality Governance Committee	2
6	Risk management strategy in place to ensure best practice in risk management and risk maturity	Risk Management Strategy approved by TME, QGC, Audit and Assurance Committee, Trust board	2/3
7	RAIT and QIS meeting	CGG report to TME and Quality Governance Committee	2

REF	CONTROL	ASSURANCE	LEVEL
8	Band 7, 8 development sessions	People and Culture Committee	2
9	Risk Maturity assessment	Oxford University Hospitals	3
10	Triangulation of ward accreditation/ward to board reporting/QI training	CCG report to TME and QGC	2
11	Quality Impact Assessment process overseen by Quality Improvement Matron	CCG report to QGC, Audit and Assurance Committee	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Annual monitoring of quality improvement strategy	Publication of Quality Account	Jun 2020	

2	Ward to Board flow	Bespoke quality walk abouts
		• Matron for patient flow
		• Matron for Quality Improvement
		• Infection Prevention and Control ward reviews
		• Back to the floor
		• NED ward visits
		  ○ Revision of tools
		  ○ Observation of care process
		  ○ Process up and running
			Aug 2019
			
			Feb 2020
			Feb 2020
			March 2020
				
				Complete
				Complete
				Complete
				Complete

3	Robust QIA process	Revision of policy and process	July 2019	Competed
4	Oxford University risk maturity assessment	Arrange for OUH to visit and assess	tbc	
5	Significant QIA training	Roll out training from November 2019, review March 2020	March 2020	In place. Action closed.
6	Framework for monitoring corporate teams	Roll out RAIT for corporate teams (Infection control, safeguarding, pressure ulcers, falls) Peer panels set up	 Mar 2020	

REF	GAP	ACTION	BY WHEN	PROGRESS
		Panels commenced Review of effectiveness	Mar 2020 July 2020	
7	Clear escalation process in place for quality issues	Develop a framework for escalation Implement	Mr 2020 July 2020	

BAF RISK REFERENCE *Summary for Datix entry*	3 Lack of delivery of statutory requirements of the Hygiene Code	**DATE OF REVIEW**	Feb 2020
DATIX REF	3931 (linked to corporate risks 3852, 4213)	**NEXT REVIEW DATE**	

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET		RATING	L	C	R	CHANGE
IF we do not deliver all 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	3	4		
			CURRENT	3	4		

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and outcomes for our patients
GOAL	Quality and Improvement
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	2019/20 forward Improvement plan in place	Monthly reports to TME and QGC	2
2	Key standards in place	Monthly reports to TME and QGC	2
3	Reporting from Trust Infection Prevention and Control Committee (TIPCC)	Monthly reports to TME and QGC and Trust Board	2
4	PFI Contract management	Regular reports to F&P	1
5	Infection control link professionals	Report to TIPCC	0
6	Hand hygiene audits	Report to CCG/TME/QGC	2
7	TIPCC scrutiny and learning meeting (holding to account)	TIPCC reporting to TME and QGC	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS

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	On track
2	Annual monitoring of quality improvement strategy	Publication of Quality Account	Jun 2020	On track
3	PFI contract monitoring	Implementation of the new governance structure for the PFI contract (including KPIs)	TBC	Partnership meeting in place. Carried forward
4	Annual Report – TIPCC	Publication	June 2020	
5	A clear policy on antimicrobial stewardship	Review antimicrobial stewardship and prescribing. Develop an action plan	Dec 2019	Carried forward
6	Variations across the Trust in application of IPC actions	Increased focus of divisional directors of nursing and matrons Weekly inspections by the CNO and deputy DIPC	Immediate Immediate	

BAF RISK REFERENCE *Summary for Datix entry*	4 The Trust is unable to ensure efficient patient flow through our hospitals	**DATE OF REVIEW**	Feb 2020
DATIX REF	3832 (linked to corporate risks 3482,)	**NEXT REVIEW DATE**	

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 possible compromise to patient safety	**INITIAL**	4	5		⇔
	TARGET Apr 20	3	3		
	PREVIOUS	4	5		
	CURRENT	4	5		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people
GOAL	Performance
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	Delivery of the Home First Worcestershire Plan	TME and F&P Committee	1-2
2	Delivery of the referral to treatment (RTT) recovery plan/cancer plan/diagnostics plan	TME and F&P Committee	1-2
3	System wide capacity and demand modelling work	TME and F&P Committee/A&E delivery Board/Carnall Farrah/System Review Meeting	1-2-3
4	Service reconfiguration actions	Health Overview and Scrutiny Committee/A&E Delivery Board/	3
5	4 weekly multisite MADE review	NHS EI	3
6	Implementation of the onward care team (OCT)	A&E Delivery Board, System Improvement Board	3
7	Additional 33 beds, open Feb 2020	F&P	2
8	CQC inspection report	CQC	3

ASSURANCE LEVELS: 0 No independent assurance |1 Internal review or Trust governance meeting | 2 Board or committee| 3 External review

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Implementation of the Urgent care Improvement Plan	Implementation of the 6 work streams contained within Home First Worcestershire including the MADE recommendations	April 2020	Additional resource commissioned by CEO to support the implementation of the programme
2	The Trust is not commissioned to deliver the NHS constitutional standard for incomplete RTT	Maintain size of incomplete waiting list Reduce maximum wait to 40 weeks	Mar 2020 Sept 2019 Dec 2019	Gynae/oral surgery/orthodontics

BAF RISK REFERENCE *Summary for Datix entry*	5 Lack of system capacity plan	**DATE OF REVIEW**	Feb 2020
DATIX REF	3933 (linked to corporate risks 3846)	**NEXT REVIEW DATE**	

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF there is a lack of a county wide operational plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a significant 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	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people
GOAL	Performance
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	Delivery of system capacity plan and escalation framework and associated actions	System Improvement Board	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS

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**	Feb 2020
DATIX REF	3934 (linked to corporate risks 3768, 4099)	**NEXT REVIEW DATE**	

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 potential 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	4		
			CURRENT	5	4		

CONTEXT

STRATEGIC OBJECTIVE	Best use of resources
GOAL	Finance
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 review of efficiency and improvement plans including vacancy control panel, ideas and delivery	Finance Improvement Group, TME, Finance and Performance Committee	1/2
2	Operational budgets developed at divisional and directorate level	Finance Improvement Group, TME, Finance and Performance Committee	1
3	Medium Term Financial (MTF) Plan	TME/F&P/Trust Board/NHS Improvement	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	MTF Plan	Develop the MTF Plan	Dec 2019	
2	Fully identified and assignable improvement opportunities	Ensure rolling programme of continuous improvement internally and system wide working to support value for money decisions	On-going	
3	Ownership of financial situation	Finance is included within personal objectives which are aligned to trust objectives Realign budget holder responsibilities as part of planning round	On-going	

BAF RISK REFERENCE *Summary for Datix entry*	7 The Trust is unable to secure investment capital to make the best use of resources for our patients.	**DATE OF REVIEW**	Feb 2020
DATIX REF	3941 (linked to corporate risks 4130)	**NEXT REVIEW DATE**	

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 digital 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	5	4		
			CURRENT	5	4		

CONTEXT

STRATEGIC OBJECTIVE	Best use of resources
GOAL	Finance
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, TME, F&P	1-2
2	Loan funding requests and review of outcomes	TME and overseen by Finance and Performance Committee	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Medical devices strategy	Develop strategy/plan *check with Vicky*	Oct 2019	*Check with Vicky*
2	MTF plan	Develop the MTF plan	Dec 2019	

BAF RISK REFERENCE *Summary for Datix entry*	8 Ineffective digital/IMT systems	**DATE OF REVIEW**	Feb 2020
DATIX REF	3936 (linked to corporate risks 3603, 3855, 4107)	**NEXT REVIEW DATE**	

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET	RATING	L	C	R	CHANGE
IF we do not have effective digital 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	**2021 3x4**	**INITIAL**	4	4		⇔
		TARGET 2024	2	4		
		PREVIOUS	4	4		
		CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people
GOAL	Strategy
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Governance for implementation of Digital Strategy	Report to TME/F&P/Trust Board	2
2	Alignment to STP Digital Strategy	STP Digital Board	3
3	Internal audit report on clinical systems	Internal audit/Audit and Assurance Committee	3
4	Cybersecurity report	NHS Digital	3
5	Digital Strategy	Trust board	2
6	Digital care record – full business case	Trust board	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Implementation of Digital Strategy	Meet milestones within plan	2024	

REF	GAP	ACTION	BY WHEN	PROGRESS
2	Implementation of cybersecurity report	Meet cybersecurity essential plus	2021	
3	Funding for implementation	Cross reference BAF risk 7		
4	Poor infrastructure and support IY services	Computercentre exit and transition	Nov 2020	
5	Comprehensive electronic patient record	Implement full business case	2023	

BAF RISK REFERENCE *Summary for Datix entry*	9 Inability to sustain our clinical services	**DATE OF REVIEW**	Feb 2020
DATIX REF	3937 (linked to corporate risks - none)	**NEXT REVIEW DATE**	

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 2023/24	2	4		
	PREVIOUS	3	4		
	CURRENT	3	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people
GOAL	Strategy
CQC DOMAIN	Responsive, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of Strategy and Planning
RESPONSIBLE COMMITTEE	TME

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Trust clinical services strategy	Trust Board	2
2	Refresh of STP plan to deliver NHS Long Term Plan	STP Partnership Board	3
3	Strategic partnership arrangement	Trust Board	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1				
2				
3				
1	Annual plan	Develop Annual Plan	March 2020	

BAF RISK REFERENCE *Summary for Datix entry*	10 Failure to deliver cultural change programme	**DATE OF REVIEW**	Feb 2020
DATIX REF	3938 (linked to corporate risks 3842)	**NEXT REVIEW DATE**	

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 for putting patients first RESULTING IN lower quality care	**2021**	**2X5**	**INITIAL**	3	5		⇔
			TARGET 2023	1	5		
			PREVIOUS	3	5		
			CURRENT	3	5		

CONTEXT

STRATEGIC OBJECTIVE	Best People
GOAL	Culture
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	Implementation of 4ward including leadership behaviour led by the Trust Board (phase 2)	Report to TME/People and Culture Committee	2
2	Implementation of the People and Culture Strategy.	Report to TME/People and Culture Committee	2
3	Freedom to Speak Up Guardian in place, policy approved, enhanced 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	Report to 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

REF	CONTROL	ASSURANCE	LEVEL
6	Triangulate evidence and identify themes and actions	Freedom to Speak Up group bi-monthly meetings – TME – People and Culture Committee	2
7	Staff friends and family & staff survey	Report to TME, P&C Committee & Trust Board	2
8	External assurance in relation to junior doctors	Health Education England	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Organisational development strategy (OD) aligned to new vision and objectives	Refresh of P&C strategy	Mar 2020	
2	Measurement of culture	Develop new measure of indicator for measuring culture	Sept 2019	Completed
3	Good experience from junior doctors	Medical education strategy linking to the OD strategy	March 2020	
4	Model for phase 2 of 4ward	Consultation Oct/Nov	Dec 2019	Launch April 2020

BAF RISK REFERENCE *Summary for Datix entry*	11 Failure to recruit, retain and develop staff	**DATE OF REVIEW**	Feb 2020
DATIX REF	3939 (linked to corporate risks 3831, 3833)	**NEXT REVIEW DATE**	

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we 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 and higher staffing costs	**INITIAL**	4	4		⇔
	TARGET 2021	2	4		
	PREVIOUS	4	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best people
GOAL	Culture
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	Delivery of People and Culture Strategy (including the recruitment and retention plan)	Report to TME/People and Culture Committee/Trust Board	2
2	Workforce programme focussed on reduction in premium staffing costs	Monitored through Financial Improvement Group, TME, Finance and Performance Committee	1 2
3	Monthly run rate for pay costs	TME and Finance and Performance Committee	2
4	Five year strategic workforce plan	P&C Committee/TME	2
5	Weekly vacancy control panel	Financial Improvement Group	1

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
	Implementation of the People and Culture Strategy	Implementation of the 11 strands (prioritised to 6 strands) Implementation of the Learning & Development plan including the Academy Implementation of Timewise Implementation of the Recruitment and Retention Plan Implementation of Allocate & single bank and agency provider model	Mar 2020	
2	Inability to fill all vacancies	Overseas recruitment Clinical Fellowships	Mar 2020 Mar 2020	

BAF RISK REFERENCE *Summary for Datix entry*	12 Reputational damage	**DATE OF REVIEW**	Feb 2020
DATIX REF	3940 (linked to corporate risks 3877)	**NEXT REVIEW DATE**	

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET	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	2021 3x4	INITIAL	4	4		⇧
		TARGET 2024	2	4		
		PREVIOUS	4	4		
		CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people, best experience, best use of resources, best people
GOAL	Strategy/quality/finance/performance/culture
CQC DOMAIN	Responsive, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of Communication and Engagement
RESPONSIBLE COMMITTEE	People and Culture/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 putting people first	Report to 4ward and People and Culture Committee	1-2
3	On-going programme of stakeholder engagement	Communication report to TME/People and Culture/TB	2
4	Communications Strategy	People and Culture	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1				
2	Implement communications strategy	Develop and implement action plan	Apr 2020	

Summary of risks on the Corporate Risk Register (Oct 2019)

3482 Operations - overcrowding in the Emergency Department
3483 Clinical Quality and Effectiveness - effective management of tracking processes
3603 If there is a cyber attack, this means patient information can be lost/compromised, resulting in poor care
3768 Cash Flow -There is a risk that the Trust does not generate sufficient cash incomings through contracted services provided
3831 PC06 Nursing Recruitment and Retention
3832 PC07 Workforce Planning
3833 PC08a Mandatory Training completion rates
3842 PC15 HR / OD Capacity
3844 PC17 Health and Safety capability/ capacity
3852 Clinical - safe, clean environment
3855 Risk of Trust utilising an unsupported PC/Laptop Operating System after January 2020
3877 Reputational - junior doctors on rotation
3946 Clinical Quality and Effectiveness - Trustwide capacity situation
4009 Lack of comprehensive asset register
4099 Achievement of the 2019/20 Financial Plan (Delivery of the in year stretch target)
4107 Risk of loss of data and cyber attack to unsupported ICT systems that reside out of ICT
4130 Access to funding for asset replacement and renewal
4213 Risk of damaged or contaminated theatre instruments being present on theatre sets

Glossary

CGG	Clinical Governance Group
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CQC	Care Quality Commission
F&P	Finance and Performance Committee
MTF	Medium Term Financial
NHS I	NHS Improvement
OD	Organisational Development
QGC	Quality Governance Committee
QIS	Quality Improvement Strategy
RTT	Referral to treatment
STP	Sustainability and transformation partnership
TIPCC	Trust Infection Prevention and Control Committee
TME	Trust Management Executive

Board Assurance Framework – Gap analysis

This analysis shows the difference between the target risk and the current risk rating.

no	risk	gap
1	If the System Improvement Board is not able to resolve the mismatch between demand and capacity, then there will be delays to patient treatment, resulting in a significant impact on the Trust's ability to deliver safe, effective and efficient care to patients.	10
3	If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	10
5	If we fail to implement Home First Worcestershire as scheduled then there will be an impact on our ability to see, treat and discharge patients in a timely way which may result in patient harm and curtails urgent elective activity.	10
2	If we fail to effectively engage our patients, our staff, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	9
6	If we do not implement year one of the digital care record business case in a timely coordinated way, then we may not be able to utilise the system for the benefit of patients, resulting in delayed and poorly coordinated care for patients and a poor patient experience.	8
11	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.	8
7	If we fail to address the drivers of the underlying deficit then we will not achieve financial sustainability (as measured through achievement as a minimum of the structural level of deficit) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	8
8	If we are not able to secure capital financing then we will not be able to maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	8
9	If we do not have a sustainable fit for purpose diverse and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.	6
10	If we fail to sustain the positive change in organisational culture, then we may fail to attract and retain sufficiently qualified, skilled and experienced staff to sustain the delivery of safe, effective high quality compassionate treatment and care.	6
4	If we do not have in place robust systems and processes to ensure improvement of quality and safety, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	4

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	CURRENT 29 Feb 2020			CHANGE	PREVIOUS			Risk appetite	PAGE NUMBER
					LIKELIHOOD	CONSEQUENCE	RISK RATING		RISK RATING 29 FEB 2020	RISK RATING 30 JUNE 2020	RISK RATING 30 NOV 2020		
1	2020	If the System Improvement Board is not able to resolve the mismatch between demand and capacity, then there will be delays to patient treatment, resulting in a significant impact on the Trust's ability to deliver safe, effective and efficient care to patients.	CEO	F&P	4	5	20	N/A				HIGH (PARTNERSHIPS)	6
2	2020	If we fail to effectively engage our patients, our staff, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	Dir C&E/CNO	QGC	3	4	12	N/A				MODERATE (CLINICAL INNOVATION(	7
3	2020	If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	Dir S&P/ CMO	QGC	3	5	15	N/A				MODERATE (CLINICAL INNOVATION)	8

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	CURRENT 29 Feb 2020			CHANGE	PREVIOUS			Risk appetite	PAGE NUMBER
					LIKELIHOOD	CONSEQUENCE	RISK RATING		RISK RATING 29 FEB 2020	RISK RATING 30 JUNE 2020	RISK RATING 30 NOV 2020		
4	2018	If we do not have in place robust systems and processes to ensure improvement of quality and safety, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	CMO/ CNO	QGC	3	4	12	⇨				LOW (SAFETY/ QUALITY/	10
5	2020	If we fail to implement Home First Worcestershire as scheduled then there will be an impact on our ability to see, treat and discharge patients in a timely way which may result in patient harm and curtails urgent elective activity.	COO	F&P QGC	4	5	20	N/A				LOW (SAFETY/QUALITY/ OUTCOMES)	13
6	2020	If we do not implement year one of the digital care record business case in a timely coordinated way, then we may not be able to utilise the system for the benefit of patients, resulting in delayed and poorly coordinated care for patients and a poor patient experience.	Chief Digital Officer	F&P	4	4	16	N/A				MODERATE (REPUTATION)	14

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	CURRENT 29 Feb 2020			CHANGE	PREVIOUS			Risk appetite	PAGE NUMBER
					LIKELIHOOD	CONSEQUENCE	RISK RATING		RISK RATING 29 FEB 2020	RISK RATING 30 JUNE 2020	RISK RATING 30 NOV 2020		
7	2018	If we fail to address the drivers of the underlying deficit then we will not achieve financial sustainability (as measured through achievement as a minimum of the structural level of deficit) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	CFO	F&P	5	4	20	⇨				LOW (FINANCIAL/VFM)	16
8	2018	If we are not able to secure capital financing then we will not be able to maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	CFO	F&P	5	4	20	⇨				LOW (FINANCIAL/VF	18
9	2020	If we do not have a sustainable fit for purpose diverse and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.	Dir P&C	P&C	3	5	15	N/A				MODERATE (WORKFOR	20

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	CURRENT 29 Feb 2020			CHANGE	PREVIOUS			Risk appetite	PAGE NUMBER
					LIKELIHOOD	CONSEQUENCE	RISK RATING		RISK RATING 29 FEB 2020	RISK RATING 30 JUNE 2020	RISK RATING 30 NOV 2020		
10	2017	If we fail to sustain the positive change in organisational culture, then we may fail to attract and retain sufficiently qualified, skilled and experienced staff to sustain the delivery of safe, effective high quality compassionate treatment and care.	Dir P&C	P&C	4	3	12	⇩				MODERATE (WORKFORCE)	21
11	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	Dir C&E	P&C	4	4	16	⇧				MODERATE (REPUTATION)	22

Summary list of the corporate risks – page 23
Glossary – page 24

BAF RISK REFERENCE *Summary for Datix entry*	1 Mismatch between demand and capacity (system working)	**DATE OF REVIEW**	Feb 2020
DATIX REF	(Linked to corporate risks 3482, 3946)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
If the System Improvement Board is not able to resolve the mismatch between demand and capacity, then there will be delays to patient treatment, resulting in a significant impact on the Trust's ability to deliver safe, effective and efficient care to patients.	INITIAL	4	5	20	
	TARGET 2021	2	5	10	
	PREVIOUS				
	CURRENT	4	5	20	

CONTEXT

STRATEGIC OBJECTIVE	Best Services for Local People
GOAL (S)	Strategy
RISK APPETITE	High

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Executive
RESPONSIBLE COMMITTEE	F&P

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	System Improvement Board in place	NHSE/I, TME/F&P Committee	3
2	Demand and Capacity Plan in place with monthly refresh	A&E Delivery Board/TME/F&P	3
3	System Improvement Director	NHSE/I	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Demand and capacity gap	Implementation of plans to close the demand and capacity gap	Jul 2020	
2	System Improvement Director	Appointment to post • Interviews • In post	 Feb 2020 Apr 2020	

BAF RISK REFERENCE *Summary for Datix entry*	2 Engagement of patients, staff and public in the redesign & transformation of services	**DATE OF REVIEW**	Feb 2020
DATIX REF	(linked to corporate risks 3948)	**NEXT REVIEW DATE**	June 2020

RISK DETAILS

If we fail to effectively engage our patients, our staff, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.

INTERIM TARGET		RATING	L	C	R	CHANGE
2021	2x4	INITIAL	3	4		
		TARGET 2025	1	2		
		PREVIOUS				
		CURRENT	3	4		

CONTEXT

STRATEGIC OBJECTIVE	Best Services for Local People
GOAL	Strategy
RISK APPETITE	Moderate

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of Communications and Engagement
RESPONSIBLE COMMITTEE	QGC

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Communications plan for the Clinical Services Strategy	People and Culture Committee	2
2	Alignment of the communications plan with the STP communications and engagement activity	ICS executive	3
3	Youth forum/patient and public involvement forum in place	QGC	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Communications action plan	Develop an action plan that is aligned to the STP communications activity	April 2020	
2		Execute the plan	tbc	

BAF RISK REFERENCE *Summary for Datix entry*	3 Implementation of the Clinical Services Strategy	**DATE OF REVIEW**	Feb 2020
DATIX REF	(linked to corporate risks 3948)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.

INTERIM TARGET		RATING	L	C	R	CHANGE
2020/21	15	INITIAL	3	5		
2022/23	10	TARGET	1	5		
2024/25	5	PREVIOUS				
		CURRENT	3	5		

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and best outcomes for our patients
GOAL	Quality
RISK APPETITE	Moderate

ACCOUNTABILITY

CHIEF OFFICER LEAD	CMO/Dir S&P
RESPONSIBLE COMMITTEE	QGC

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Annual plan business planning cycle	Trust Board	2
2	Transformation workstreams	TME	2
3	Strategic partnership agreement	TME/Trust Board	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Annual plan	Develop annual plan	March 2020	
2	Exec leadership for workstreams	Ensure effective executive leadership	March 2020	
3	Development of ICS	ICS plan in place	April 2021	
4	Strategic partnership	Approval of strategic partner		

ASSURANCE LEVELS: 0 No independent assurance |1 Internal review or Trust governance meeting | 2 Board or committee| 3 External review

REF	GAP	ACTION	BY WHEN	PROGRESS
		Development of action plan Implementation of action plan	 Sept 2020	

BAF RISK REFERENCE *Summary for Datix entry*	4 Lack of robust systems and processes for improvement of quality and safety	**DATE OF REVIEW**	Feb 2020
DATIX REF	(Linked to corporate risks 3852, 3483)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
If we do not have in place robust systems and processes to ensure improvement of quality and safety, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	INITIAL	4	5		⇨
	TARGET Sept 20	2	4		
	PREVIOUS	3	4		
	CURRENT	3	4		

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and outcomes for our patients
GOAL (S)	Quality and Improvement
RISK APPETITE	Low

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Medical Officer/Chief Nurse
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Framework for governance including (not exhaustive) • Learning from deaths – external review • Better outcomes • Serious incident management – improving performance • Divisional governance leads – in place for 2 divisions • Outcomes • Complaints – improving performance • Learning	Clinical Governance Group (CGG) report to Trust Management Executive (TME) and Quality Governance Committee (QGC) (monthly) and Trust Board (bimonthly) monitoring via Integrated Performance Report and Learning from Deaths	2
2	Quality Improvement Strategy and associated plans	CGG report to TME	1
3	Risk Management Strategy	Reviewed by TME, QGC, Audit and Assurance Committee & Trust Board	2
4	Performance Review Meetings	TME	0

REF	CONTROL	ASSURANCE	LEVEL
5	Medical annual appraisals	NHS E/Trust Board/People and Culture	3
6	Learning from deaths – robust process in place	TME/QGC/Trust Board	2
5	Board members undertaking safety walk abouts	Report to TME, Quality Governance Committee	2
6	Risk management strategy in place to ensure best practice in risk management and risk maturity	Risk Management Strategy approved by TME, QGC, Audit and Assurance Committee, Trust Board	2/3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Framework for clinical governance	Development of a framework	Sep 2020	
2		Interim report on the development of a framework	Apr 2020	
3	Alignment of resources	Review of clinical governance staff	Apr 2020	
4	Robust learning from deaths process	Review and implement	Apr 2020	
5	Ward to Board flow	• NED ward visits ○ Revision of tools ○ Observation of care process ○ Process up and running	 Feb 2020 Feb 2020 March 2020	
6	Framework for monitoring corporate teams	Roll out RAIT for corporate teams (Infection control, safeguarding, pressure ulcers, falls) Peer panels set up Panels commenced Review of effectiveness	 Mar 2020 Mar 2020 July 2020	
7	Clear escalation process in place for quality issues	Develop a framework for escalation Implement	Mr 2020 July 2020	

REF	GAP	ACTION	BY WHEN	PROGRESS
8	Oxford University risk maturity assessment	Arrange for OUH to visit and assess	tbc	

BAF RISK REFERENCE *Summary for Datix entry*	5 Home First Worcestershire implementation	**DATE OF REVIEW**	Feb 2020
DATIX REF	3832 (linked to corporate risks 3482, 3483, 3831, 3877, 3946)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
If we fail to implement Home First Worcestershire as scheduled then there will be an impact on our ability to see, treat and discharge patients in a timely way which may result in patient harm and curtails urgent elective activity.	INITIAL	4	5	20	⇔
	TARGET Sep 2020	2	5	10	
	PREVIOUS				
	CURRENT	4	5	20	

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and best outcomes for our patients
GOAL	Performance, Quality
RISK APPETITE	Low

ACCOUNTABILITY

CHIEF OFFICER LEAD	COO
RESPONSIBLE COMMITTEE	F&P/QGC

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	CQC report from unannounced inspection Dec 2019	CQC	3
2	Action plan incorporating the must and should dos	TME/F&P/QGC	2
3	Implementation of the onward care team (OCT)	A&E Delivery Board, System Improvement Board	3
4	Additional 33 beds, open Feb 2020	F&P	2
5	Additional pathway 1 (home with support) packages	System Improvement Board/HFW Board/TME/F&P	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Implementation of the HFW Plan	Implementation of the 6 work streams contained within Home First Worcestershire including the MADE recommendations	Sep 2020	Additional resource commissioned to support the implementation of the programme

BAF RISK REFERENCE *Summary for Datix entry*	6 Implementation of year 1 of Digital Care Record Business Case	**DATE OF REVIEW**	Feb 2020
DATIX REF	(linked to corporate risks 4107, 3603)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
If we do not implement year one of the digital care record business case in a timely coordinated way, then we may not be unable to utilise the system for the benefit of patients, resulting in delayed and poorly coordinated care for patients and a poor patient experience.	INITIAL	4	4	16	⇨
	TARGET	2	4	8	
	PREVIOUS	4	4	16	
	CURRENT	4	4	16	

CONTEXT

STRATEGIC OBJECTIVE	Best use of resources
GOAL	Digital
RISK APPETITE	Low

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Digital Officer
RESPONSIBLE COMMITTEE	F&P

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Governance for implementation of Digital Strategy	Report to TME/F&P/Trust Board	2
2	Alignment to STP Digital Strategy	STP Digital Board	3
3	Implementation of cybersecurity plan	Audit and Assurance Committee	2
4	Internal audit report on clinical systems	Internal audit/Audit and Assurance Committee	2
5	Implementation of the three digital strategy strands	F&P	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Infrastructure modernisation programme funding	Business cases developed and agreed	Jun 2020	

REF	GAP	ACTION	BY WHEN	PROGRESS
2	Recruitment and staffing	Detailed recruitment plan	April –Sept 2020	(phased implementation)

BAF RISK REFERENCE *Summary for Datix entry*	7 The Trust is unable to ensure financial sustainability (to the level of structural deficit) and make the best use of resources for our patients.	**DATE OF REVIEW**	Feb 2020
DATIX REF	(linked to corporate risks 3788, 4099)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGETS		RATING	L	C	R	CHANGE
If we fail to address the drivers of the underlying deficit then we will not achieve financial sustainability (as measured through achievement as a minimum of the structural level of deficit) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	2021	5x3	INITIAL	5	3		⇨
			TARGET 2023	4	3		
			PREVIOUS	5	4		
			CURRENT	5	4		

CONTEXT

STRATEGIC OBJECTIVE	Best use of resources
GOAL	Finance
RISK APPETITE	Low

ACCOUNTABILITY

CHIEF OFFICER LEAD	CFO
RESPONSIBLE COMMITTEE	F&P

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Grip and Control measures including weekly vacancy control process in line with NHSI best practice and regular review of Standing Financial Instructions and Scheme of Delegation	TME, Finance and Performance Committee, Audit and Assurance Committee	2
2	Divisional Performance Review Meetings (including Corporate teams) with focus on financial / improvement outcomes and monitoring of devolved operational budgets	TME, Finance and Performance Committee via finance report and IPR	2
3	Medium Term Financial (MTF) Plan	TME/F&P/Trust Board/NHS Improvement	2/3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	MTF Plan (Road-Map)	Align the MTF Plan to Clinical Services Strategy, other Enabling Strategies (People and Culture, Digital, Estates, Quality	Jun 2020	

REF	GAP	ACTION	BY WHEN	PROGRESS
		Improvement, Communications), 2020/21 Operational Plan and ICS 5 year plan and publish		
2	Fully identified and assignable improvement opportunities based on recognised benchmarks (e.g. Model Hospital / GIRFT)	Ensure rolling programme of continuous improvement internally and system wide working to support value for money decisions	Mar 2021	
3	Ownership of financial situation	Finance is included within personal objectives, and roles and responsibilities clearly defined, which are aligned to Trust objectives Embed improved through life-cycle contract management principles Embed the standardised approach to benefits realisation for key financial decisions	Mar 2021	

BAF RISK REFERENCE *Summary for Datix entry*	8 The Trust is unable to secure appropriate capital financing to make the best use of resources for our patients.	**DATE OF REVIEW**	Feb 2020
DATIX REF	(linked to corporate risks 4048, 4130, 4213)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGETS		RATING	L	C	R	CHANGE
If we are not able to secure financing then we will not be able to maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	**2021**		**INITIAL**	3	5		⇨
			TARGET 2022	3	4		
			PREVIOUS	5	4		
			CURRENT	5	4		

CONTEXT

STRATEGIC OBJECTIVE	Best use of resources
GOAL	Finance, Estates
RISK APPETITE	Low

ACCOUNTABILITY

CHIEF OFFICER LEAD	CFO
RESPONSIBLE COMMITTEE	F&P

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Prioritisation of investment bids based on risk to ensure best use of limited funds available, including in year re-prioritisation where required	Capital Prioritisation Group, Strategy & Planning Group, TME and F&P Committee	2
2	Pro-active seeking and management of funding bids and review of outcomes	Strategy & Planning Group, TME and F&P Committee	2
3	Medical devices strategy	TME/QGC	2
4	Estates and facilities condition assessment plan for implementation	TME/F&P	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Medical Devices strategy	Scoping / Stocktake exercise completion Develop investment strategy and prioritised replacement plan based on operational asset register.	Jun 2020 Dec 2020	
2	Estates and Facilities Condition	Undertake 6 Facet Survey to confirm current backlog position	June 2020	

REF	GAP	ACTION	BY WHEN	PROGRESS
	Assessment	and enable development of rectification plan.		
3	MTF plan	Align the MTF Plan to Clinical Services Strategy, other Enabling Strategies (People and Culture, Digital, Estates, Quality Improvement, Communications), 2020/21 Operational Plan and ICS 5 year plan and publish	June 2020	

BAF RISK REFERENCE *Summary for Datix entry*	9 Diverse and flexible workforce (workforce transformation)	**DATE OF REVIEW**	Feb 2020
DATIX REF	(linked to corporate risks 3877, 3831, 3832)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET	RATING	L	C	R	CHANGE
If we do not have a sustainable fit for purpose diverse and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.	2022 4x3	INITIAL	5	3	15	
		TARGET 2023	3	3	9	
		PREVIOUS			15	
		CURRENT	5	3	15	

CONTEXT

STRATEGIC OBJECTIVE	Best people
GOAL	Workforce and culture
RISK APPETITE	Moderate

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Revised P&C Strategy – year 1 of implementation	TME/P&C Committee	2
2	Workforce transformation – delivery of financial targets	TME/F&P Committee	2
3	5 year strategic workforce plan	TME/P&C Committee, NHS E/I	2/3
4	Recruitment and retention plans	TME/P&C Committee	2
5	Academy development	TME/P&C Committee	2
6	Equality and diversity strategy	TME/P&C Committee/Trust board	2
7	Timewise/flexible working	TME/P&C Committee	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Revise P&C Strategy	Strategy revised and presented to Trust Board	Jun 2020	Mar P&C, Jun TB
2	Workforce plan	Implementation of year one of strategic workforce plan	March 2021	

BAF RISK REFERENCE *Summary for Datix entry*	10 Organisational culture	**DATE OF REVIEW**	Feb 2020
DATIX REF	(linked to corporate risks 3877, 3831, 3832, 3842)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
If we fail to sustain the positive change in organisational culture, then we may fail to attract and retain sufficiently qualified, skilled and experienced staff to sustain the delivery of safe, effective high quality compassionate treatment and care.	INITIAL	3	5	15	⇩
	TARGET	2	3	6	
	PREVIOUS	3	5	15	
	CURRENT	4	3	12	

CONTEXT

STRATEGIC OBJECTIVE	Best people
GOAL	Workforce and Culture
RISK APPETITE	Moderate

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	People and Culture Strategy	TME/P&C Committee	2
2	4ward phase 2	TME/P&C Committee	2
3	Leadership plan	TME/P&C Committee	2
4	Communications and Engagement Strategy	TME/P&C Committee	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	P&C Strategy	Develop revised strategy and present to TB	Jun 2020	
2	Phase 2 – 4ward	Roll out of phase 2 of 4ward	May 2020	
3	C&E strategy	Implement year 1 of the C&E strategy	March 2021	

BAF RISK REFERENCE *Summary for Datix entry*	11 Reputational damage	**DATE OF REVIEW**	Feb 2020
DATIX REF	3940 (linked to corporate risks 3877, 3948, 3831)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET		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.	2021	3x4	INITIAL	4	4		⇧
			TARGET 2024	2	4		
			PREVIOUS	3	4		
			CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people, best experience, best use of resources, best people
GOAL	Strategy/quality/finance/performance/culture
RISK APPETITE	Moderate

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of Communication and Engagement
RESPONSIBLE COMMITTEE	People and Culture/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 putting people first	Report to 4ward and People and Culture Committee	1-2
3	On-going programme of stakeholder engagement	Communication report to TME/People and Culture/TB	2
4	Communications Strategy	People and Culture	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Implement communications strategy	Develop and implement action plan	Mar 2021	

Corporate Risk Register (summary) as at 6-2-20

3482 – Operations – crowding in the Emergency Department
3483 – Clinical Quality and Effectiveness – effective management of tracking processes
3603 – risk that a cyber-attack could lead to the potential loss or theft of patient data and could compromise patient care
3788 - Cash Flow – there is a risk that the Trust does not generate sufficient cash incomings through contracted services provided
3831 – nursing recruitment and retention
3832 – Workforce Planning
3833 – Mandatory Training completion rates
3842 – HR/OD capacity
3852 – Clinical – safe, clean environment
3855 – risk of Trust utilising an unsupported PC/laptop operating system after January 2020
3877 – reputational – junior doctors on rotation
3946 – Clinical Quality and Effectiveness – Trust wide capacity situation
3948 - Fragile services
4009 - Lack of comprehensive asset register
4048 – Decontamination of medical devices
4099 - Achievement of the 2019/20 financial plan
4107 – Risk of loss of data and cyber attack to unsupported ICT systems that reside out of ICT
4130 – Access to funding for asset replacement and renewal
4213 – Risk of damaged or contaminated theatre instruments being present on theatre sets

Glossary

CGG	Clinical Governance Group
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CQC	Care Quality Commission
C&E	Communications and Engagement
F&P	Finance and Performance Committee
HFW	Home First Worcestershire
ICS	Integrated Care System
MTFP	Medium Term Financial Plan
NHS E/I	NHS England/Improvement
OCT	Onward Care Team
OD	Organisational Development
QGC	Quality Governance Committee
RTT	Referral to treatment
STP	Sustainability and transformation partnership
TME	Trust Management Executive

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	D3

#WeAreVolunteering:
Worcestershire Acute Hospitals Trust Volunteering Strategy 2020-2025
"Putting Patients First": an integrated partnership for our staff, volunteers, the public, voluntary organisations and healthcare providers

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

Accountable Director	Vicky Morris – Chief Nursing Officer		
Presented by	Anna Sterckx, Head of Patient, Carer and Public Engagement	**Author /s**	Anna Sterckx, Head of Patient, Carer and Public Engagement

Alignment to the Trust's strategic objectives							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Patient Public Forum	09.01.2020	Endorsed
TME and QGC	December 2019	Noted
TME	January 2020	Further clarification sought in relation to finance and links to Putting Patients First
TME	February 2020	Approved
QGC	March 2020	Approved subject to further discussion about the involvement of charitable funds

Recommendations	The Trust Board is asked and invited to: • Note and discuss the strategic principles, priorities and aims underpinning the #WeAreVolunteering Strategy. • Approve the strategy.

Executive summary	This is the first time the Trust has developed a strategy for volunteering. The process undertaken in the development of the strategy has been a collaborative one throughout with volunteers, Patient Public Forum members and staff. This has resulted in all involved feeling that their voice has been heard. The outcomes from this strategy have been aligned throughout with our mission as a Trust of *Putting Patients First;* it facilitates the enabler within the organisational pyramid of the *Quality Improvement Strategy* and it directly supports the *People and Culture Strategy* and the *Medium Term Financial Plan*. Volunteering sits directly within the

	Quality Improvement Strategy and by attracting more volunteers, there is increased opportunity for direct engagement to shape further the implementation plans for our Clinical Services Strategy going forward into 2020. The strong message from our volunteers was that they ultimately come to support our Trust for the benefit of the patients and to support our staff; this is out of a deep "Pride in the NHS" (engagement events in October). This strategy sets out a clear path to enable our Trust to meet our Vision of working *in partnership/to provide the best healthcare/ supporting teams to move 4ward* by providing a non-paid workforce of hundreds of committed, skilled and dedicated members of the local community to free up time for our paid workforce to clinically care and work in partnership for improved patient experience.

Risk									
Key Risks	*Core investment is needed in volunteering to support the effective administrative functioning of the service and to maintain scrutiny with key safety compliance.*								
Assurance									
Assurance level	**Significant**		**Moderate**	*x*	**Limited**		**None**		
Financial Risk	*Current funding for the temporary Volunteer Manager will end in March 2020. Winter pressures funding for volunteering will part-support a fixed term 11 month post. The volunteering model across Acute settings is a service supported either by an existing agency, such as RVS or by the hospital Charity.*								

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	D3

Introduction/Background

The volunteer strategy will have a supporting implementation plan with specific milestones to enable the Trust to become the "go to" organisation for volunteering in the county and realise the ambition to be recognised as a local and national leader of excellence and innovation.

The co-designed approach throughout the development of the Strategy stands as an example of best practice and is an enabler of the Trust vision and purpose of *Putting Patients First* by focusing on the delivery of better services through direct engagement and partner working with our patients, volunteers and staff.

To achieve the strategic aims, it is necessary to invest in volunteering financially to develop core building blocks in year 1 with the potential for sustainable growth development from year 2 going forwards. The method of active engagement with stakeholders will continue with the roll out of the strategy, ensuring active participation and inclusion of Trust volunteers, partner agency volunteers, Trust staff and the public, alongside partners across the health economy, locally and nationally. This collaborative approach will ensure continued "by-in" and ownership and supports sustainability of the volunteering programme in terms of joint ownership.

Volunteers add a significant, positive impact and directly support with operational pressures, with the right fundamental framework in place. This support requires dedicated staffing to ensure a considered and standardised approach to delivery. Funding is being sought from NHS E/I and the Worcestershire Acute Hospitals Charity.

We are developing a volunteer app which will support live reporting and tracking of volunteer activity.

Issues and options

This strategy is our commitment to implement a considered approach to volunteering over the next 5 years that will match volunteers with a variety of extended opportunities across our hospitals, strengthening our community partnerships and directly draw on the expertise of volunteers to work with us to address increasing complex needs. Our responsive approach will ensure that relevant training programmes and mentor schemes are part of our offer, alongside clear expectations for staff and volunteers.

An implementation plan with Key Performance Indicators per year will be drawn up, setting out yearly aims, objectives, commitments and goals. Key to implementation success each year will be the active engagement of and subsequent ownership by staff across Divisions for volunteers and volunteering.

Our volunteers have asked for investment to make it easier to be a volunteer at our hospitals and this will be our primary focus in year 1: developing the infrastructure to launch developments in year 2 onwards.

The strategy is focused around four key "**We Will**" pillars;

1. **We Will** Effectively Communicate
2. **We Will** Make it Easier to Volunteer

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	D3

3. **We Will** Value and Appreciate our Volunteers
4. **We Will** do this by

Recommendations

The Trust Board is asked and invited to:

- Note and discuss the strategic principles, priorities and aims underpinning the #WeAreVolunteering Strategy.
- Approve the strategy.

Appendices: #WeAreVolunteering strategy

#WeAreVolunteering

Worcestershire Acute Hospitals NHS Trust Volunteering Strategy 2020-2025

"Putting Patients First": an integrated partnership for our staff, volunteers, the public, voluntary organisations and healthcare providers

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Graphic illustrations capturing themes and conversations as they happen about why people volunteer.
Above: Volunteer Engagement Strategy Workshops: October 2019 in Redditch and Worcester.

1. INTRODUCTION

The purpose of this strategy is to realise our ambition to grow, develop and raise the profile of volunteering at Worcestershire Acute Hospitals Trust (WAHT).

The process to design this strategy has been about inclusivity and continued conversation throughout the development process; starting as we mean to continue forwards, valuing the contribution of volunteers alongside paid professionals. This has been a process of collaboration which has resulted in our volunteers feeling that their voice has been heard.

#WeAreVolunteering is a strategy that draws on where we are "getting it right" and where we can improve – it is a responsive document that focuses on providing a sustainable volunteering programme designed directly from the feedback shared by volunteers, some of whom have been volunteering at WAHT for more than 50 years and others who have recently joined us. This is underpinned by a national recognition of the positivity of volunteering – for both the organisation and the health and wellbeing of the individual and is set against the backdrop of a proud NHS tradition with volunteering playing a vital role in supporting the service for more than 70 years.

Volunteers have pride in our NHS and give their unpaid time, commitment, energy, skills and life experiences. These volunteers carry out a beneficial and significant role in supporting patients, their carers, families and staff, making a positive contribution to our NHS community. This vital and practical support, given in a variety of ways positively enhances the patient, carer and staff experience.

Our volunteering strategy is underpinned by our local trust mission of *Putting Patients First* and directly supports *Our Vision* and Our Strategic Objectives of *working in partnership to provide the best healthcare for our communities, leading and supporting our teams to move 4ward*. More than a document, this strategy is a practical implementation tool with a clear focus and measurable milestones. This is about an ongoing effective partnership between our volunteers, our carers, our patients and our staff, enabling the *best use of resources* with teams of empowered volunteers supporting our staff to prioritise critical care.

Our volunteering strategy is about *best services for local people* and the potential to support with some of the biggest challenges facing our health services locally and nationally today. It is also about *best people* and includes a focus on how volunteers support the delivery of high standards of patient and person-centred care and not only focuses on current volunteer retention but on the mobilisation and recruitment of a greater number of volunteers from a wide variety of backgrounds.

Staff, patients and volunteers benefit from well-designed volunteering initiatives. The NHS Long Term Plan includes a commitment to doubling the number of volunteers in the NHS with the provision of resources to "up-scale" the Helpforce programme. To realise the benefits that this programme can offer both now and in the future, the development of sufficient staffing infrastructure is key to the success of the strategy alongside commitment from staff across wards and clinics to actively engage with our volunteer workforce: https://www.longtermplan.nhs.uk/online-version/chapter-4-nhs-staff-will-get-the-backing-they-need/8-volunteers/.

When we asked our volunteers, why they volunteer with us, we heard that people "want to make a difference", "to improve the experience" and "do everything I can to help". Our volunteers are proud of their hospitals and proud of our NHS.

"Volunteering is a key enabler in transforming the way the NHS works with people and communities". The NHS 5 Year Forward View conveys the importance for health organisations to design "easier ways for voluntary organisations to work alongside the NHS" and that the NHS can go further, accrediting volunteers and devising ways to help them become part of the extended family – an active part of the caring partnership.

Survey data analysis for The King's Fund report, funded by the Department of Health Volunteering in acute trusts in England: Understanding the scale and impact estimates "that for the average trust, the return on investment is likely to be around 11 times the actual cost of supporting volunteering". Over the past 6 years volunteering has gained prominence with social and community action receiving unprecedented national recognition. This has supported an evolution of volunteering in acute hospital settings, offering an ever widening scope of volunteering, matching volunteers to organizational, staff and patient needs. Emerging best practice driven by support from new national programmes has enabled a reduction in "Did not attend" rates by around 50%, bleep volunteers in emergency departments, support with end of life care, improved hospital discharge times and patient mobility support.

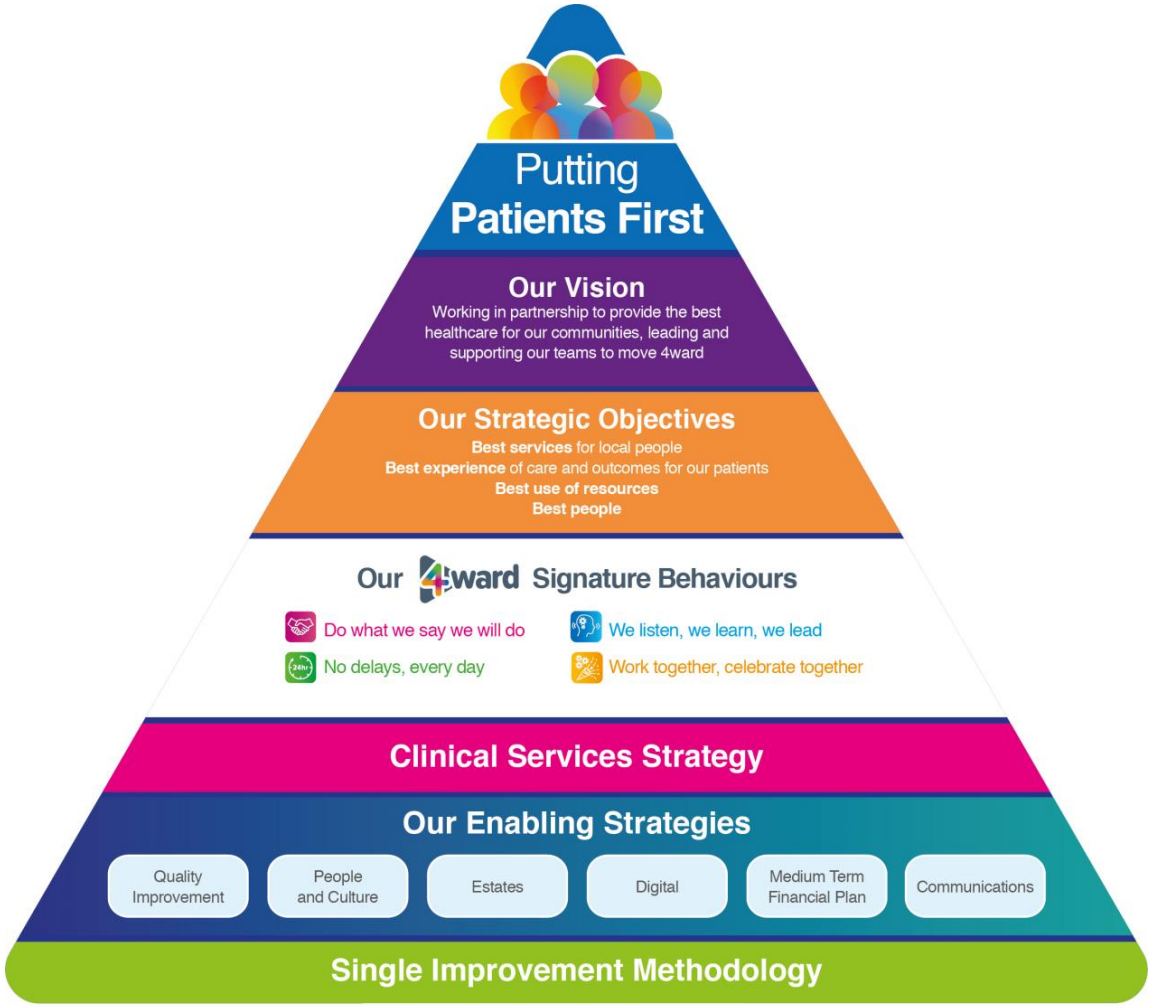
The public shared with us (at consultations in November 2019) that patients sometimes feel that they do not want to disturb nurses – volunteers are well placed to support our patients with what may seem like the "little things" but which actually can have huge and very positive implications. This ranges from help to get out of bed and take a short walk to escorting patients to collect medicine and tackle #PJParalysis https://www.worcsacute.nhs.uk/news-and-media/714-70-days-to-end-pyjama-paralysis. In a variety of ways our volunteers can directly support with mobilisation and isolation, they can help in a number of ways that are not necessary "core duty" but all of which can *increase productivity* in the clinical environment and deliver *person-centred care with improved outcomes.*

#WeAreVolunteering enables us to increase the diversity of our volunteer roles and increase the numbers of volunteers within a quality framework. This facilitates the NHS People Plan by "releasing time to care", supporting critical capabilities in the key areas of systems leadership and service quality improvement and by developing a potential future workforce through increased volunteering and work programme experiences.

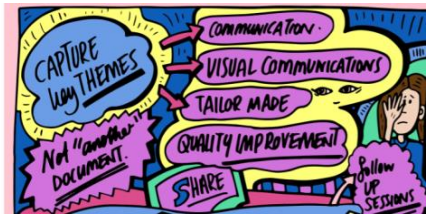
#WeAreVolunteering is about *Putting Patients First*, it is one of the solutions to each of our four trust strategic objectives *Best Services, Best experience, Best use of resources and Best people* and it sits as one of the commitments in our *Quality Improvement Strategy* which is one of our trust *enabling strategies.*

#WeAreVolunteering is about a process of creation and the resulting responsive outcomes, all of which have been created using our *4ward signature behaviours*. The roll out of this strategy enables us to *Do as we say we will do* following direct feedback from our volunteers, the public and staff and the details and design demonstrate how *We listen, we learn, we lead.* The core focus is themes around our 4ward behaviours and our trust core values.

#WeAreVolunteering is an enabling strategy for our hospitals and our community that will ensure our ability to create a significant and positive impact to the patient, carer and staff experience.



#WeAreVolunteering makes a positive contribution to the delivery of our vision for the future of our trust. The strategy supports our focused purpose, Putting Patients First, it is a mechanism to realise our four strategic objectives and is firmly rooted in our enabling strategies.
Our 4ward Signature Behaviours have guided this strategy in both its development and delivery.



2. WHAT OUR STRATEGY WILL DO

Each step taken in the design of this strategy has been taken *with* our volunteers. Our strategy has been developed and created through a series of engagement events and workshops, consultations with staff and the public and networking with health providers and advisors, locally, regionally and nationally. The result is a co-produced "fit for purpose" strategy to meet current need and future development against a local and national background of mounting challenges, pressures and complexities locally and nationally in the NHS.

This strategy is for everyone who has responsibility for, interest in or would like to support the development of volunteering in health across Worcestershire.

"Volunteering is something people do because they want to, not for financial reward. They will want their contribution to be clearly defined and valued and they will need support" (National Council for Voluntary Organizations NCVO).

Active engagement from the start of the recruitment process, through to placement and on-going support is crucial to support every volunteer to feel part of a welcoming team that values, respects and appreciates volunteers.

This strategy is our commitment to implement a considered approach to volunteering over the next 5 years that will match volunteers with a variety of extended opportunities across our hospitals, strengthening our community partnerships and directly draw on the expertise of volunteers to work with us to address increasing complex needs. Our responsive approach will ensure that relevant training programmes and mentor schemes are part of our offer, alongside clear expectations for staff and volunteers.

Our volunteers have asked for investment to make it easier to be a volunteer at our hospitals and this will be our primary focus.

The strategy is focused around four key "**We Will**" pillars. These pillars sit within our *4ward Signature Behaviours* as a set of commitments;

1. **We Will** Effectively Communicate
2. **We Will** Make it Easier to Volunteer
3. **We Will** Value and Appreciate our Volunteers
4. **We Will** do this by

Wrapped around this, is a commitment to ensure that an effective induction process is in place for every volunteer alongside on-going opportunities to feedback.
Volunteers shared their expectations of the strategy at October 2019 Volunteer Engagement Strategy Workshops – to **ensure 4ward Signature Behaviours** "**Do what we say we will do**", create an **effective implementation document** and keep communication open.

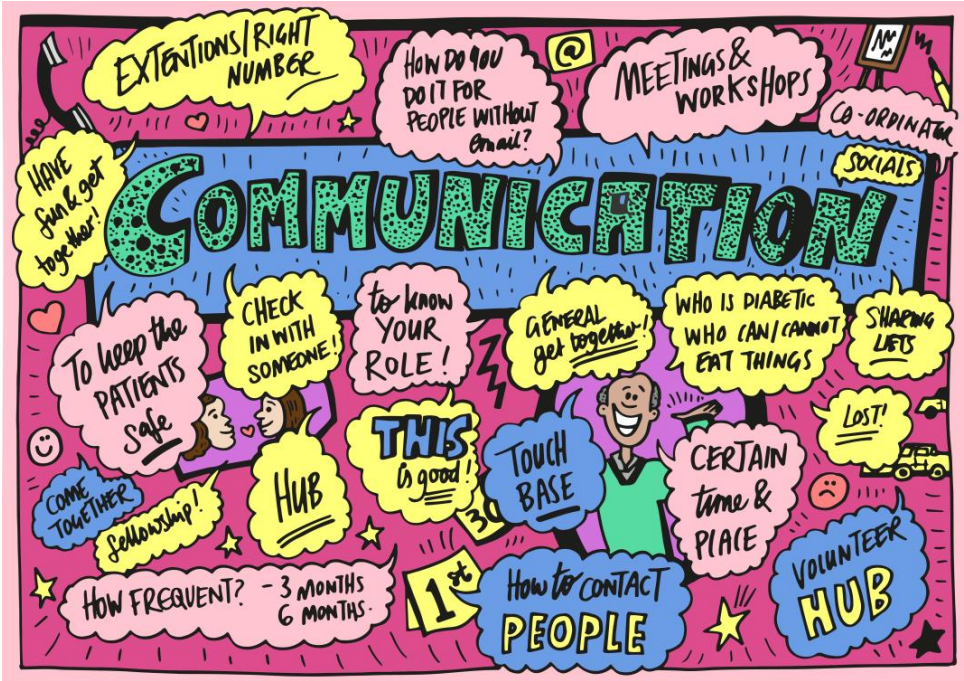
Do what we say we will do

Pillar 1

We Will:

1 Effectively Communicate

- We will provide a **Hub** and touch base spaces for volunteers to come together
- We will support **Volunteer Newsletters** and a noticeboard
- We will provide access to a designated **online "V" portal**
- Recruit a team of "volunteers for volunteers" to directly support the strategy
- We will provide a variety of ways for volunteers to regularly feed back
- Volunteer handbook
- We will launch our "**Adopt a Volunteer**" programme to support staff to support our volunteers
- Explore opportunities for volunteers to "do more" including bleeps for volunteers



Graphic illustration from October Strategy Workshop events capturing "Communication" as a key theme: October 2019 in Redditch and Worcester.

At December Engagement Events, volunteers voted for communication as a top theme.

No delays, every day

Pillar 2

We Will:
2. Make it Easier to Volunteer

- Strengthen support for volunteering and demonstrate our commitment to deliver by appointing a Volunteer Programme Manager who will be supported by a Volunteer Co-ordinator
- We will aim to recruit, train and place volunteers every 2 months
- We will offer relevant training
- We will offer mentoring and shadowing to every volunteer
- We will explore ways to ensure that every volunteer feels part of a team
- We will make sure that every volunteer knows their role and what is expected
- We will offer volunteer expenses and promotion of the park and ride

The key theme of "making it easier to volunteer" as shared by volunteers at all Engagement Events in 2019 and by the Patient Public Forum members at the January 2020 strategy review meeting.

At December Engagement Events, volunteers voted for making it easier to volunteer as a key priority.

We Will:
3. Value and Appreciate our volunteers

- We will recognise Volunteer Week annually
- We will hold an annual celebration event to recognise the contribution our volunteers make and to say thank you
- We will provide uniforms and badges "**I'm a volunteer: Ask me Why"**
- We will launch "**Swap Shop**": a skill matching online exchange to link what volunteers can give against skill requests from staff. This will be an internal recruitment process for existing volunteers
- **Xchange**: provide opportunity to visit other NHS Trust volunteering programmes
- Confirm an Executive Lead for Patient Experience and Volunteering on our Hospital Trust Board

The key theme of "value and appreciation" for our volunteers as shared by volunteers at all Engagement Events in 2019 and by the Patient Public Forum members at the January 2020 strategy review meeting.

At December Engagement Events, volunteers voted for valuing and appreciating volunteers as a key priority.

Measuring our progress

It is important to us to not only "**Do what we say we will do**" but work to make sure that we understand how we are doing every step of our volunteering journey. We listen, we learn, we lead

4. We will do this by:

- Improving ways volunteers and staff can feed back
- Continue conversations at x4 volunteer "touch base spaces" per year: for face to face conversations
- Include Volunteering in our Ward Accreditation Path to Platinum Quality Improvement Programme
- Exploring ways we can gain two-way "real time" volunteer and staff feedback
- Recruiting a Volunteer Programme Manager to support evaluations of strategy milestones
- Developing joint volunteering projects and strengthening partnership opportunities with local health providers
- Capturing our "reach" via virtual communication platforms
- Carrying out an Annual Volunteer Survey
- Responding to feedback and progress at an annual celebration event
- Benchmark the quality of our volunteering management programme through *Investors in Volunteers*
- Explore annual national benchmarking survey opportunities
- Annually sharing progress in our Quality Account report

“Help us to help you” (do more): “Volunteers for Volunteers”

Best people

Many of our volunteers are retired nurses and doctors, many are current professionals in HR, Managing Directors, cleaners, artists, accountants, Head Teachers… and they all have one thing in common; they want to do more. Conversations started in December 2019 to explore *with* staff what further opportunities could be opened up at WAHT. This strategy will provide opportunity to continue this dialogue.

Volunteers have shared that they can do more: accompanying patients to theatres, supporting administration, delivering training for volunteers, encouraging patients with exercises and fundraising. Many of our volunteers would like us to “tell us how we can help” – this ranged from patients on wards without family or clean clothes, to wanting to do “anything” to help “release nurses”. This strategy will enable pilot projects in key areas to grow our volunteering offer and will explore viability for work experience partnership projects – growing volunteering alongside growing our future workforce.

Implementation Plan

Year 1:

- **Staffing structure in place to provide a solid framework to take the strategy forward and benchmarking with national innovators in acute hospitals**

Year 2:

- **Engagement across Divisions embedded (clinical and non-clinical areas) to enable rapid support for volunteers**

Year 3:

- **Implement benchmarking tools to monitor effectiveness**

Year 4:

- **Embed non priority areas**

Year 5:

- **Evaluate**

Appendix 1

OUR APPROACH: HOW WE GOT HERE

568 people are registered as volunteers across our hospitals, enhancing and supporting the care and wellbeing of our patients, their carers, families and friends. Our volunteers support in a variety of ways from helping our visitors find their way to wards and clinics, which we call "Wayfinding", to assisting patients with feeding, supporting with drinks rounds and talking with our patients. This group is made up of Trust volunteers and people who volunteer at our hospitals with our partner organizations...

In 2018 as part of our NHS 70 celebrations, 150 volunteers came together to a thank you and networking event. Conversations at this event were picked up informally with volunteers and staff throughout 2019 to build a better picture of the experience of volunteering at Worcestershire Acute Hospitals Trust. These conversations included the emerging themes of communication, untapped potential and support.
Steps we have taken in 2019 to develop **#WeAreVolunteering**:

- In January we launched x50 Patient Experience Champions as part of our #TogetherWeArePatientExperience movement. Our champions told us that they wanted more volunteers to support work on the wards
- At Patient Experience Champion Days throughout 2019, staff started to explore ways to engage with volunteers
- The Helpforce Daily Mail campaign resulted in an additional 102 volunteer applications to join the Trust. One of the first Trusts to be selected the focus was to support the delivery of person centred care by enhancing our compassion and communication with an assisted feeding training programme and supporting access to the Friends and Family Test
- In April as part of our Patient Experience Week we opened recruitment to our first Hospital Youth Forum and recruited 12 young people aged 14-24 . This group was established following public feedback in 2018 from young people on our Riverbank ward.
- In October 2019 more than 100 came together from volunteering organizations to discuss and explore what was working well and where improvements are needed. The events were solutions focused
- In December 2019 76 people came together across the three hospital sites for a mince pie volunteer celebration, to look at the themes from our October events, discuss priorities and continue to shape our strategy together
- A November public consultation in Redditch led by members of our Patient Public Forum and Head of Patient, Carer and Public Engagement was undertaken to find out what the public know and how they feel about volunteering at our hospitals
- November conversations with staff in Redditch led by members of the Patient Public Forum and Head of Patient, Carer and Public Engagement to find out where volunteers could potentially support and to feedback from the public consultations
- Opportunities for staff to come together *with* volunteers and to "start the conversation" began in December 2019 and are an ongoing focus of the strategy. Active networking with other trusts began in January 2020 with access to sharing platforms to gather best practice nationally. The strategy will support a series of measures including the creation of Volunteering staff Leads across the hospital.
- Benchmarking/ Networking with local, regional and national Health and Care and Acute Hospital Trusts, local Clinical Commissioning Groups and NHS England has taken place throughout 2019 and continues into 2020

Appendix 2

Organisations that have been involved in the creation of this strategy include:

- Volunteers and staff at Worcestershire Acute Hospitals Trust
- The Patient Public Forum
- Worcestershire Acute Hospitals Trust Youth Forum
- Worcestershire Acute Hospitals Charity (Charitable Funds)
- Macmillan
- Therapy Dogs
- Chaplaincy
- Breastfeeding Friends
- Choice Radio
- The League of Friends of Alexandra Hospital
- The League of Friends of Kidderminster Hospital
- Friends of WRH
- Age UK
- Royal Voluntary Service
- Sight Concern
- Alzheimer's Society
- Charles Hastings Education Centre
- Beci Ward: illustrator
- The Pear Tree: Smite, Worcestershire

Appendix 3
A comprehensive set of illustrations capturing conversations from Engagement workshops and Events in 2018 and 2019 (available to members in the reading room).

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	D4

COVID-19 (Coronovirus) preparedness

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

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

Alignment to the Trust's strategic objectives							
Best services for local people	xx	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board are requested to receive this report for information

Executive summary	This paper summarises the response from the Trust with respect to COVID-19 (Coronavirus). This risk to individual patients remains low and the response is being coordinated centrally. The Trust is responding to the central requirements.

Risk									
Key Risks	As far as we are aware, people over the age of 50 with other conditions are at the most risk of having a serious illness as a result of contracting COVID-19. We are also mindful that if there is a serious outbreak, there may be significant numbers of staff who will have to either self-isolate or be off sick due to being infected.								
Assurance	The Trust is following national guidance on being prepared.								
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**		
Financial Risk	All expenditure relating to the COVID-19 virus is being met centrally.								

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	D4

Introduction/Background

At the time of composing this report, 51 individuals within the UK have contracted COVID-19 or Coronavirus. The NHS remains well prepared for further cases and this paper gives a local update to the preparations. The situation remains fluid and a verbal update will be given at the meeting.

I should like to thank you everyone who has been working hard to help with our preparations.

Issues and options

We are committed to keeping staff up to date and have set up a dedicated information page on the Trust intranet which contains links to the latest national picture and guidance. Weare also using screen savers and wallpaper to raise awareness on a daily basis.

For our response to COVID-19, we have followed the national guidance and we continue to do so. We have put in place three NHS 111 pods, so that anyone attending with symptoms of the virus can be swabbed in an area away from other patients and avoid causing unnecessary pressure in A&E. These are currently at the Working Well Centre in Worcester (24/7), at Alexandra Hospital (24/7) and at Kidderminster Treatment Centre (open during the day, 7 days a week). The pod at the Working Well Centre will be relocated to the main WRH site week commencing 9 March 2020.

We continue to respond to the national requests for information and we attend national telephone conference calls when requested to do so. We have also reviewed our infection control procedures and processes in relation to the management of infectious diseases and we are cascading Public Health England information as and when we receive it. We are monitoring our levels of stock (PPE and other clinical disposables) to ensure that we have sufficient without stockpiling.

We continue to work closely with our partners on this issue, including those within the private sector such as nursing homes. The Sustainability and Transformation Partnership will be reviewing the overall preparedness for COVID-19.

It should be remembered that the risk to individuals remains low.

Recommendations

The Trust Board are requested to receive this report for information

Appendices - none

Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	E1

Home First Worcestershire Programme – Update

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

Accountable Director	Paul Brennan COO		
Presented by	Paul Brennan COO	**Author /s**	Marsha Jones, PMO

Alignment to the Trust's strategic objectives							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust board are requested to receive this report for assurance.

Executive summary	The Home First Worcestershire (HFW) Programme has been created to improve the safety, efficiency and performance of the urgent and emergency care pathways at the Trust, focusing primarily on the elements of the pathway that are within our control. This summary report is not exhaustive in the description of improvements, new developments and new models of care, but captures the main areas of progress with the programme. There is an urgent need to accelerate implementation and in this respect, the improved governance and the recently strengthened resource in terms of capacity and expertise will increase pace and delivery.

Risk									
Key Risks	BAF risk 4								
Assurance									
Assurance level	**Significant**		**Moderate**	*X*	**Limited**		**None**		
Financial Risk									

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	E1

HFW Programme Update

The Home First Worcestershire (HFW) Programme has been created to improve the safety, efficiency and performance of the urgent and emergency care pathways at the Trust. Delivery against all work streams simultaneously is the only option to realise the benefits of this programme.

The overarching programme impact measures being monitored by the Home First Worcestershire Programme Board are as follows:

1. Reduction in the number of over 60 minute ambulance handover delays (SPC 1)
2. Comparison of discharge and admission rates (daily, weekly, monthly) (SPC 2)
3. Total time in A&E - 95th percentile - Trust – daily (SPC 3)
4. 30 day readmission rates for same clinical condition* - Trust – Daily (SPC 4)
5. Capacity gap - Trust – Daily (SPC 5)

*balancing measure

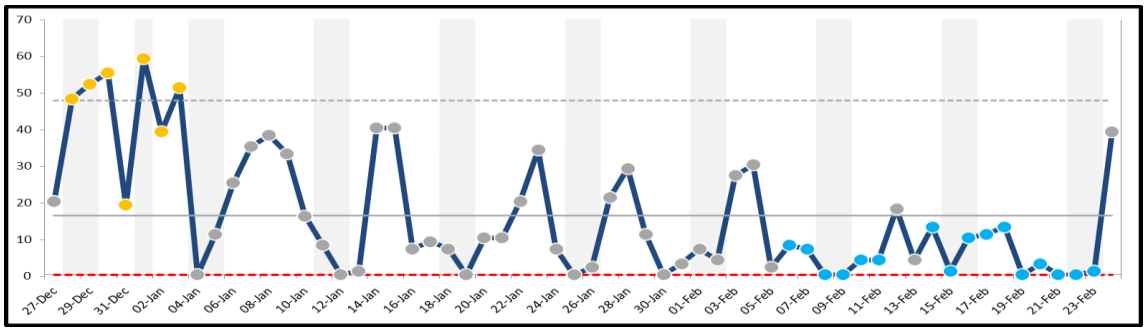
1.Overview of programme impact to date

SPC 1: WMAS > 60 minute handover delays - Trust – Daily

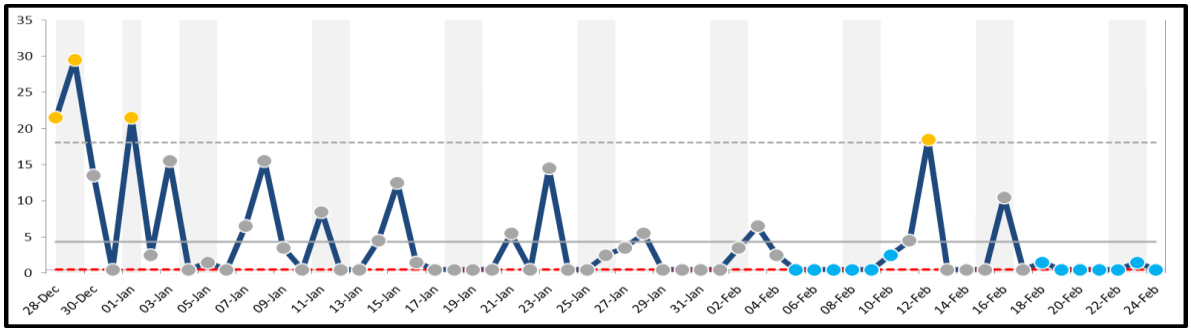
27th December 2019 to 23rd February 2020

Analysis shows improvements in the ambulance handover standard since the second week in February at both sites. This is follows a sustained period of poor performance over the Christmas period and uncontrolled variance throughout January on both sites but more notable on the Worcester site, particularly Monday to Friday.

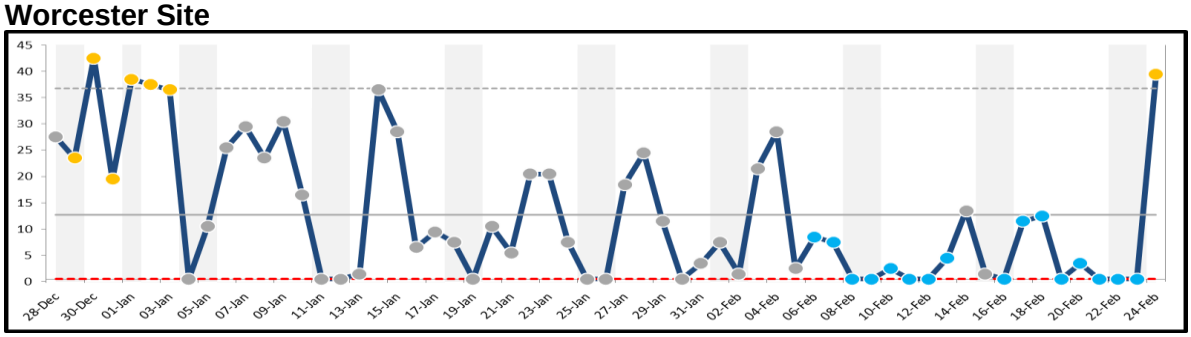
Trust wide – Daily



Redditch Site



Worcester Site

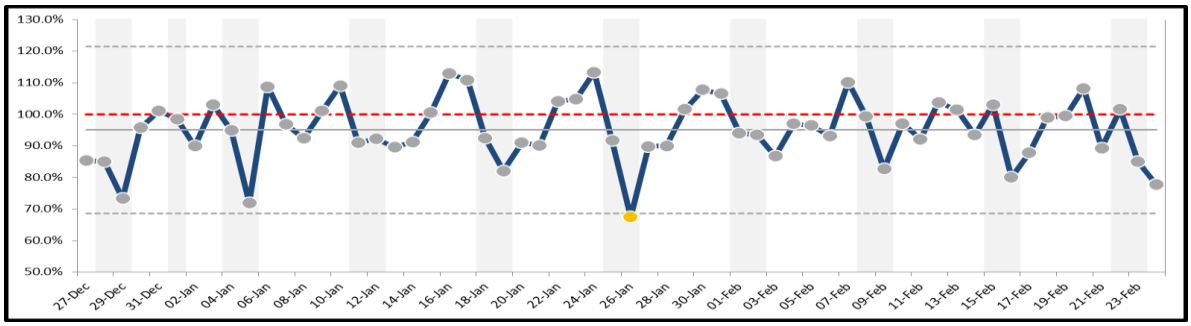


SPC 2: Comparison of discharge and admission rates (daily, weekly, monthly)

27th December 2019 to 23rd February 2020

Discharges from the hospital as a percentage of total admissions (Including non-elective and elective patients) has not shown any significant improvement in performance, since the start of 2020. Analysis shows that weekends (particularly Sundays) are where performance is at its worse. This is being addressed and aligned to the Red2Green/SAFER work stream and a programme of work has been developed to reinvigorate and sustain criteria led discharge to support more patients being discharged at weekends. The plan is discussed later in the Red2Green/SAFER work stream update.

Trust wide – Daily



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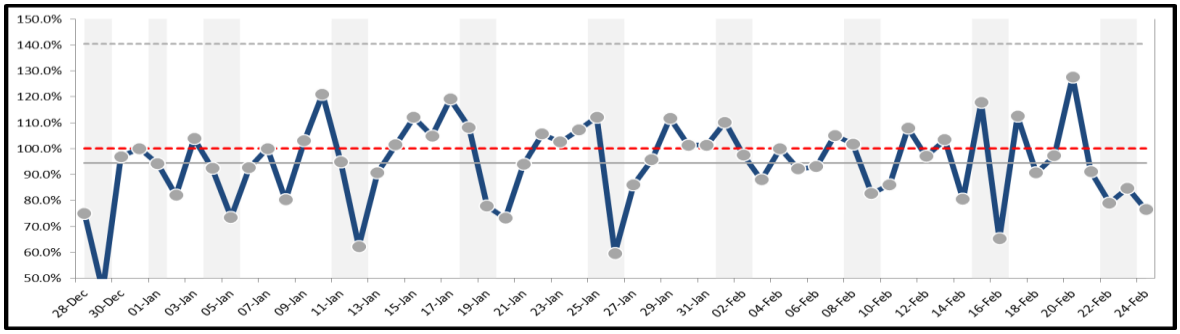
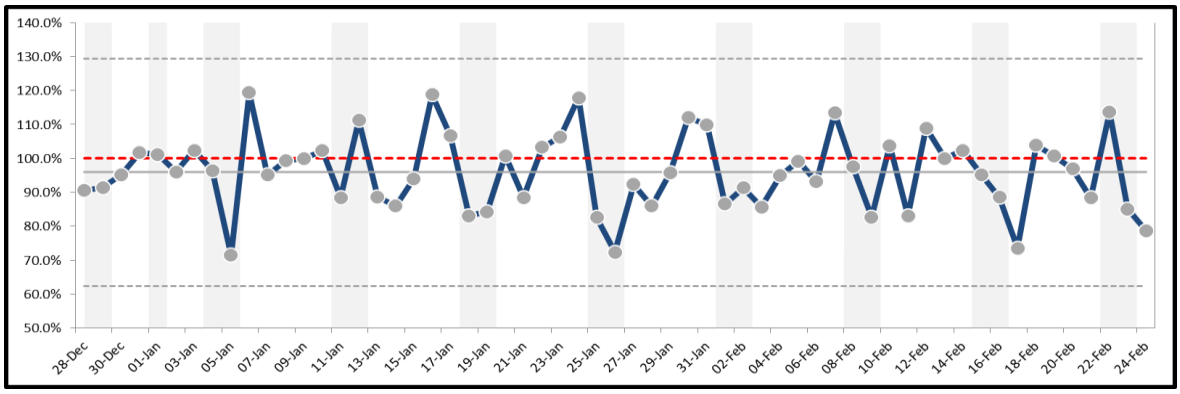
Redditch Site



Worcester Site

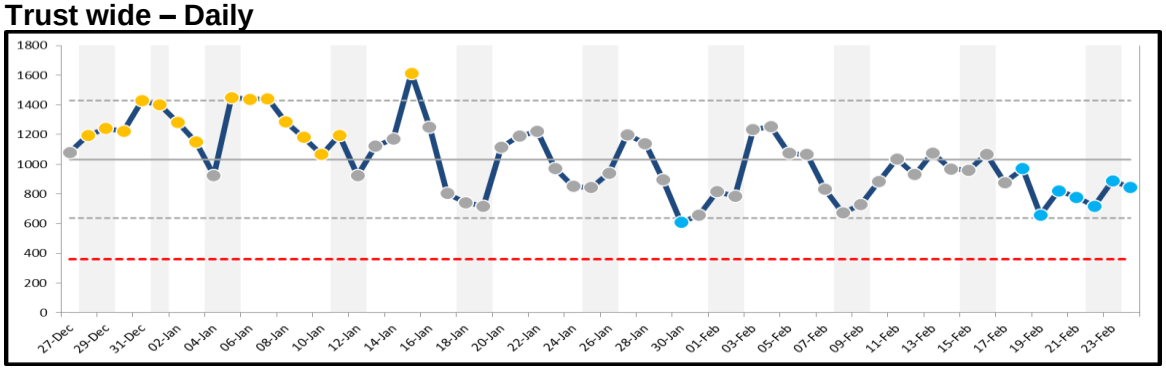


SPC 3: Total Time in A&E 95th percentile

27th December 2019 to 23rd February 2020

Length of stay in ED (95th percentile) has improved marginally across the Trust; however, this is predominately through improvement at the Worcester Royal Hospital site. The data for the Alexandra Hospital ED shows continued episodes of special cause variation, whereas, on the Worcester site the last 2 weeks have been more controlled moving to a shift in daily performance.

Trust wide – Daily



Meeting	Trust Board
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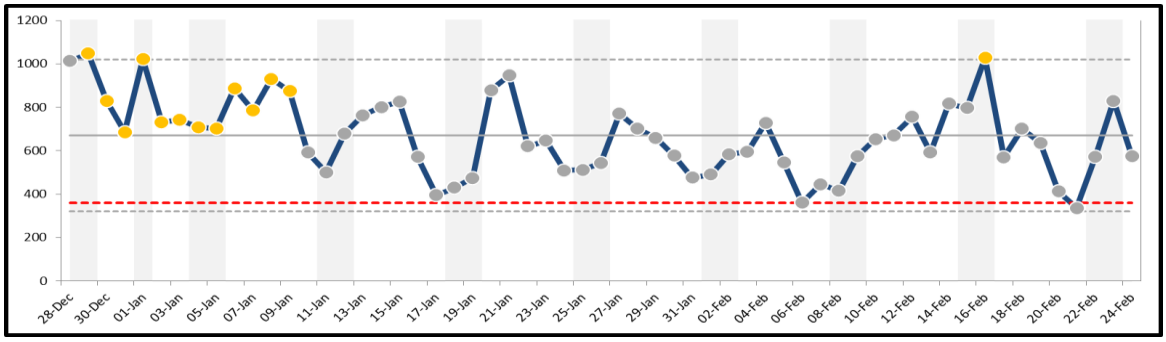
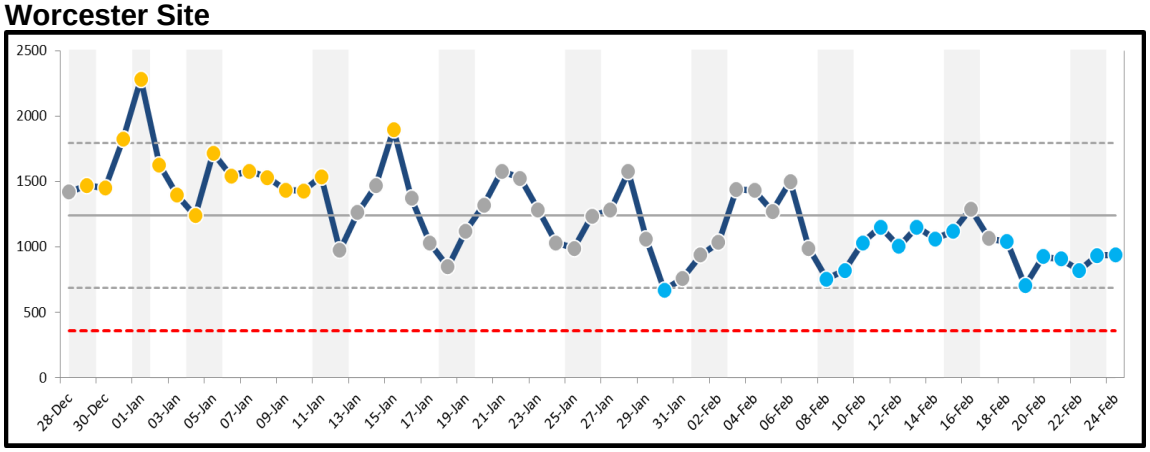


Worcester Site



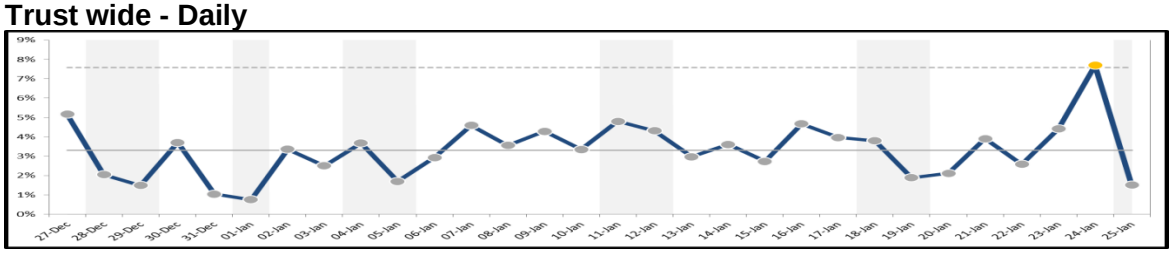
SPC 4: 30 day Readmission rates for same clinical condition - Trust – Daily

27th December 2019 to 23rd February 2020

The number of admitted patients that had been discharged from the hospital in the previous 30 days (only includes those readmitted with the same condition) is being closely monitored. This is in particular aligned to the Frailty/HAFD work stream following recent tests of change and is discussed in the Frailty/HAFD work stream update. This will also become an increasingly significant impact measure as we move to more same day emergency care through the SDEC work stream actions.

Whilst there was a special cause variation on a single day in January this does not relate to any related tests of change. Other than this single day there has been controlled variation not exceeding the upper process limit of 7%.

Trust wide - Daily



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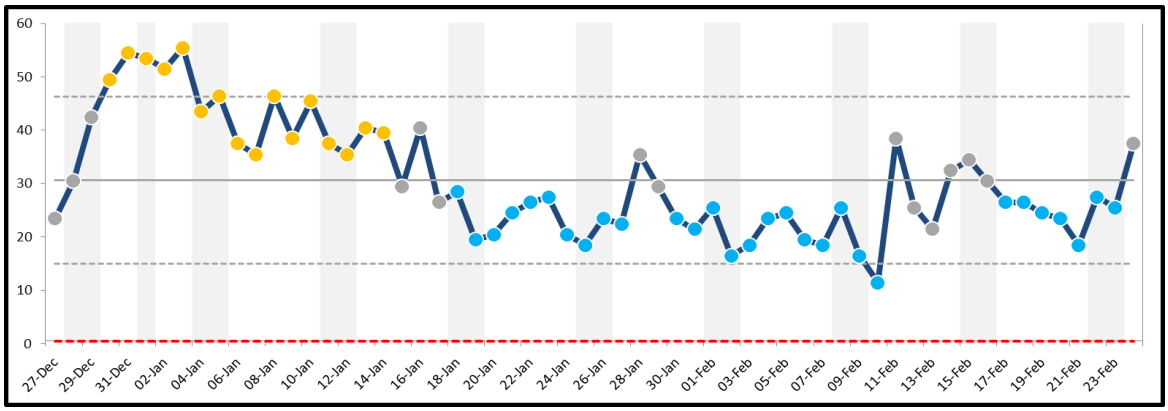
SPC 5: Capacity gap

27th December 2019 to 23rd February 2020

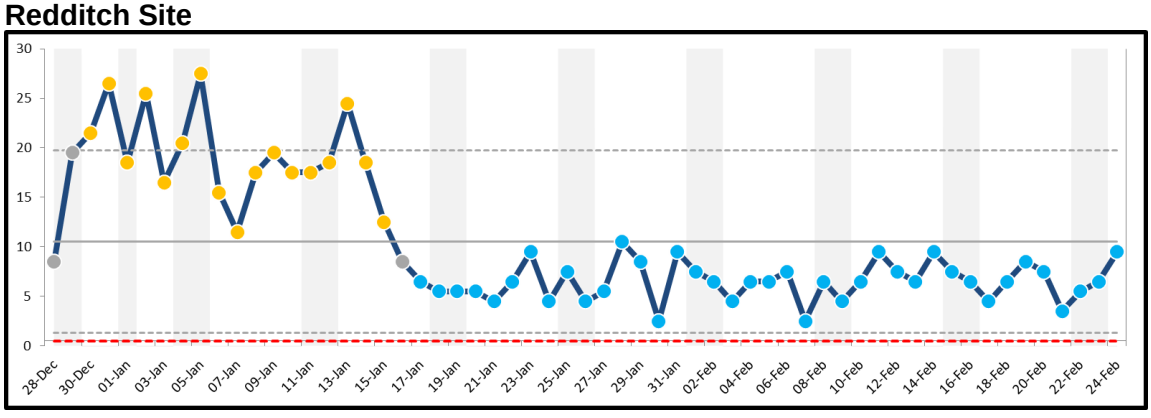
This metric has evolved to include patients either in ED with a decision to admit or boarding on a ward at midnight. Boarding is calculated by the difference between the capacity and number of patients on each ward. This is to represent a true reflection of the site whereby, there may be additional 'surge' capacity in use.

Despite a reduction in the overnight bed capacity gap we have not yet generated enough capacity to cope with peak periods of attendances which then result in corridor care and/or ambulance handover breaches. The bed occupancy levels at the Worcester site remained above 100% in January, with Redditch fluctuating between 98 - 99%.

Trust wide – Daily



Redditch Site



Meeting	Trust Board
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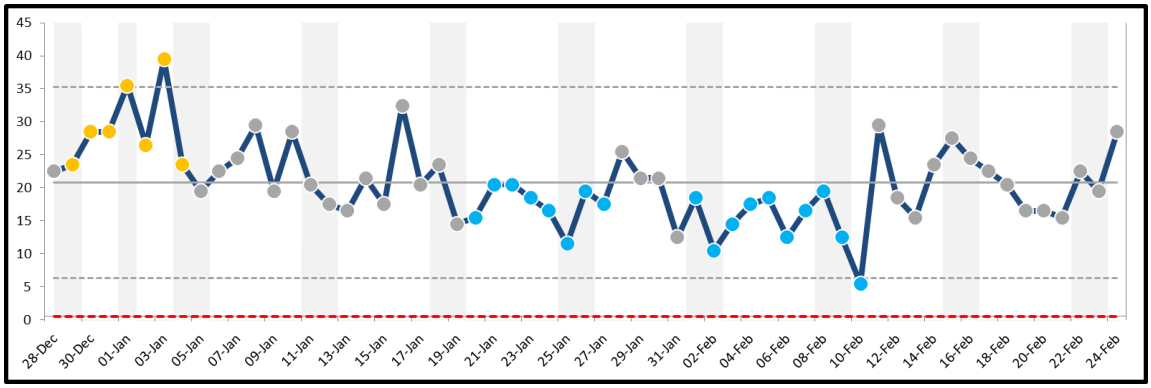
Worcester Site



HFW Work Stream Updates

The HFW Programme Board drives the implementation of six work streams supporting the headline measures of improvement. There continues to be tangible improvement from the Home First Programme with a reduction in the overnight bed capacity gap, improving numbers of midday discharges and a reduction of ambulance handover delays.

The six work streams are as follows:

1. Implementation of SAFER and Red2Green
2. Reduction in Long Length of Stay (LLOS)
3. Same Day Emergency Care (SDEC) and Primary care streaming
4. Clinical Site Management
5. Internal Professional Standards
6. Implementation of a Frailty sensitive approach to care including Hospital Acquired Functional Decline (HAFD)

This summary update for the Trust Board focuses on recent progress in implementing HFW, through these work streams, and the next steps.

2. Work stream progress updates

<u>SAFER and Red2Green work stream</u>

27th December 2019 to 23rd February 2020

The SAFER discharge bundle compliments the Red2Green initiative to improve patient flow across the Trust. Red2Green is a visual management system to identify internal and external constraints and delays in the system to maintain patient flow. The R2G dashboard enables oversight of the top constraints and escalation to unblock and facilitate flow.

The work stream project team provide leadership to coach ward teams and clinical leaders to embed SAFER and Red2Green. Roll out is being delivered at pace to reset and reinforce staffs knowledge, skills and habits to ensure this nationally recognised best practice is embedded across all wards.

Most recently, there has been notable impact on outcome measures following a two - day

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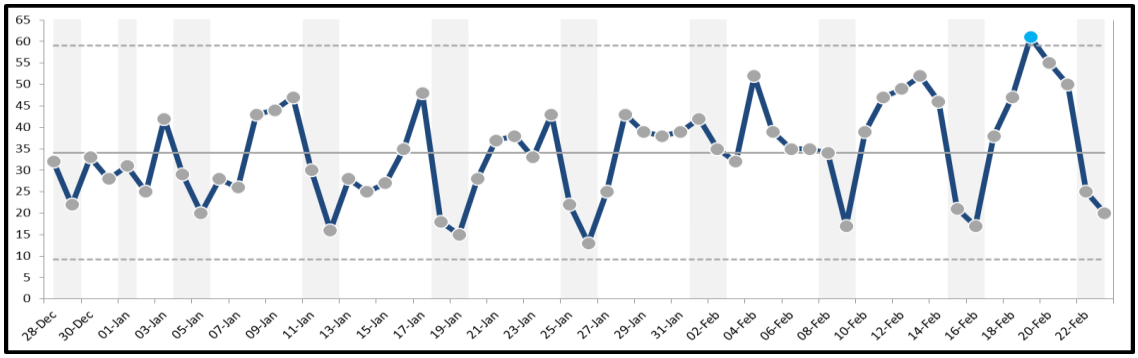
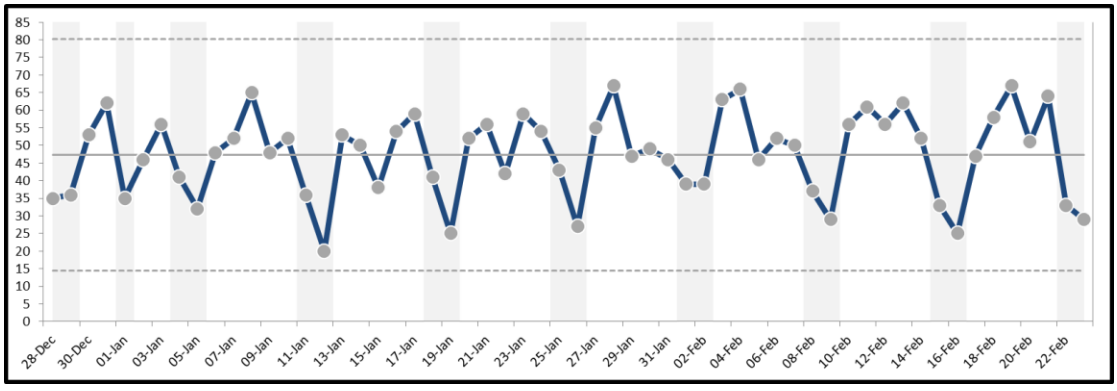
SAFER Red2Green 'call to arms' event attended by over 100 colleagues. There has been a concerted effort to identify a 'Golden' patient: that is a patient planned for early discharge the night before, thereby incrementally improving on the admission/discharge process before 10 am. Early in the day bed capacity is contributing to the improvements in reducing waiting time in ED. Analysis of the related SPCs identify as previously noted that discharge performance is not maintained 7 days a week and these events included next steps in rolling out criteria led discharge and the new patient welcome booklet providing information for patients to help manage expectations about discharge processes.

In terms of further developments, as well as criteria led discharge, the work stream will progress the functionality of the Whiteboard for real time reporting and a 'single version of the truth' informing daily situation reports for internal and system use and monthly DTOC reports. Initial review of the current Whiteboards has led to some streamlining of content for ease of use, and the next actions are with the ICT team to progress.

Discharges before Midday – All wards (Trust) – Daily



Admissions before 10 am – All wards (Trust) – Daily



This work stream has also evolved as one of three system - wide plans supporting the System Improvement Board work programme.

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Long Length of Stay (LLOS) work stream

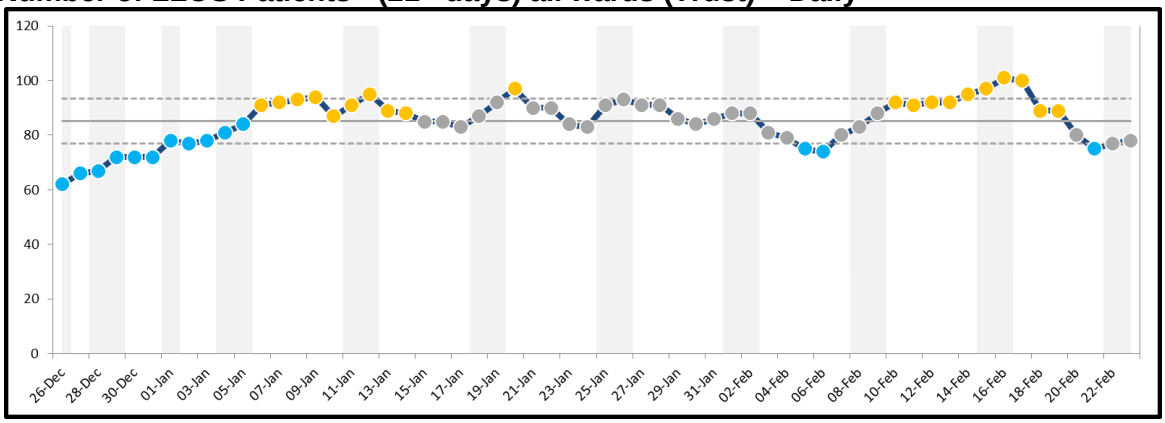
27th December 2019 to 23rd February 2020

The national requirement is to reduce the number of patients with a stay over 21 days by 40% by end of March 2020. This is a target of no more than 73 patients per week exceeding a stay of over 21 days across the Trust. In April 2019 the baseline number of inpatients with a stay of over 21 days was 114 patients.

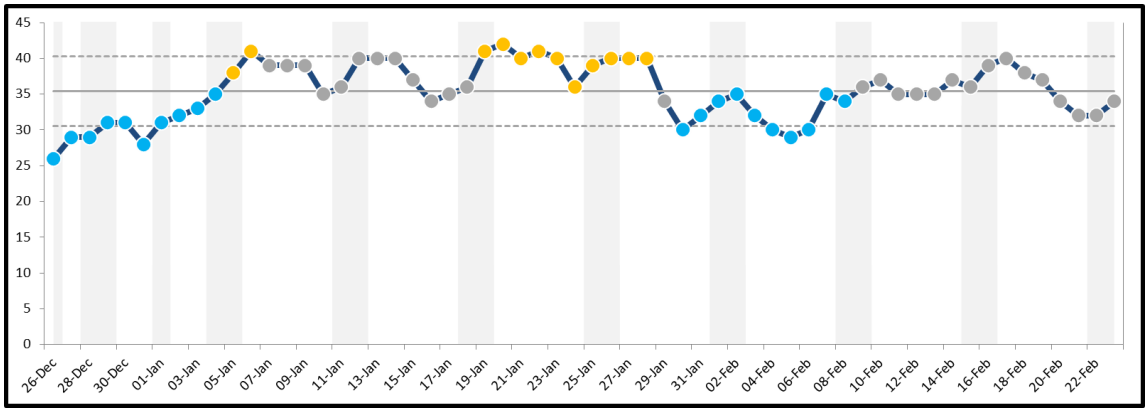
There is an established robust system to review all patients whose stay is over 21 days across the Alexandra Hospital and Worcestershire Royal Hospital (Long Length of Stay Reviews). The reviews are carried out weekly on each ward on Tuesdays and Wednesdays respectively. The coaching style of leadership for these reviews has had a positive impact on the ward team's approach to escalation of related issues with an action focus to unblock patient delays. Until recently there has been a multidisciplinary approach to the reviews which consists of a Discharge Liaison Nurse, Social Worker, Divisional Director of Nursing, Matron for Patient Flow and an administrator. Post-Christmas fortnight there was deterioration in performance however the increase to 97 patients of 21+ days was recovered to 74 patients by week ending 7th February. With the launch of the Onward Care Team, members of the LLOS review meetings were withdrawn by the OCT lead (Worcestershire Health and Care Trust). The withdrawal of complex discharge experts from this review meeting has had a further negative impact on the delivery of actions with LLOS peaking to 101 patients 21+ days following the OCT launch.

This has been raised as an issue and will continue to be monitored as an unintentional consequence of the OCT with greatest impact on the WRH site. At the time of reporting progress has been made to recover with the number patients 21+ days to 78.

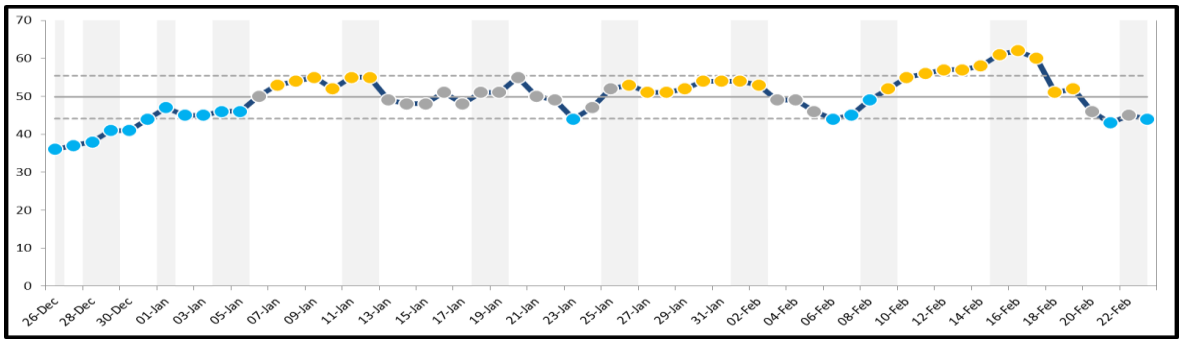
Number of LLOS Patients - (21+ days) all wards (Trust) – Daily



Redditch site



Worcester site



<u>Same Day Emergency Care (SDEC) work stream</u>

27th December 2019 to 23rd February 2020

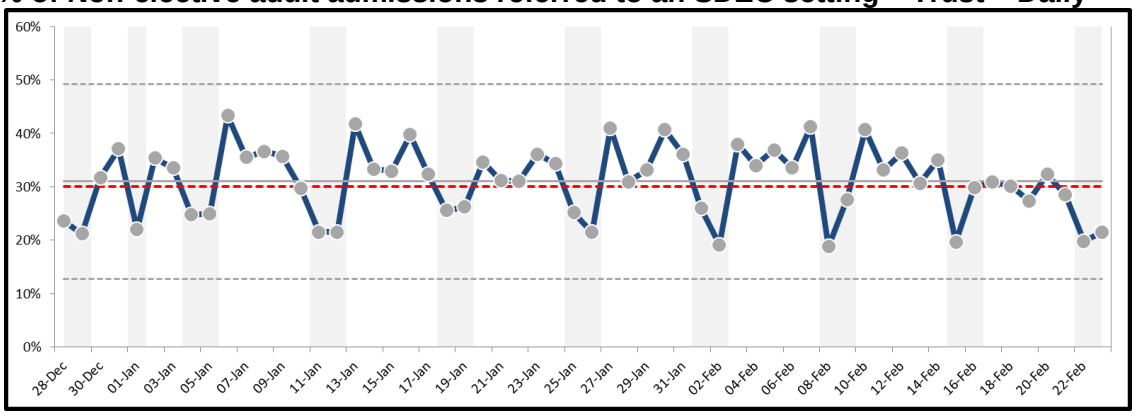
Monitoring of performance against nationally set SDEC measures occurs through the work stream to ensure we achieve >30% emergency care through SDEC pathways with a target of 85%-90% patients to be discharged daily from SDEC services.

Critical success factors for SDEC include triage capacity, assessment capacity and a robust streaming function. Additional programme expertise has been sourced and this work stream is currently being reset to ensure that there is focus on all three of these factors simultaneously.

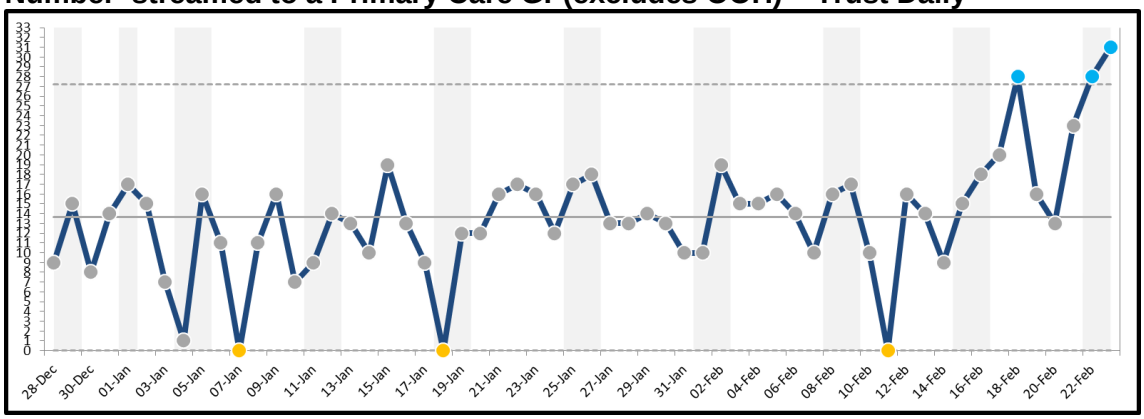
This work stream has also evolved as one of three system - wide plans supporting the System Improvement Board. Some community services are a prerequisite to enable some elements of SDEC to be realised e.g. a comprehensive home IV therapy service that can meet demand. System enablers such as this are included as actions for Worcestershire Health and Care Trust in the integrated system plan for SDEC.

Analysis identifies that whilst the 30% SDEC target is being achieved there is needed to further improve performance to achieve the overall HFW Programme Impact measures.

% of Non-elective adult admissions referred to an SDEC setting – Trust – Daily



Number streamed to a Primary Care GP(excludes OOH) – Trust Daily



Clinical Site Management work stream

A new model covering both sites is under development with increased capacity funded initially by the NHSI/E regional team, but the implementation has been delayed due to the day to day operational demands on the Director of Capacity however additional support has been identified to progress this. Aligned to this, a formal consultation process for the strengthening the On Call Manager and Matron arrangements is underway.

These changes will ensure that there is a 24 hour robust operational site management function which will provide safety, continuity, and a clinical focus to help ensure that the Trust delivers its objectives around improvements to the emergency care pathway and patient flow.

Impact measures are yet to be developed for this work stream.

Internal Professional Standards work stream

27th December 2019 to 23rd February 2020

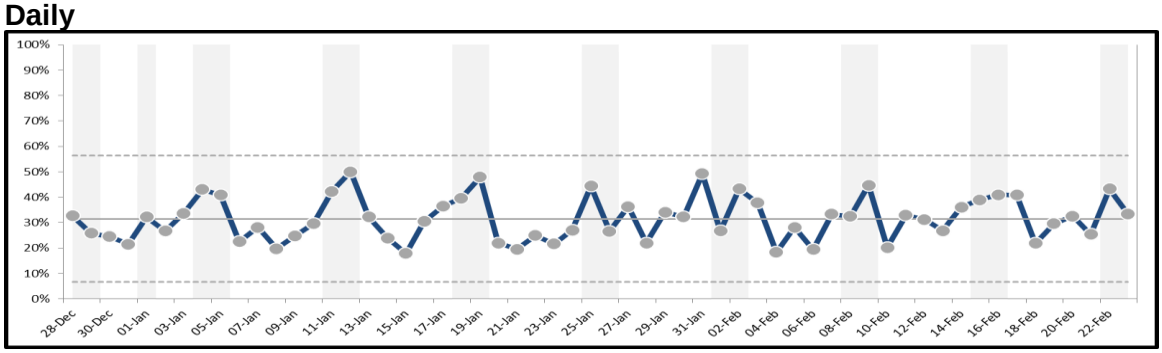
Internal professional standards have been developed at the Trust that are a clear, unambiguous description of the professional values and behaviours expected in the organisation. Compliance of the Internal Professional Standard's (IPS) at the Trust will impact on time spent in ED and overcrowding of the department to ensure:

1. Safe management of patients attending the Emergency Department.

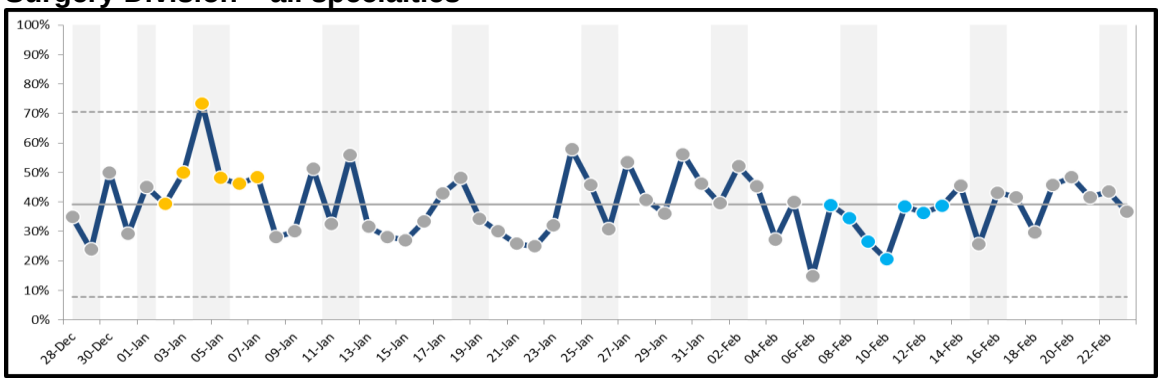
2. Timely, safe, quality care is delivered to provide a positive patient experience in all areas that provide clinical care.

There has been little if any progress with specialty reviews within 30 minutes. At no time during January and February was the set upper process control limit of 55% achieved across the Trust. The SPC's below provide a snapshot of the specialty responses during January and February. Consequently there has been a review of the policy with further consultation with the Clinical Leads. The Chief Medical Officer (CMO) has charged the divisional medical leads to oversee implementation of the IPS with dedicated programme support. The first phase will progress improvements in the percentage of patients reviewed by specialities within 30 minutes of ED referral. Each division will receive their baseline data the first week in March and an improvement plan will be agreed and and an improvement trajectory set.

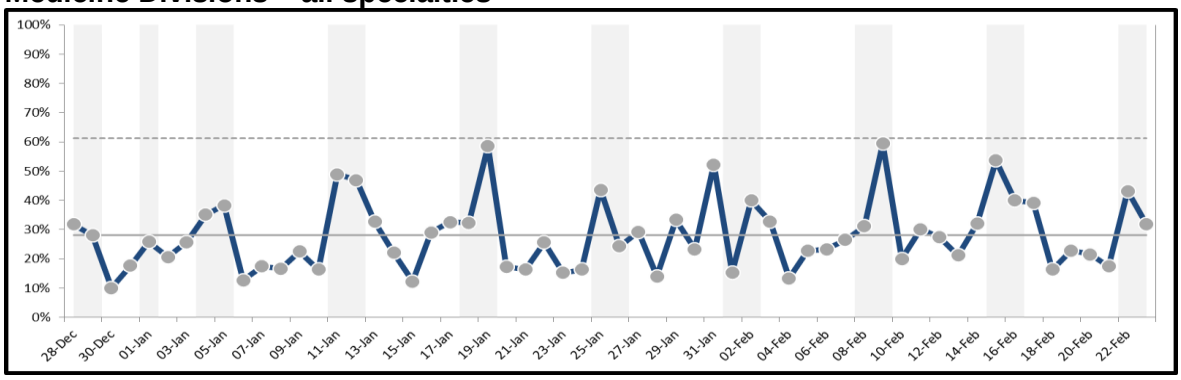
% Reviewed by Specialty within 30 minutes – All Divisions – All Specialties – Trust – Daily



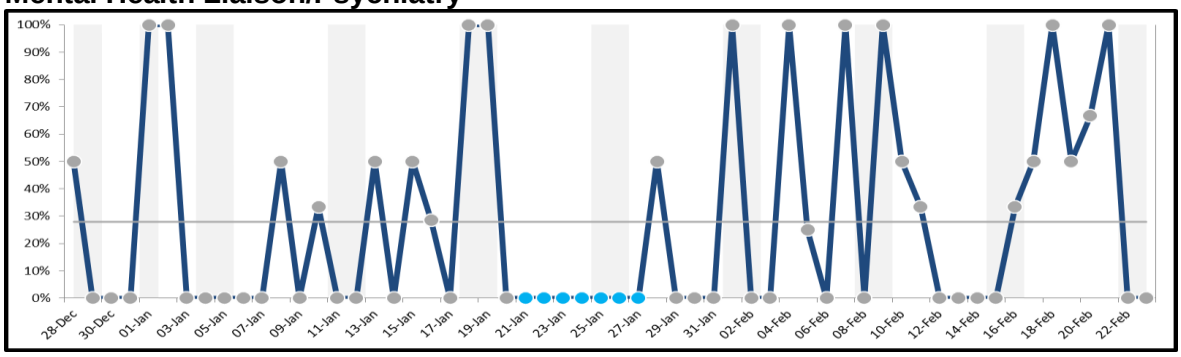
Surgery Division – all specialties



Medicine Divisions – all specialties

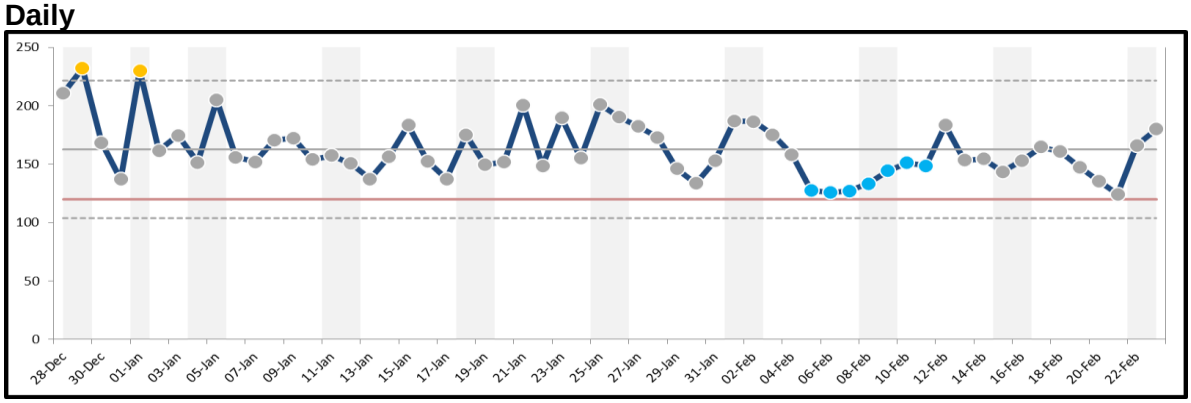


Mental Health Liaison/Psychiatry



To achieve a safe department, it is also imperative that ED teams to refer to specialty in a timely manner and within 2 hours of arrival. There has been some slight improvement across both EDs through February which corresponds with improved ambulance handover times and less overall time spent in ED.

Average time from arrival to specialty referral – All Divisions – All Specialties – Trust - Daily



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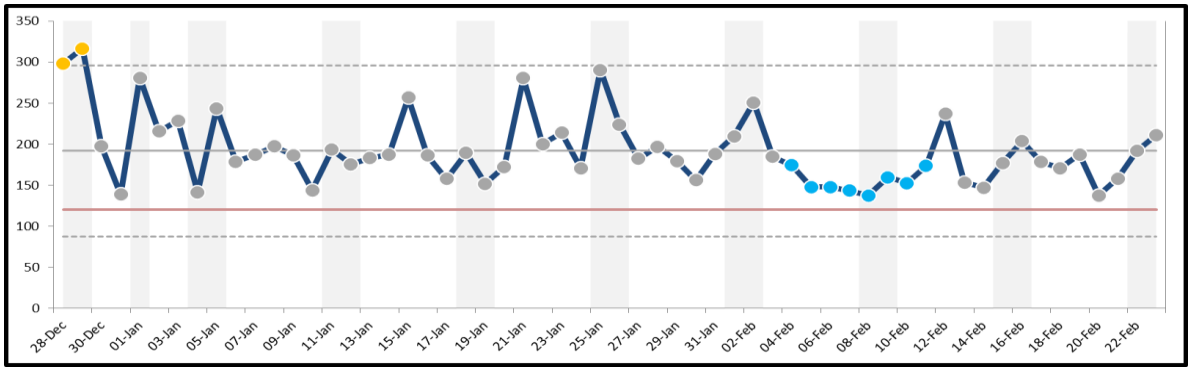
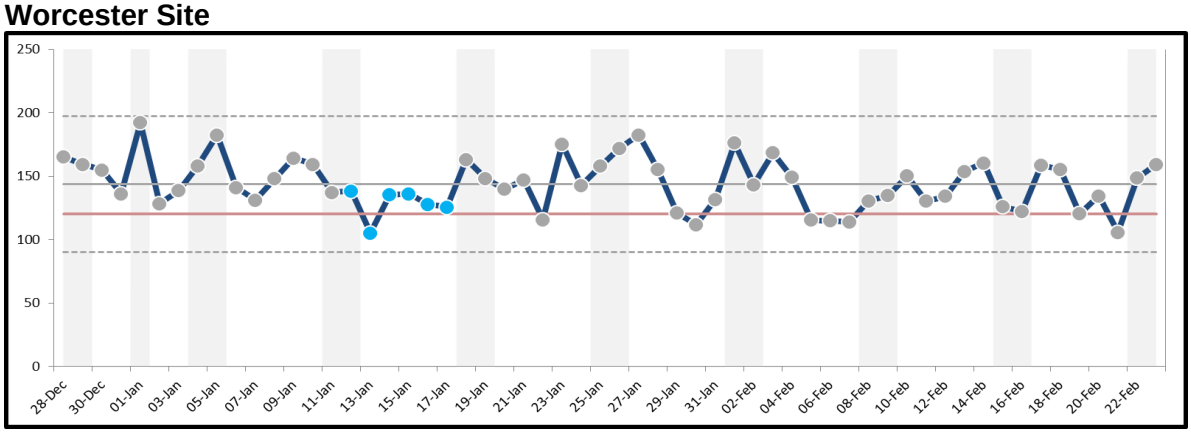
Redditch Site



Worcester Site



Frailty/HAFD work stream

27th December 2019 to 23rd February 2020

The frailty work stream group is well established and has extended its remit to hospital acquired functional decline (HAFD); the commonest harm event in hospitals and a hidden epidemic with 25-40% older people affected.

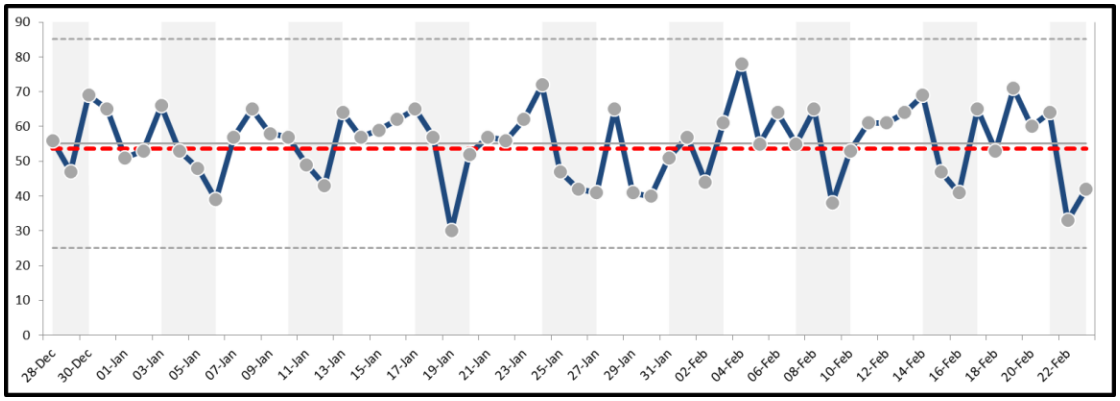
The frailty and hospital acquired functional decline (HAFD) work stream is working to:

- confirm the new frailty management model at both sites including the geriatric emergency medicine service (GEMS) at the front door and the processes / pathways that support it
- introduce HAFD /FrailSafe bundle principles on pilot wards, link to SAFER/R2G and Path to Platinum ward accreditation to support agreed measures of improvement
- establish Trust wide education in frailty management (frailty sensitive approach) and awareness of HAFD and communicate HAFD widely to contribute to a social movement of awareness and prevention
- develop the FrailSafe Bundle in co-ordination with the CNO to pilot new documents as part of fundamentals of care.

The business case for an optimal elderly care service (incorporating GEMS) will be presented at TME in April. Meanwhile through sequential tests of change, it is recommended that pre

business case, the existing frailty team resource is concentrated on the WRH site as part of the Home First Worcestershire Programme.

The measure of impact will be against the baseline emergency admissions (Aged 75+)



This work stream has also evolved as one of three system - wide plans supporting the System Improvement Board. There are a number of enablers to this work stream from system partners such as developing and delivering a 2 hour rapid response to aid admission prevention.

Winter System Plan

As part of a focus on December 2019 performance, system predictive data was submitted as part of the Winter Pulse Check to NHSE/I in October. Predictions were based on previous trends, plus growth and demand improvements/interventions from the system winter Capacity plan.

The interventions from the system plan have not supported demand improvement nor closed the bed capacity gap over the period November to February. The analysis below highlights performance in February:

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Paper number	E1

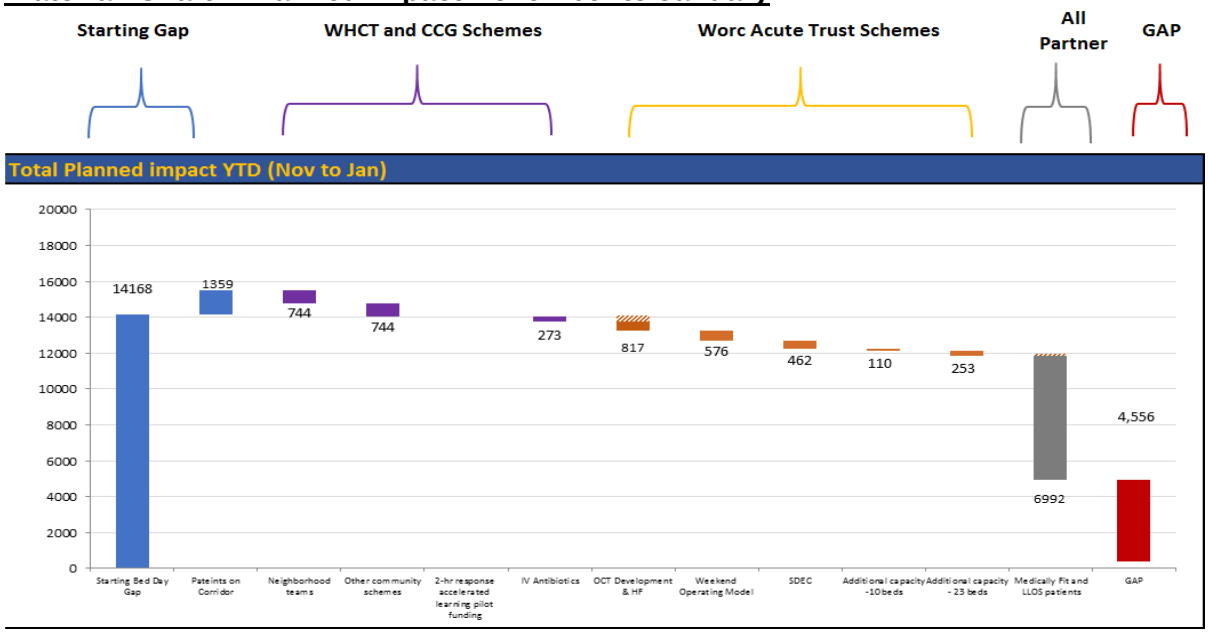
Worcestershire Royal - Comparisons of February

	Year			Growth		
	2018	2019	2020	%	act	per day
A&E Attendances	5,391	5,558	5,299	-4.66%	-259	-9
Ambulance Arrivals	2,475	2,547	2,418	-5.06%	-129	-4
Emergency Admissions	3,324	3,743	3,686	-1.52%	-57	-2

The Alex - Comparisons of February

	Year			Growth		
	2018	2019	2020	%	act	per day
A&E Attendances	3,769	4,159	4,069	-2.16%	-90	-3
Ambulance Arrivals	1,385	1,643	1,660	+1.03%	+17	+1
Emergency Admissions	1,416	1,431	1,585	+10.76%	+154	+5

Waterfall Chart – Planned Impact November to January



Meeting	Trust Board
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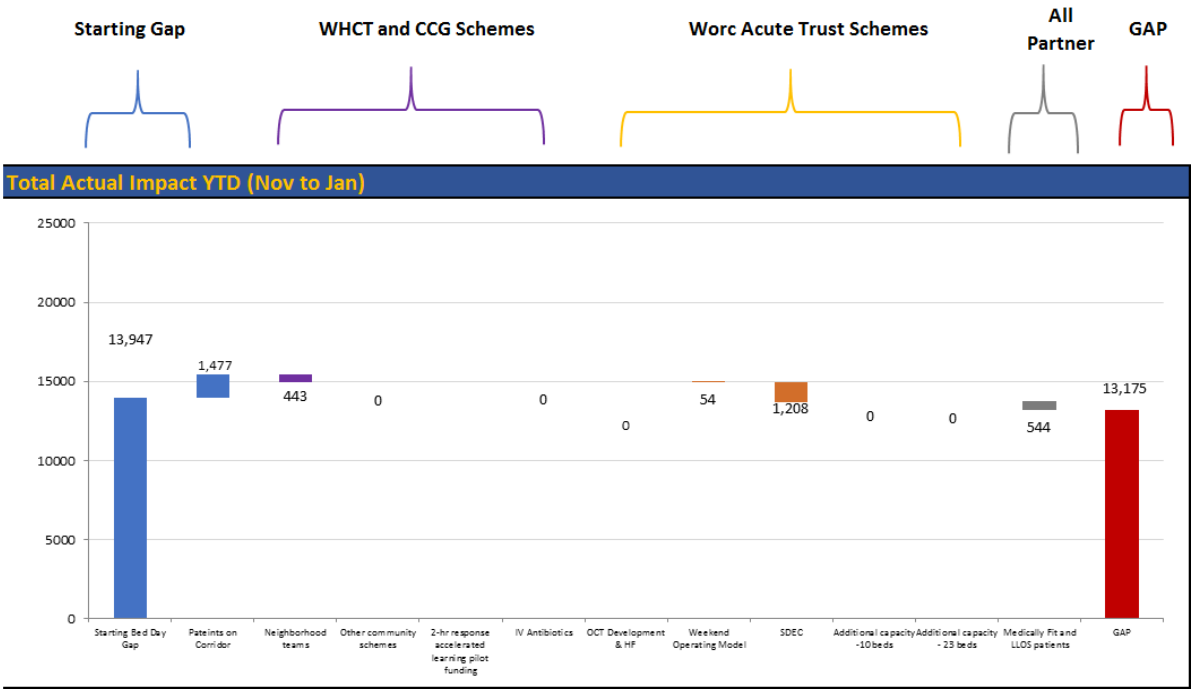
Paper number	E1

Waterfall Chart – Actual Impact November to January



Conclusion

Home First Worcestershire is the top quality improvement priority for the Trust. There has been some limited progress however there are further changes and new initiatives coming on stream in February and March to improve programme delivery.

The additional new beds opened mid-February will be measured against impact on overall time spent in ED. Reducing the number of internal moves for non - clinical reasons is also important to provide a better patient experience, but also to reduce length of stay. Close monitoring and working with the new Onward Care Team is also important.

This summary report is not exhaustive, but captures the main areas of progress with the programme. There is an urgent need to accelerate implementation and in this respect, the improved governance and the recently strengthened resource in terms of capacity and expertise will increase pace and delivery.

There has been no discernible impact to date from the system wide interventions included in the winter plan.

Recommendations

The Trust board are requested to receive this report for assurance.

Glossary

ED – Emergency Department	DTA – Decision to Admit
SPC – Statistical Process Chart	SDEC – Same Day Emergency Care
LLOS – Long Length of Stay	HAFD – Hospital Acquired Functional Decline

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	E2

Trust Board - Integrated Performance Report – Month 10 2019/20

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

Accountable Director	Matthew Hopkins Chief Executive		
Presented by	Matthew Hopkins Chief Executive	**Author /s**	Nicola O'Brien – Head of Information and BI Analytics Steven Price – Senior BI Analytics Manager

Alignment to the Trust's strategic objectives							
Best services for local people	✓	Best experience of care and outcomes for our patients	✓	Best use of resources	✓	Best people	✓

Report previously reviewed by		
Committee/Group	**Date**	**Outcome**
Trust Management Executive	19 February 2020	Approved
Finance and Performance Committee	26 February 2020	Limited assurance
Quality Governance Committee	27 February 2020	Limited assurance

Recommendations	The Board is asked to: 1. Review the update on the annual plan priorities that are in this cover report 2. Review the key messages from the Integrated Performance Reports provided in Month 10 2019-20 3. Note areas of improved, sustained and under-performance. 4. Seek assurance as to whether the risks of under-performance in each area have been suitably mitigated, with robust plans for stabilisation and recovery. 5. Note the NHSEI mandated operational performance metrics for 2020/21 that require trajectories.
Key points to note	The key points from this paper are as follows: ▪ There continues to be some tangible improvements in the Home First Programme with a reduction in the overnight bed capacity gap, improving numbers of midday discharges and a reduction of ambulance handovers at the Alexandra Hospital particularly. Despite these efforts the bed occupancy remains above 100% at the Worcestershire Royal and is only just below 100% at the Alexandra Hospital. ▪ The winter interventions from the system wide improvement plan have not closed the bed day gap for November to January; as a Health system we had planned to save 9,612 bed days by putting in interventions, increased demand

	negated some of the bed days we achieved (3,283) and the end result was a net difference 329 bed days saved. ▪ The NHSEI operational planning and contracting guidance has been published. Trusts are required to set 2020/21 trajectories for the RTT, Diagnostics, UEC and Cancer standards; including the new faster diagnosis (28 day) standard. These are currently being modelled and negotiated with commissioners. ▪ Trajectories are also needed for reducing the number of patients staying in hospital for over 21 days and reducing acute bed occupancy to no more than 92%. ▪ No statistically significant change to Cancer 2WW, Breast symptomatic and RTT performance. The 62 day untreated backlog and 104 waits decreased. ▪ Diagnostics remains on track to meet the year-end target. ▪ We are over the monthly cumulative trajectory for MRSA, MSSA and CDiff but on trajectory for E-coli. With two cases YTD, MRSA will not meet the year-end target of zero. ▪ ReSPECT training remains below target. ▪ There is improved performance in respect of both SHMI and HSMR. ▪ The backlog for primary mortality reviews has decreased. ▪ Friends and Family Test response and recommended rates are being met by Inpatients and Maternity. ▪ There have been 3 reportable Never Events. ▪ For Month 10 of 2019/20 against the £(82.8)m submitted external plan is a deficit of £(6.3)m, £(0.4)m adverse to the £(6.0)m plan. ▪ The cumulative position at the end of month 10 is a deficit of £(67.4)m, £2.4m positive to the submitted plan. This is a reduction in the previous favourable YTD variance primarily due insufficient levels of CIP delivery and premium staffing costs. ▪ The internal savings/CIP target remains at £22.5m of which opportunities to the FYE value of c. £21.5m have been identified to date with £16.2m removed from budgets. ▪ Non-Medical appraisal rates and mandatory training compliance have not changed from the previous month. ▪ The sickness absence rate has increased and is higher than January 2019. Long-term absence remains predominantly stress/anxiety. ▪ This paper is provided in a presentation that should aid discussion and challenge regarding how effective our action/recovery plans are.
BAF risk numbers are: 1,2,3,4,5,6,7,8,10,11 and 12	
Appendices:	▪ Appendix 1 – Improvement Statements and Committee Assurance Reports ▪ Appendix 2 – SPC Charts and Trajectories

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	12 March 2020
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Introduction/Background

This Integrated Performance Report (IPR) provides Board Members with an update on the Trust's quality of care, financial performance, operational performance and workforce 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 Finance and Performance Committee (FPC), People and Culture Committee (PCC) and the Quality Governance Committee (QGC).

Issues and options

Strategic Objective: Best services for local people

1. Core objective: We committed to delivering an overarching Trust Strategy with a Clinical Services Strategy and a Digital Strategy by October 2019.

Below are the improvement priorities that underpin delivery of the core objective and progress updates against our success measures.

More effective alignment of our capacity with our current and future demand for our services

(Executive lead: Sarah Smith)

- Trust Clinical Services Strategy was approved November 2019 including the vision for elective centres of excellence delivered alone and in partnership from the three Trust sites. Work is in train, through the Right Site Right Surgery programme, to realign elective capacity across the three Trust sites with a specific focus on greater utilisation of KTC and AGH respectively.
- The 2020/21 annual plan planning process commenced in September 2019 and we have completed the work to align demand with capacity in 2020/21 in term of both workforce and facilities. Work has now commenced on the enabling plans to mitigate the impact of the AGH theatres refurbishment programme during 2020/21 following completion of the ASR Full Business Case.

Improve medical staff engagement and leadership alignment with our strategic objectives, annual goals and improvement priorities

(Executive lead: Paul Brennan) (Executive lead: Mike Hallissey)

- Increased participation levels in the 4ward process – Consultant meetings have been held to reinforce the importance of the programme
- A revised clinical management structure has allowed the recruitment of suitable clinical leaders in areas which lacked leadership previously.
- Job planning has been maintained and was above the local target for the latest reported data (January 2020 – 91%) and the target has been met for sessional planning. During the next year will see a focus on objective setting within the job plan.

Improve the training experience for junior doctors in line with their feedback.
(Executive lead: Mike Hallissey)

- A formal review of workforce requirements has been initiated to establish the support required to deliver safe care and adequate support to the trainees. The initial draft of the Junior Medical Workforce has been presented to TME and an advert for additional PAs has been placed. The support to the acute assessment areas will be subject to a separate review as the impact of the increased bed stock changes the dynamics

Strategic Objective: Best experience of care and best outcomes for our patients

2. Core objective: We committed to implementing Year 2 of the Quality Improvement Strategy to improve quality and safety of patient care.

Below are the improvement priorities that underpin delivery of the core objective and progress updates against our success measures.

Embed our infection prevention and control (IPC) recovery plan
(Executive lead: Vicky Morris)

- We are at our trajectory for E.Coli with 49 cases (April to January) and higher than trajectory for C.Diff, MSSA and MRSA. However we have concerns about sustainability due to observed variation from expected standards.
- We are 100% compliant with the completion of hand hygiene audits, which then show 98.90% compliance to the expected standards, so we are above the 95% target (January 2020).
- Improved clinical engagement is being sought in relation to anti-microbial prescribing and each Division has been asked to provide a clinical lead to ensure that the actions to be included in the assurance plan will realise improvement, and can be owned by the clinicians.

Embed our risk management policy and procedures within the clinical divisions
(Executive lead: Vicky Morris)

- We committed to reducing the number of red rated risks; the number of open extreme risks remained about the same from April 2019 to October 2019 ranging between 61 and 67, subsequently reducing to 53 to February 2020. Extreme risks continue to undergo review and discussion at Risk Management Group with appropriate challenge around scoring, mitigation and actions in place. There has been a demonstrable shift in the risk profile for the Trust toward an increase in lower rated risks and reduction in the number of extreme risks.
- The revision of risk management strategy has been completed and was approved by the Board in January 2020; the risk appetite statements have been developed, which support the identification of priorities and business planning.

Reduce medicines management incidents leading to patient harm
(Executive lead: Mike Hallissey)

- We committed to increasing the reporting of medication incidents to >4.88 per 1,000 bed days, we are currently achieving the target with 7.37 per 1,000 bed days. This is a result of a targeted approach with staff to consistently report all incidents. The volume of incidents causing harm is 14.21% in January 2020 which is above the target of 14.1%. The last two months (November and December) were below the 14.1% target, so this is not yet a trend raising statistical cause for concern. The implementation of the Digital Care Record and Electronic Medicines Prescribing and Administration system will increase this further and allow a focus on timely administration.

Strengthen our compliance with health and safety practices and regulations
(Executive lead: Paul Brennan)

- Quarterly Health and Safety Committee meetings recommenced and well attended by all departments.
- Processes and procedures currently under review to ensure adequacy, audit plans being developed to check adherence with policies.

Improve our learning from deaths processes
(Executive lead: Mike Hallissey)

- The most recent Summary Hospital-level Mortality Indicator (SHMI) was published in February 2020 and covers the 12 months to September 2019. Our SHMI for this period is 1.1094 and, having improved throughout 2019, is now described as 'as expected'. Furthermore, for the first time since the SHMI has been reported at site-level, both the Alexandra and Worcester sites have an 'as expected' SHMI. This improvement is set against a backdrop of decreasing crude mortality, increasing patient numbers and improvements in clinical coding.
- Our Hospital Standardised Mortality Ratio (HSMR) has not shown the same level of improvement (currently 110.49 for the year to September 2019) and the Trust remains an outlier in this regard. The proportion of mortality reviews completed within 30 days remains above 50% (52.9% for December 2019) and the backlog of outstanding and late reviews has shrunk to 489 (the lowest it has been since October 2018).
- The trust continues to address the challenges faced in recruiting to the new medical examiner roles.The programme to integrate a Medical Examiner system and mortality review process is progressing. The external review of Learning from deaths has reported and has shown no major care failings. The issues identified have helped inform a system wide mortality approach to establish methods of admission avoidance, ensuring patients receive the right care in the right environment and to focus on how we reduce delays in care initiation in the trust.

Core objective: Implement our Urgent and Emergency Care Recovery Plan to eradicate corridor care and ambulance handover delays by September 2019
(Executive lead: Vicky Morris/Mike Hallissey)

- We continue to focus on reducing the number of medically fit for discharge / super stranded patients and have set a target of having no more than 72 patients with a

long length of stay (21 days or more) by March 2020. The current performance is 86 (January 2020) against a baseline position of 92 in March 2019.

- To drive forward the reduction we have implemented the national best practice approach to the review meetings and are looking to work more closely with the Onward Care Team.
- Following the successful pilot of the Onward Care Team at the Alexandra Hospital at the end of 2019, we have agreed that this becomes permanent and is extended to the Worcestershire Royal site also. This has been implemented in February 2020.
- The increase in assessment unit capacity has been temporarily achieved with the opening of the Surgical Clinical Decision unit (SCDU), that has reduced the time to assessment by surgery and work in medicine is showing a reduction in delay to assessment. A business case is being developed to retain SCDU into 2020/21.
- In order to move the median discharge time to an earlier time of 4pm, we are looking to have 33% of all discharge before midday. We are currently achieving 17.93% across all wards (January 2020), with several wards achieving closer to 30%. We are implementing criteria led discharge onto all Wards commencing February 2020, which will improve weekend discharges.

Strategic Objective: Best use of resources

4. Core objective: Implement a financial recovery plan to achieve agreed deficit plan by March 2020.

Below are the improvement priorities that underpin delivery of the core objective and progress updates against our success measures.

Strengthen pay controls and use of resources via weekly/regular review of all vacancies and structures across the Trust, including governance and compliance with electronic rostering and temporary staffing

(Executive lead: Robert Toole)

- Weekly panel now in place for all recruitment of a week or more.
- The nursing (12 week rotas) e-rostering is operational.
- E-rostering fully implemented for the nursing and midwifery workforce with rota's submitted 12 weeks in advance.
- Single bank and agency provider model in place for nursing and medical staff group with AHP and A&C staff groups to be implemented by 30th June 2020.
- A half year review of controls undertaken, document adherence reinforced e.g. Provision of Organisation Structures – further work required on benchmarking internally and across comparable Trusts. On Call and Divisional management Structures being consulted with implementation dates into 20/21. Despite this and given ongoing and increased pressures on capacity our lack of success to implement Finance Recovery Plan to reduce bed capacity aligned to the agency and bank spend remains high so assurance would be limited.

Review underlying finance position including impact of significant Long-Term committed/outsourced high value contracts

(Executive lead: Robert Toole)

- Currently on plan to achieve maximum outturn deficit
- Continuing focus though ability to deliver further stretch deficit target
- Income and expenditure run rates remain variable although income remains above plan even though adjusted for exceeding upwardly extended non-elective threshold adjustment.
- The Q3 overall deficit to end December 2019 of £(20.1)m is a £1.1m improvement on the Q1 deficit of £(21.2)m. This is 5% better than Q1.
- Looking at income and expenditure independently, pay had reduced by 0.2%, non-pay increased by 3% largely aligned to increased patient care activity and income levels increased by 5.5%. Noting the phasing of activity throughout the period.
- Improved contract oversight
- Forecast QCIP FYE 2019/20 at £12.1m
- Financial forecasting improved with consistent quarterly updates

Develop a medium term financial plan (3 years) aligned to outputs of the Clinical Services Strategy and associated strategies.

(Executive lead: Robert Toole)

- Medium Term Financial Plan discussed at Trust Board on the 16th January 2020
- Target for ICS / MTFP approval at 12th March Trust Board

Strategic objective: Best services for local people

Core objective: Implement our People and Culture Strategy, with particular focus on embedding 4ward.

Refresh our recruitment and retention plan and reengineer our recruitment and retention practices and approach

(Executive lead: Tina Ricketts)

- We committed to reduce the overall turnover rate by 1% by March 2020, which has been achieved. The turnover rate as at 1st April 2019 was 12.2% and as at 31st January 2020 it stands at 11.06%.
- We committed to reduce our vacancy rate to below 9% by March 2020, which has been achieved. The vacancy rate at 1st April 2019 was 12% and as at 31st January has reduced to 8.87%.
- This year we have focused on recruiting to our medical and registered nursing vacancies to reduce our reliance on the temporary workforce. Successful schemes include the overseas nursing recruitment campaign (104 wte in post to date) and the Clinical Fellow Programme.
- A line by line review of the establishment has been completed which supported the development of a workforce recovery plan. PIDs have been/ are being developed for all of the schemes identified in the plan and these are reflected in the next iteration of the strategic workforce plan which will be reviewed by TME and People and Culture Committee in March 2020.

Achieve 90% compliance with mandatory training

(Executive lead: Tina Ricketts)

- Our current performance (January 2020) is at 89.4%. Our target increases to 95% on

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	12 March 2020
Paper number	E2

1st April 2020.

Recommendations

The Board is asked to:

1. Review the key messages from the Integrated Performance Reports provided in Month 10 2019-20
2. Review the update on the annual planning priories
3. Note areas of improved, sustained and under-performance.
4. Seek assurance as to whether the risks of under-performance in each area have been suitably mitigated, with robust plans for stabilisation and recovery.
5. Note the NHSEI mandated operational performance metrics for 2020/21 that require trajectories.

Trust Board

Enc

Worcestershire Acute Hospitals NHS Trust

Integrated Performance Report

Improvement Statements & Committee Assurance Reports

January 2019

Month 10

12th March 2020

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PERFORMANCE IMPROVEMENT STATEMENTS

NHS Worcestershire Acute Hospitals NHS Trust

1. Patient Flow as supported by the Home First Programme (validated)

Strategic Objective: Best services for local people

Metrics	Current performance (January)	January trajectory	February trajectory	19/20 Year-end target
Total time spent in A&E (mins) – 95th percentile	1,095	Reduction on previous month		
Discharge as a percentage of admissions	99.04%	Improvement on previous month - >100%		
30 day readmission rate for same clinical condition	2.96%			
Capacity Gap (Daily Average)	33.29			
Number of ambulance handovers (60 minutes)	566	330	107	0
% of patients waiting less than 4 hours from arrival to admission, transfer or discharge (EAS)	74.18%	86.00%	86.00%	86.00%
Number of patients spending 12+ hours from decision to admit to admission	167	0	0	0

How have we been doing?

- Despite a reduction of the overnight bed capacity gap we have not yet generated enough to cope with peak periods of attendances which then results in some corridor care or ambulance handover breaches. The occupancy levels at WRH remained above 100% in January, with the Alexandra fluctuating between 98 -99%.
- We are planning the launch across all Wards on both sites of Criteria Led Discharge in February which will support more timely discharges and increase weekend discharges. The launch will focus on the cultural change needed to support CLD.
- SAFER/Red to Green has now been launched across all wards on both sites and the focus will now be on those wards who need continued support to embed the programme.
- LLOS performance deteriorated in December and early January, but is recovering towards the end of January and we are therefore still confident of meeting the target of no more than 72 patients at the end of March 2020.

What actions are being taken to make the improvements?

- The clinical site management team structure has been developed and on formal agreement will be recruited to.
- The Same day emergency care work stream has been in place for several months, with some successes in AEC. However, we are now re-basing to identify the scope and delivery of the next phase of work
- We will be looking at options for a communication programme for the public following feedback from our staff, so that we can be clear regarding what you should expect during any emergency stay in the hospitals.
- The internal professional standards for the Emergency Departments will be launched in late Feb/early March.
- In mid Feb we will be opening an additional 33 beds (23 beds will be dedicated to Renal care) with 10 other beds being used by General Medicine until the end of May.

PERFORMANCE IMPROVEMENT STATEMENTS

1. Patient Flow as supported by the Home First Programme Cont. (validated)	
Strategic Objective: Best services for local people	
How have we been doing?	**What actions are being taken to make the improvements?**
• We have been developing an internal communication strategy to ensure staff are fully aware how they contribute towards the Home First Programme. • The internal professional standards for the clinical teams have been drafted and are awaiting final sign off.	• The onward care team (OCT) which is a multi-agency team focusing on identifying immediate onward care needs for patients as soon as possible during their hospital stay, (so that patients can be discharged to an appropriate location for the remainder of their treatment / recovery) will commence in February. • We are continuing to work with other providers from the health system to identify their contribution towards admission prevention and care in the community.
Assurance level – LEVEL 3	**SRO: Dependant on work stream**

PERFORMANCE IMPROVEMENT STATEMENTS

2. Two week wait cancer waiting times (unvalidated)

Strategic Objective: Best services for local people

Metrics	Current performance (January)	January trajectory	February Trajectory	19/20 Year-end target
% patients seen within 14 days (2WW) (All Cancers)	87.53%	93.34%	94.05%	93.10%
% patients seen within 14 days (2WW) (Breast Symptomatic)	89.82%	91.72%	96.00%	84.80%

How have we been doing?	What actions are being taken to make the improvements?
• Although there has been no significant change with performance for 2WW (All Cancers) and 2WW Breast Symptomatic as noted above, the specialities put on additional clinics over the month to ensure that the impact of the Christmas period was mitigated as far as possible. • 27% of all breaches in January were due to patient choice (down from 50% the previous month) and 59% were due to capacity. Gynaecology, Skin and Urology were the specialties with the most breaches due to capacity. • 2WW referrals since 31st December have been, although not significantly high, above average for Breast, Gynaecology and Lower GI. This increase in referrals particularly impacted Gynaecology. • Shadow monitoring of the new constitutional Faster Diagnosis standard has performance at 68% of patients receiving communication within 28 days (informing them of a diagnosis, ruling out or if treatment is required before a diagnosis can be made). • Of the 652 breaches, 283 (43%) were due to delays in clinic / result letters being sent.	• Although Breast and Breast Symptomatic performance is currently recovering, replacements for a Breast locum radiologist who is due to leave the Trust within 1 month and an impending retirement are being sought. WLI spend continues to be used and recruitment to sixth consultant post will provide substantive extra capacity in the long term but will be limited by radiologist capacity. • Capacity to ensure adequate cover for half-term is being actively managed by the Divisions for all Specialties. • Routine capacity is being diverted to 2WW where appropriate and achievable. • Gynaecology – a nurse hysteroscopist has been appointed and trained to assist with PMB demand, supporting 3 clinics (15 slots) per week from February. Also developing a referral criteria and triage process to manage the demand. • To improve the faster diagnosis standard, a template has been developed and is being reviewed by a urology consultant. The aim is that patients will receive a standard letter informing them their results were normal, with a formal letter to follow. If the template is approved it will roll out to all specialties to use.
Assurance level – LEVEL 3	**SRO: Paul Brennan (COO)**

PERFORMANCE IMPROVEMENT STATEMENTS

NHS Worcestershire Acute Hospitals NHS Trust

3. 62 day cancer waiting times (unvalidated)

Strategic Objective: Best services for local people

Current performance (December)	Current performance (January)	January trajectory	February trajectory	19/20 Year-end target
% patients treated within 62 days	62.74%	86.04%	86.04%	86.04%
Number of patients waiting 62+ days	188	0	0	0
Number of patients waiting 104+ days	50	0	0	0

How have we been doing?	**What actions are being taken to make the improvements?**

• Please note that the performance shown above is unvalidated until mid March and therefore is subject to change.
• There has been no significant change with performance for 62 Day Cancer (All) in January.
• The number of patients waiting 62+ days has decreased below 200 but it remains statistically significantly high.
• Of the number of untreated patients over 62 days Urology is accountable for 38% of these with 71 breaches.
• The reduction in patients waiting 104+ days to 50, from 71, is now within normal variation; 13 patients of the patients are currently waiting for treatment at a tertiary centre. Harm reviews on all patients waiting over 104 days have been requested from the Directorates and are being monitored by the Cancer Services team.
• 18.5 treatments were undertaken on patients waiting 104+ days.
	• Skin histology continues to be outsourced to Backlog to reduce turnaround times.
	• Timeliness to CT guided biopsy is being reviewed as it's currently taking 2 weeks from referral to date (lung).
	• Active recruitment and reviewing alternative models of delivery are being undertaken to ensure that respiratory vacancies are filled appropriately.
	• Urology
	  • MDT Co-ordinator to pre-book urology clinic appointments following positive histology results and ensure that OPA's are booked before MDT meeting.
	  • RAS service set up on ERS for CNS nurses to triage referrals throughout the day which aims to minimise delay from the start of the pathway.
	• Gynaecology – the PMB pathway is being reviewed and a proposal is going through W&C governance in February.

Assurance level – LEVEL 2	**SRO: Paul Brennan (COO)**

PERFORMANCE IMPROVEMENT STATEMENTS

4. Consultant-led referral to treatment (RTT) waiting times (validated)

Strategic Objective: Best services for local people

Metrics	Current performance (January)	January trajectory	February trajectory	19/20 Year-end target
Percentage of patients on a consultant led pathway waiting less than 18 weeks for their first definitive treatment	82.56%	83.02%	82.92%	82.39%
Number of patients waiting 40 weeks or more for their first definitive treatment	67	0	0	0

How have we been doing?	**What actions are being taken to make the improvements?**
• Please note that the performance shown above is unvalidated until 19th February and therefore is subject to change. • The number of patients waiting 40+ weeks has increased to 67 from 23 the previous month, with 61 patients under the care of the Surgery Division; this is predominantly Oral Surgery (35) and Urology (21). • Ophthalmology remains one of the specialties with the highest backlog (c900 patients) but this has reduced from the previous month. • The overall waiting list has grown compared to this time last year, with 2,468 more patients, but fewer patients are waiting over 18 weeks. • There are no 52 week incomplete breaches. • We have participated in a national waiting list data quality exercise and the feedback has been received. This is being evaluated currently, and action will be taken in Feb/March.	• Discussions are on-going with NHSEI to determine the risk appetite to stop or reduce referrals to Oral Surgery. • An internal action plan is also being drawn up to outline what else can be done to address the backlog and reduce the number of patients waiting 40+ weeks. Other than in Specialty Medicine who are working on no waiters above 35 weeks currently. • A revised job plan for a Maxillofacial consultant is with the Royal College. • Ophthalmology - Cataract capacity increases underway, from conversion of routine OP & IP activity. Job Plan reviewing imminent, which will plan to make some permanent changes to enable capacity improvement for Cataract. PTL monitoring of all patients who are 30+wk, and forward looking at patients who are potential long waits with escalation as required. • Contracts with in-sourcing and out-sourcing companies are being reviewed to ensure we continue to maximise the opportunities presented. • Capacity to ensure adequate cover for half-term is being actively managed by the Divisions.
Assurance level – LEVEL 2	**SRO: Paul Brennan (COO)**

PERFORMANCE IMPROVEMENT STATEMENTS

NHS Worcestershire Acute Hospitals NHS Trust

5. Diagnostic test waiting times (validated)

Strategic Objective: Best services for local people

Metrics	Current performance (January)	January trajectory	February trajectory	19/20 Year-end target
% patients waiting less than 6 weeks for a diagnostic test	95.28%	94.99%	96.71%	99.03%

How have we been doing?	What actions are being taken to make the improvements?
• Please note that the performance shown above is unvalidated until submission and therefore is subject to change - delivery against the 6 week diagnostic target continues to be ahead of plan; there has been no significant change with Diagnostic test performance at 95.28% • The majority of breaches are associated with cystoscopy with 209 of 452 patients waiting 6+ weeks . • Radiology, with continued use of CT mobile, and physiology are both performing well against the target. Endoscopy, specifically cystoscopy within the urology specialty, which are continuing to be the area with greatest challenge and is resulting from insufficient capacity of clinicians to scope. The service are improving the position and are aiming to increase February's capacity with medical and CNS activity and are reviewing booking practices within the service to minimise breaches. • The Trust overall position is expected to meet and exceed trajectory. Midmonth predictions for this month suggest a likely 3% achievement against the 3.3% plan. • For the organisation to achieve the 1% target and plan in March, the Urology service will need to significantly improve their breach position by 85%.	• Urology have a new directorate manager commencing who will be focusing on efficient booking of patients to reduce the backlog of breached patients with support from Endoscopy. • Urology to identify locum capacity for cystoscopy. • Urology to review opportunities for further CNS activity. • Creating all day Endoscopy capacity for Urology to maximise on list utilisation. • CT mobile activity continuing. • MRI capacity for paediatric anaesthetic GA lists to manage current demand, longer term review to assess need to increase monthly capacity to meet on-going demand.
Assurance level – LEVEL 6	**SRO: Paul Brennan (COO)**

PERFORMANCE IMPROVEMENT STATEMENTS

6. Stroke (Validated)

Strategic Objective: Best services for local people

Metrics	Current performance (December)	December trajectory	January trajectory	February trajectory	19/20 Year-end target
% of patients spending 90% of time on a Stroke Ward	71.70%	80.0%	80.0%	75%	80.0%
% of patients who had Direct Admission (via A&E) to a Stroke Ward	54.10%	53.0%	55.0%	55%	90.0%
% patients seen in TIA clinic within 24 hours	63.10%	75.0%	75.5%	72%	70.0%
% of patients who had a CT within 60 minutes of arrival	51.00%	42.0%	42.0%	57%	80.0%

SSNAP Overall Score	Q1	Score: 59.4	Grade: D	Q2	Score: 68.4	Grade: C

How have we been doing?

- The impact of the ward move is yet to be realised, considering the move was completed beginning of January (2020) it is deemed too early. The anticipated outcome of the ward move and ring-fencing of all stroke beds would impact Q4 position. The gains would include:
    1. Improvement in direct admission to the unit (within 4 hours)
    2. Improvement in percentage of patients spending 90% of stay on Stroke unit.
- The ward move and ring-fencing of Stroke beds has enhanced Trusts ability to pull Stroke from A&E and should ensure stroke patient receive access to timely stroke service but the challenge of finding community rehab beds to facilitate timely discharges would remain.
- Q2 SSNAP Performance - achieved a strong C for Quarter 2, which shows an improvement compared to Quarter 1 (D) and anticipating this to be maintained for Quarter 3.

What actions are being taken to make the improvements?

- Workforce Planning – Appointment of two 12 month fixed term locum Consultants (Commencing May and August). This leaves one Consultant vacancy as per the establishment which we will shortly be going out to advert for. Successful recruitment to this post will mean we are fully established and will enable us to provide consistent 7 day Consultant Services.
- Discussion are on-going with regards to Stroke adopting Consultant of the Week model (CoW). This would ensure the stroke team is able to provide 24/7 on-call CNS/Consultant cover and allow for a dedicated consultant to focused on all front door activity. This should further support the ideal of pulling Stroke patient to stroke unit within 4 hrs.
- The above changes will significantly help Stroke reach the trajectories set as a Department and help us continuingly improve and take the service forward.

Assurance level – LEVEL 3

SRO: Paul Brennan (COO)

Finance | Key Messages

		RAG
Delivery of the External Financial Plan £(82.8)m	At Q3 a final assessment of the full year forecast was completed with directorates. The refresh focused primarily on assessing the impact of the changes in bed capacity as a result of the requirement to improve A&E performance over the winter period to address increased non elective activity. The January deficit of £(6.3)m is £0.1m better than the profiled forecast that delivers a £(82.8)m out turn. Although the Q3 full year forecast continues to be aligned to our external plan, assessment shows a material level of downside risk which needs active management and mitigation by all budget holders. This forecast shows that that the positive £2.4m YTD variance against the external plan continues to reduce in the remaining months of the financial year as a result of lower levels of CIP delivery against the back ended external plan. Our ability to hit our internal target of £(73.7)m would require a material reduction in our agency and bank costs, as well as continued focus on improving flow and reducing ED attendances / activity through Home First Worcestershire, maintaining and further improving decisions on expenditure and delivering identified efficiency and productivity opportunities at every level.	Level 4 > relatively confident that external plan can be achieved subject to level of winter pressure.
Capital	The Trust has a minimal £2.24m internal source of funding for the 2019/20 capital programme. This is after repaying the capital loans, accounting for IFRIC 12 and PFI capital repayments. The Full Year Forecast Capital position for the financial year shows a breakeven position against available funds on the basis that the full available funding will be utilised. January – Month 10 capital expenditure totals £6.92m. The 2019/20 Capital loan was granted approval in January 2020, and it is expected that £1.1m will be drawn down in 2019/20 and £6.87m in 2020/21 (total approved amount – £7.97m). Therefore, the remaining capital funds of £1.96m (£1.1m loan plus £0.859m remaining capital contingency balance) is being allocated to the Trust's most urgent schemes to ensure that completion is achievable during this financial year.	Level 5 > to have sufficient capital funding. Plan complete and some capital funds secured. Ongoing requirement for funding.
Cash Balance	As a result of the ongoing deficit position, we continue to rely on additional cash support from the Department of Health and Social Care (DHSC) and request cash in line with financial performance on a monthly basis. At the end of January the cash balance was £14.3m (£13.3m net of un-cleared payments) which is significantly over the £1.9m minimum balance required owing to the timing of due payments, the year to date favourable variance to plan and timing of receipt of 2018/19 PSF cash. Future loan requests have been recalculated to manage the cash balance down and meet the minimum month end balance requirements. The Trust has received £6.989m working capital cash support in January 2020. The 2018-19 capital loan of £5.64m has now been approved and £2.4m of this has been drawn down to date. 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. NHSI/E have confirmed that revenue loan principal repayments due during 2019/20 have been re-profiled into 2020/21. Capital loans are repaid through the capital programme.	Level 6 > Plan to access cash and deferral of loan repayments.

Finance | Key Messages

2019/20 Plan	For 2019/20 the Trust committed to delivering a deficit of no more than £(82.8)m with a stretch target of £(73.7)m. This stretch target requires delivery, all other things being equal, of £22.5m of savings/margin improvement. The Trust has not signed up to the revised control total set by NHSI of £(64.4)m [£58.4m+£6m] (excluding PSF, FRF and MRET funding). Whilst we recognise that it is disappointing that we have been unable to submit a plan closer to the control total, we believe that the submission reflected a credible plan based on the existing plan information and assumptions available to us at the time. Notwithstanding the aforementioned, we continue to challenge all areas to improve further in order to deliver as close as possible to the £(73.7)m 2018/19 internal stretch out-turn target.
I&E Position	**For January**, month 10 of 2019/20 is a deficit of **£(6.3)m**, £(0.4)m adverse to the £(6.0)m plan. **The cumulative position** at the end of month 10 is a deficit of **£(67.4)m**, £2.4m positive to the submitted plan. This is a reduction in the previous favourable YTD variance primarily due insufficient levels of CIP delivery and premium staffing costs. The impact of these adverse variances has been reduced by the shifting of costs for new capacity and not spending to planned levels on business cases. (Electronic Prescribing & Medicines Administration – EPMA and proposed expansion of Managed Equipment Service - MES). **The internal target is to have a deficit no bigger than the 2018/19 out-turn of £(73.7)m deficit. Using the £22.5m Savings target) as a proxy to deliver £(73.7)m the I&E deficit position in month 10 would be £(1.4)m adverse and £(4.2)m adverse year to date. In order to get closer to our internal target it will be vital to:** **continue to prioritise our efforts on improving flow; reducing ED attendances / activity through Home First Worcestershire; maintain and further improve decisions on expenditure ; and deliver identified efficiency and productivity opportunities at every level.**
Income	**The combined income (including Other Operating Income and adjusting for the blended payment mechanism) was £0.7m above plan in January (YTD position is £3.8m above plan on the same basis). If the £3.4m blended adjustment did not apply (20% Marginal Rate), income would be £7.2m above the year to date plan. Patient Care Income was £0.8m above plan in month (excluding drugs & devices) incorporating the blended payment marginal rate (£0.4m in January).** In-patients were £0.7m above plan in January (before the blended payment adjustment). Emergency activity was £0.6m above plan in month, driven by a mix of volume and value. Day case and Electives were £0.1m above plan. The endoscopy improvement activity target (incorporated within the annual plan to achieve the diagnostic waiting standards) was not fully met in January. Outpatients were £0.1m above plan, the activity run-rate increased in January compared to December across a number of specialties allowing for the Christmas period. Other Income was on plan.
Expenditure	Pay and non pay costs (excluding Non PbR and finance charges) exceeded plan by £(1.1)m in January. This adverse variance is largely as a result of the alignment and slippage against the submitted CIP plan, premium staffing and non-pay overspends. **Pay expenditure increased by £(0.3)m from £(25.3)m to £(25.6)m in January, the majority of this is due to costs associated with increased nurse staffing across the ED floor in response to section 31 condition notices and additional medical cover in ED, an extension in AEC medical cover and additional cover supporting weekend discharges.** The combined agency and bank spend is £(4.3)m in January and represents 16.6% of the pay bill, an increase of £276k compared to last month across both bank (£81k) and agency (£195k). Agency expenditure for January of £(2.5)m exceeds the agency ceiling by £(1.0)m and represents 9.7% of gross staff costs. Temporary staffing costs are forecast to increase further aligned to changes in bed capacity. Non pay spend (excluding Non PbR and finance charges) increased by £(0.6)m from £(11.2)m to £(11.7)m. The increase in expenditure largely reflects the CNST rebate received and reported in the December position.
CIP (Savings Improvement Plans)	In January, month 10 2019/20, a nominal £8.79m vs £10.1m Plan target [note £22.5m Full Year delivery required] of CIP delivery (year to date) has been achieved adverse (£1.3m). The operational forecast assumes c.£12.m FYE CIP delivery in the 2019/20 financial year. We remain focused on maximising the savings plans and are continuing every effort to drive further improvements to our financial position, whilst ensuring a credible plan for delivery. As a result the internal savings/CIP target remains at £22.5m of which opportunities to the FYE value of c. £21.5m have been identified to date with £16.2m removed from budgets.

Finance & Performance Committee Assurance Report

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom Associate Non-Executive Director	Richard Oosterom Associate Non-Executive Director	Martin Wood Deputy Company Secre

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 Finance & Performance Committee met on 26th February 2020. At this meeting our particular focus was on the annual plan priorities, annual operational plan and Home First Worcestershire.

Divisional Attendance – Chief Medical Officer: We received an informative presentation from the Chief Medical Officer. We noted the financial position which is largely flow through funding, but an important element of our financial position We focused our discussion on the need to get the medical workforce model right and how to improve clinician engagement. The Chief Medical Officer explained how improving job planning and medical appraisal and revalidation processes play an important role in that. Job planning is a crucial input into freeing up consultant resources to deliver Homefirst. Plans are in place through the recruitment of Associate Divisional Directors to meet the required number of Medical Examiners to improve performance in reviewing deaths which in turn will improve patient experience. We are building links with the University of Worcester to provide non Deanery training and it is hoped that courses will be available from September 2021. Work is underway to improve the governance surrounding the Serious Incident Learning and Review Group to move away from a culture of acceptance of low standards. There is now greater clarity of dignity at work requirements which will assist in holding to account where necessary. There is also a focus on reviewing the workforce needed to deliver urgent care (and reflecting that in the Job Plans) recognising that there is a national issue where juniors are trained to be generalists and then specialists rather than the other way round. The Chief Medical Officer has an important role to play in the Digital strategy implementation. There is more than sufficient interest from clinicians to support this work, which will be built into the Job Plans.

Annual Plan Priorities and 2020/21 Annual Operational Plan First Cut: We received the Annual Plan priorities as presented to the last Trust Board meeting. We expressed concern that to date the resources to deliver the plan are not yet fully defined, noting that further work is taking place . We also requested to receive more clarity about the Single Improvement Methodology and roles & responsibilities of the improvement director. This is seen as critical to become more successful in change/execution.

We received a revised 2019/20 bridge to 2020/21 and a detailed explanation of how the position was arrived at. We noted that further work is required to further reduce the proposed deficit. We expressed concern that a credible plan needs to be developed with the numbers and narrative included. Currently we have improved little on last year's position, both in terms of the absolute financial position as well as the state of the operational plan/budget. The process needs to commence sooner. Divisional sign off is important and the final plan is on the Trust Board agenda.

Finance & Performance Committee Assurance Report

Executive Summary (cont.)

Home First Worcestershire: We were informed that one system plan is to be signed off later this week. This plan is granular in detail with the desired outcomes, an assessment against performance metrics and clear accountability. There is a requirement for actions in the current plan to be completed by 25 February 2020 so that there is a clear starting point for the signed plan. This plan is aligned with the safer red to green, frailty and Same Day Emergency Care Plans. Additional support is being provided to deliver the plan and to ensure that all Divisional Teams are aligned to the required actions. Although we see some progress, we are fundamentally still missing our four main priorities, but we received an assurance that by the end of Q2 or sooner if possible there will be no patients waiting in the corridor, no one hour ambulance handover delays and no 12 hour breaches. The fourth priority is that there will be a minimum of six empty beds at the start of each day. There are cultural issues to address and staff will be clear as to delivery of the required actions with a firm stance being taken where these are not delivered by all staff working to Homefirst. The financial impact of improved patient flow has yet to be fully costed.

We remain concerned, however, that not all patients have a discharge plan and there is no system in place to provide an accurate picture. The whiteboards have been streamlined but are not being used consistently. We recognize that the introduction of the digital care record will be helpful, but only in the longer term, where we need improvement now. We are to consider how we receive ward to board assurance on this .

Integrated Performance Report: We focused our discussion on the Homefirst elements of the IPR as detailed above. We noted the IPR which appears on the Trust Board agenda. We noted that our incomplete list target for next year is 37,059 based on the numbers at January 2020 in line with the national standard.

Financial Performance Report (M10): Bank and agency spend has increased in month due to the opening of the additional beds and this will reduce as substantive staff are appointed and this forms part of our plans. Taking into account the risks and opportunities ,we have received cautious confidence that the external target will be achieved at year end. We have also expressed our support of the Treasury Management Policy.

Digital Strategy Update: We received our first update and focused on risks. The initial analysis of technology infrastructure has identified, to date, a number of core infrastructure components that require replacement and updating with new infrastructure. The DCR remains funded within the 2020/21 Annual Plan and is on track to deliver phase 1 in 20/21. The business cases for interdependencies are in development. This infrastructure upgrade will also mitigate cybersecurity breaches. A longer term IT Infrastructure strategy and financial plan will be developed in the coming weeks. A much needed upgrade to the Trust Patient Administration System (Oasis) will need to take place prior to the commencement of the DCR. The system supplier, which is also our DCR partner, is finalising the upgrade project plan for consideration by the Trust. Digital innovation projects will be taken forward in parallel with the Digital Care Record and aligned to our Annual Plan priorities.

Procurement Quarterly Update: We noted this update and have asked that a deep dive be prepared on the implementation plan for contract management, in line with the agreed nine principles.

Progress Update – Lessons Learnt from Grant Thornton External Audit Report on Forecasting: We have noted progress on implementation of the main actions which were on the approach to building (and securing the right approvals for) a credible annual plan/budget and forecasting process to ensure delivery of that plan. Quite a few of the recommendations have been taken on board and result in us meeting the external financial target. However we have not met our internal target and we still have not succeeded in running an annual planning process that results in a timely and well prepared plan, enabling thorough and timely review by FPC and board. A number of the remaining actions relate to the development of a realistic medium term financial plan, based on the clinical services strategy and associated enabling strategies and this work is underway. Whilst there have been improvements, we have asked for an assessment of the 2020/21 annual plan preparation. Our role in this process is to be considered at a future development session.

Board Assurance Framework: We approved the 2019/20 update of the BAF and the 2020/21 BAF which appears as a separate item on the Trust Board agenda.

Finance & Performance Committee Assurance Report

Executive Summary (cont.)

Going Concern: The primary risk to us remaining a going concern is the financial deficit and resultant shortfall in cash to discharge our liabilities. Nonetheless, on the balance of assessment of the various risks, opportunities and uncertainties, we endorsed the Chief Finance Officer's recommendation for ratification and approval by the Trust Board that the Trust considers itself to be a going concern in line with the accepted definition for public sector bodies. Neither NHSI/E nor the DHSC have deemed the going concern basis to be inappropriate for the for The Trust.

Review of Terms of Reference: We have approved revised terms of reference subject to the addition of oversight of cyber security and IT in the Committee's purpose. Our changes are incorporated in the separate item on the Trust Board agenda.

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.
- approve the recommendation that the Trust considers itself to be a going concern.

QUALITY IMPROVEMENT STATEMENTS

1. Infection Prevention – Embed our infection prevention and control recovery plan

Strategic Objective: Provide the best experience of care and best outcomes for patients.

YTD Current performance(January)	February trajectory	March trajectory	19/20 Year-end target
CDif – 50(45 Traj)	CDif – 49	CDif – 49	CDif – 53
E-Coli – 49(49 Traj)	E-Coli – 54	E-Coli – 54	E-Coli – 59
MSSA – 15 (10 Traj)	MSSA – 10	MSSA – 10	MSSA – 10
MRSA -2 (0 Traj)	MRSA - 0	MRSA - 0	MRSA - 0

How have we been doing?

- During January we had 6 C-Diff cases, 4 E-coli cases, 0 MRSA and 3 MSSA.
- We are over the monthly trajectory for 3 metrics, but on trajectory for E-coli. 2 metrics (MSSA & MRSA) have failed the year-end target.
- Staff flu vaccination uptake is 75.2% (end of Jan), with frontline nursing/midwifery staff (c600).
- Significant increase in flu positive patients admitted in December (60 of the 78 since Oct 2019). This has since subsided.
- Mandatory training for IPC (L2 clinical staff) has been below the target all year (performance is 87% - target is 90%) and Divisions have been tasked with plans to improve this.
- Anti-microbial prescribing remains a concern. Microbiology colleagues are attending divisional meetings to ensure awareness and compliance to this standard, and to educate where necessary.
- Improved clinical engagement is being sought in relation to anti-microbial prescribing and each Division has been asked to provide a clinical lead to ensure that the actions to be included in the assurance plan will realise improvement, and can be owned by the clinicians.

What actions are being taken to make the improvements?

- Nursing and midwifery staff is the group with the lowest take up of the staff flu vaccination, therefore these staff groups will be the focus in the coming month. There is a risk that we will not quite meet the 80% by the end of March 2020.
- We have received a small number of patients arrive at WRH A&E department for Coronavirus screening. All patients were seen in line with the protocol which worked well.
- All patients had negative results.
- Work is underway to ensure all key units have plans in place to safely care for possible coronavirus patients should they require admission
- From Feb 7th we will have set up an assessment 'pod' in collaboration with Health Economy partners situated away from the WRH A&E department and all patients requiring screening will be sent to this location, this is in line with national guidance.
- NHSE/I / CCG will be back to inspect on April 29th.
- Improved clinical engagement is being sought in relation to anti-microbial prescribing and each Division has been asked to provide a clinical lead to ensure that the actions to be included in the assurance plan will realise improvement, and can be owned by the clinicians

Assurance level – LEVEL 3

Assurance level last month – LEVEL 3

SRO: Vicky Morris (CNO)

Expectation for assurance level improvement:
Q1 2020/21

QUALITY IMPROVEMENT STATEMENTS

Worcestershire Acute Hospitals NHS Trust

2. ReSPECT training – awareness and authorship

Strategic Objective: Provide the best experience of care and best outcomes for patients.

Current performance in December for :
Awareness – 36.44% (1021/2802) – Target is 75%
Authorship 23.55% (219/930) with a target of 75%

How have we been doing?	What actions are being taken to make the improvements?
• Both ReSPECT Awareness Training and Authorship Training have increased, but are both significantly below target. • 'Essential for the Job' ESR dashboard is now being developed and will be available by mid Feb. This will enable visibility for staff regarding whether they are expected to complete the training, current compliance status and when their training expires.	• All Divisions are developing action plans to improve their compliance with ReSPECT training, these will be discussed at the next CGG in March. • There is an e-learning training package available to all, however we are still discussing how best to provide face to face training for those that require it, following the cessation on the additional funded support that we had. • We will be discussing with the Health and Care Trust and WM Ambulance service, how the 2 hour rapid response team (being implemented by the H&CT in Feb/Mar) will be using ReSPECT to ensure only appropriate conveyancing to the Acute. • Leaflets will be distributed to patients and their families informing how ReSPECT can be used by patients. • ReSPECT will be incorporated into the Fundamentals of Care and linked to the Ward accreditation programme to ensure it retains a visible profile.
Assurance level – LEVEL 2 Reason: Some measurable impact evident from actions thus far taken, but action plans in development to accelerate improvement. **Assurance level last month - LEVEL 2**	**SRO: Mike Hallissey (CMO)** **Expectation for assurance level improvement:** March 2020 – following the 'GO live' of the 'essential to role' dashboard through ESR.

QUALITY IMPROVEMENT STATEMENTS

3. Improve our learning from death processes.

Strategic Objective: Provide the best experience of care and best outcomes for patients.

Current performance (December)

Improved SHMI: 1.255 up to August 2019 (was 1.1347) and 'as expected'
Improved HSMR: 110.49 up to September 2019 (was 112.24) but remains 'higher than expected'
Mortality reviews within 30 days rose to 59.91% in November 2019 (was 54.31%).
Backlog of incomplete and outstanding reviews has fallen to 544 cases in November 2019 (was 554)

How have we been doing?	What actions are being taken to make the improvements?
• The Trust continues to show improved performance in respect of both SHMI and HSMR. • The most recent published SHMI shows the trust back within the 'expected' range for the first time in 12 months. • However we remain an outlier in respect of HSMR despite recent improvements. • Our crude mortality rates continue to improve but, in some areas, are higher than other similar trusts. More detailed work has been actioned to unpick these differences within the Trust. • The completion rate for mortality reviews within 30 days has continued to improve. Furthermore, the backlog of uncomplete and outstanding reviews has fallen to its lowest level since November 2018. • The most recent reduction in the backlog indicates that those more recent reviews are being completed albeit in excess of 30 days. • The most recent Learning from Death group was well attended with robust discussion and ensuing actions for future work.	• Examination of mortality by age groups including elective/non-elective surgical procedures and a ward (of admission) by age for Medicine has been requested. • We are continuing to develop a mortality performance framework. • Examination of links between extended waiting times (A&E) and subsequent mortality risks will be investigated. • A review of any elective cases within the backlog has been commenced and feedback will be discussed at the Mortality Review Group. • A 'system-wide' mortality workshop is being held on mid-February to identify any systemic improvements. • Continued recruitment into Medical Examiner roles, including Consultants from the Health & Care Trust and Primary Care Networks. • ME examiner recruitment will be complete once the Divisional Governance leads are appointed and this will complete the workforce requirements to achieve daily review. Training completion should be by March 2020.
Assurance level – LEVEL 3 **Assurance Level Last Month – LEVEL 2**	**SRO: Mike Hallissey (CMO)** **Expectation for assurance level improvement:** Q1 2020/21 – as the plan matures and becomes more embedded.

QUALITY IMPROVEMENT STATEMENTS

4. Friends and Family Test

Strategic Objective: Provide the best experience of care and best outcomes for patients.

Current performance (December)

	ED	Inpatient	Maternity	Outpatient
Response Rate	16.64%	35.30%	32.81%	8.99%
Recommended Rate	82.69%	95.11%	98.60%	93.63%

How have we been doing?	What actions are being taken to make the improvements?
• Inpatient and Maternity met both the response rate target of 30% and the recommended rate target of 95%. • A&E and Outpatient did not meet their targets for either metric and the performance is still fluctuating. • New guidance, which was released in September 2019, is expected to be implemented in April 2020. One of the main changes is a move away from an emphasis of quantity of responses to a focus on quality of responses – what the public is telling us and "You said We Did" from the Trust	• FFT – work continues to think of innovative ways to engage patients and their families to improve the response rates for the FFT surveys. • We are writing a business case for submission to increase the volume of PALS staff which will be reviewed at CGG in March. • We have secured some temporary funding for the Volunteer co-ordinator post which is an essential to ensure efficient use of the volunteers we have. • We are developing a Volunteer Strategy. • We will be focusing on triangulating themes from PALS, Complaints, Performance metrics and survey results to identify key objectives for the Patient Experience plan for 20/21. • We are expecting the results of the Inpatient Adult Survey and will be analysing results and sharing learning with our clinical colleagues
Assurance level – LEVEL 5/6 Reason: Evidence of improved outcomes and actions identified to facilitate implementation of new guidance. **Assurance level last month - LEVEL 5**	**SRO: Vicky Morris (CNO)** **Expectation for assurance level improvement:** Robust level 6 - End of Q1 2020/21

QUALITY IMPROVEMENT STATEMENTS

Worcestershire Acute Hospitals NHS Trust

5. Complaints / patient safety incidents (PSI) / never events

Strategic Objective: Provide the best experience of care and best outcomes for patients.

Complaints January 2020	PSI Q3 19/20
Performance: 83.33% **Target : 80%**	**Performance: Average per month: 1236**
How have we been doing?	**What actions are being taken to make the improvements?**
• We are currently meeting the target of 80% for complaints being responded to within 25 days of receipt. • PSI's remain in accordance with expected levels and positively benchmarks against other similar acute trusts. • There has been a review of complaints and PSIs looking at themes which have been shared with divisional colleagues to better inform their annual planning processes. • Never Events – there were 3 reportable never events.	• PSI recording – there is ongoing work with divisional staff looking at application of severity levels. • PSI – There is still some improvements required in recording/documentation of our compliance with 'Duty of Candour'. • The incident reporting system – DATIX will be amended to make the data fields and flow of data capture more intuitive and efficient for staff to us. This will be happening in the coming months.
Assurance level – LEVEL 4 **Assurance level last month - LEVEL 5**	**SRO: Vicky Morris (CNO)** **Expectation for assurance level improvement:** • Level 5 – expected Q2 20/21 following the implementation of system changes that will enable a granularity of data to be captured. • Q2 – sustained evidence of improvement will be seen.

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 27 February 2020. A summary of key points discussed is as follows:-

Board Assurance Framework (BAF): We approved the 2019/20 update of the BAF and the 2020/21 BAF which appears as a separate item on the Trust Board agenda.

#WeAreVolunteering Strategy: We liked the visual presentation of this strategy. Volunteers are critic al to the services we deliver and we consider that there is more which can be done on the benefits and cost of volunteers and it is our view that greater investment is required. We have suggested that other Trust's approaches be considered to take this forward. We have asked that improved outcomes for staff be included in the Strategy. With this addition, we approved the #WeAreVolunteering Strategy which appears as a separate item on the Trust Board agenda.

Infection Prevention and Control: We noted that the assurance level is 3. We were pleased to note that we have met the 80% flu vaccination target enabling us to receive the CQIN payment. Nonetheless we were concerned at the number of nurses who are not engaged in this process. We received a comprehensive update on coronavirus, the guidance received and the actions being taken. We are conscious that dealing with coronavirus is diverting resources in our Infection Prevention and Control Team from business as usual given that some of the IPC metrics are being missed by a considerable margin. A further update on the coronavirus is on the Trust Board agenda,

Integrated Quality Report: We consider that there needs to be more rigour over the actions being taken by the identification of a responsible person , a date when it is expected that the actions will be completed and learning identified. We can understand why A&E did not meet their Friends and Family Test targets but are disappointed that outpatients did not meet their target. We have asked that this is addressed. On complaints we considerer that it is now the right time for the metrics be move to an outcomes approach with how the learning is being used. The ReSPECT training target has been missed by a substantial margin. We have been informed that the are issues with how the training is recorded which may indicate that compliance is higher. This is being looked at. There is a system wide workshop looking at learning from deaths and there is acceptance from all of the need to work together. The recruitment of five Associate Divisional Directors will also provide a Medical Examiner role bringing the total number of Examiners to 12. We received an explanation on how the backlog is being addressed. In considering the SPC charts we observed some positive news – hand hygiene, falls and some poor performance – Sepsis 6 and ICE reports not being viewed. There also needs to be a focus on completing the overdue actions.

Safeguarding Quarterly Update: We received a comprehensive report and clear presentation which provided evidence and assurance on what is happening with regard to safeguarding. Every opportunity is being provided for safeguarding training and yet there are gaps in compliance. The Chief Medical Officer has undertaken to write to those clinical staff who have not yet undertaken their safeguarding training taking a firm stance over non compliance.

Quality Governance Committee Assurance Report

Executive Summary (cont.)

Local Maternity and Neonatal Service (LMNS) : The LMNS has been tasked to half the still birth, neonatal and maternal death rates; half neonatal brain injuries by 2025; and reduce smoking and prematurity rates to 6% by 2022. The LMNS objectives for 2019/20 also include Saving Babies Lives v2; undertake a gap analysis against the national postnatal pathway; support the Neonatal Critical Care review; scope the citing of maternal medicine centres with maternity network and support trusts with their CNST and #MatNeo activities. We noted the activities taken place over the last six months to further these tasks.

Quality Annual Priorities 2020/21`: In determining the priorities for the Trust for 2019/20, three data sources have been used to identify those which are important in going forward for Quality Account 2020/21. These sources are: feedback from patients, their carers and public; the outcomes from the quality priorities for Year 2 of the Quality Improvement Strategy and Care Quality Commission reports 2019 "Must Dos". We noted the schedule for the publication of the Quality Account in June 2020. The Account incorporates the continued requirement to report progress made with seven day services and the detailed ways in which we facilitate staff to speak up (including whistleblowing). We have asked that the Hospital Acquired Functional decline element addresses how we manage the forthcoming winter pressures. We approved the proposed Quality Account priorities for 2020/21.

Proposed System of Governance: We have given support to a proposals to be developed by the Chief Medical Officer and Chief Nursing Officer.

Risks: We have agreed that the risks surrounding coronavirus be included in the Corporate Risk Register.

Background

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

Recommendations

The Board is requested to receive this report for assurance.

PEOPLE & CULTURE IMPROVEMENT STATEMENTS

Worcestershire Acute Hospitals NHS Trust

1. Appraisal Rates – Ensure all our staff have annual appraisal (Non-Medical)

Strategic Objective: Best People

Current performance (January) against local target of 90%	February trajectory	Year end trajectory	19/20 Year end target	April 2020 target
Non-Medical Appraisal 84%	85%	86%	90%	95%

How have we been doing?	What actions are being taken to make the improvements?
• Non-Medical Appraisal rates have remained at 84% • Improvement of 7% from same period last year • We are performing well against Model Hospital benchmark which is 85% (December 2019)	• 1:1 training provided to managers on appraisal functionality • ESR sends email 4 months prior to expiry of appraisal to remind manager and individual • Appraisal rates are covered in Divisional PRM meetings • HR send monthly reports to Divisions for discussion at Divisional Board meetings • Further ESR Self Service training for managers planned for Spring 2020 • Target to be raised to 95% from April 2020.
Assurance level – LEVEL 4	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS

2. Mandatory Training Compliance – Ensure that all our staff are suitably trained				
Strategic Objective: Best People				
Current performance (January) against local target of 90%	February trajectory	Year End Trajectory	19/20 Year-end target	April 2020 target
89.4%	90%	91%	90%	95%

How have we been doing?	What actions are being taken to make the improvements?
• Mandatory training compliance has remained at 89.4% which is slightly below current target • Model Hospital benchmark is 90% (Sept 2019) and 88% within our Peers • Automated emails from ESR and RAG rated matrix continue to be well received by staff in maintaining compliance • WRAP training has increased by a further 4% in one month and is now at 82% which is only 1% short of the same period last year, which demonstrates the effectiveness of ESR functionality.	• Mandatory Training compliance is covered in Divisional PRM meetings • HR currently continue to send monthly reports to Divisions for discussion at Divisional Board meetings • Plan to stop monthly divisional reports to push towards ESR Manager self service with rollout of further training in Spring 2020 • Publicity for "Act on Amber" to be sent out • HR BP's to push further action within divisions • Target to be raised to 95% from April 2020
Assurance level – LEVEL 6	**SRO: Tina Ricketts (DPC)**

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3. Medical Appraisal Rates – Ensure all our doctors have annual appraisal as part of revalidation process				
Strategic Objective: Best People				
Current performance (January) against local target of 90% and Model Hospital benchmark of 100%	February trajectory	Year end trajectory	19/20 Year end target	April 2020 target
Medical Appraisal 94%	95%	95%	90%	95%

How have we been doing?	What actions are being taken to make the improvements?
• Medical appraisal has reduced by 1% this month • Compliance is 94% which is well above the current 90% target • Improvement of 9% from the same period last year • Trajectory and Assurance Level reflects our confidence that we will reach 95% by year end • Model Hospital Benchmark is 100%	• Allocate E-appraisal and revalidation functionality implemented and embedded • Automated email notifications from Allocate system and from ESR Self Service • Dedicated resource in HR medical resourcing team • Outstanding appraisal/revalidation escalated to Divisional Directors and HR BP's to follow up • Target to be raised to 95% from April 2020.
Assurance level – LEVEL 5	**SRO: Tina Ricketts (DPC)**

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4. Consultant Job Plan Compliance – Ensure all our Consultants have up to date Job Plans

Strategic Objective: Best Use of Resources

Current performance (January) against local target of 90%	February trajectory	Year End Trajectory	19/20 Year-end target	April 2020 target
91%	92%	93%	90%	95%

How have we been doing?	What actions are being taken to make the improvements?
• Consultant job planning compliance has increased by 2% this month • Compliance is 91% which is above the current 90% target • Trajectory and Assurance Level adjusted to reflect improved performance but remains unlikely to reach 95% by year end • Model Hospital Benchmark is 100%	• Job Plan consistency panel taking place to ensure that agreed plans best meet service needs • Dedicated resource in HR medical resourcing team has uploaded the majority of job plans on e-job plan • Outstanding job plans escalated to Divisional Directors and HR BP's to follow up • E-job plan automated email notifications to be turned on from April 2020 once all job plans are live, which will support the next annual job planning round • Target to be raised to 95% from April 2020
Assurance level – LEVEL 4	**SRO: Tina Ricketts (DPC)**

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5. Vacancy Rates – Ensure we have adequate staff to ensure patient safety

Strategic Objective: Best Use of Resources

Current performance (January) against local target of 7%, and national benchmark of 8.1%	February trajectory	Year end trajectory	19/20 Year end target	April 2020 target
8.87% Substantive plus new wards	8.75%	8.5%	7%	7%
7.79% Substantive vacancies only	7.6%	7.4%	7%	7%

How have we been doing?	What actions are being taken to make the improvements?
• Successful domestic and international recruitment campaigns continue to show impact • Our overall vacancy rate including funded bank and agency for new wards has reduced by 0.39% since last month • Our overall vacancy rate (including funded bank and agency for new wards) is now at 8.87% which is more than 3% lower than our substantive vacancy rate for same period last year (11.41%) • Our substantive vacancy rate (excluding new wards) has reduced to 7.79% which is now better than the HEE Regional average and NHS average of 8.1% (source ONS survey/NHSI) • However, opening Ward 5 in February 2020 will increase establishment to staff 33 new beds with the resultant increase in vacancies	• Rolling Programme of centralised recruitment for Band 5 and Band 2 Nurses and all Medics • Our recruitment pipeline for B5 nurses will reduce our vacancies from 175 currently to less than 55 by June 2020 as a result of increased domestic recruitment and international recruitment supported by HEE and NHSP • Clinical fellow programme in place to reduce career grade vacancies • Medics recruitment requirement reduced by 23.72 wte since October and will reduce to 42.65 wte by June 2020 • Interviews are scheduled for appointments to new centralised recruitment model which will enable reporting on ALL vacancies, and slicker timescales for all recruitment, rather than just B2 and B5 nurses and Medics.
Assurance level – LEVEL 5	**SRO: Tina Ricketts (DPC)**

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6. Staff Turnover Rates – Make this a good place to work so that we can retain our staff

Strategic Objective: Best Use of Resources

Current performance (January) against national benchmark of 0.89% (Monthly rate)	February trajectory	Year end trajectory	19/20 Year end target	April 2020 target
Monthly Turnover 0.73%	0.70%	0.70%	0.89%	0.89%
Annual Turnover rate 11.06%	11%	11%	12%	11%

How have we been doing?	What actions are being taken to make the improvements?
• Our monthly turnover has reduced to 0.73% this month which is lower than Model Hospital average • Our monthly turnover for November 2019 (latest rates on Model Hospital) was however 1.01% against Model Hospital average of 0.89% • Annual turnover rates are better than target and continuing to improve with further 0.09% improvement this month to 11.06% • Annual Turnover is 1.4% lower than same period last year and improving since May 2019.	• Phase 2 of 4ward launched • Embedding of the Education Academies • Results of 2019 Staff Opinion Survey to be analysed against national benchmark, once published by CQC in respect of staff recommending Trust as place to work, and staff stating they are intending leaving the organisation • Target to be reduced from 12% to 11% from April 2020
Assurance level – LEVEL 6	**SRO: Tina Ricketts (DPC)**

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7. Total Hours Worked – Ensure we have adequate staff to meet patient needs within financial envelope.				
Strategic Objective: Best Use of Resources				
Current performance (January) against budgeted establishment of 6022.98 wte	February trajectory	Year end trajectory	19/20 Year end target	April 2020 target
Hours worked (substantive, bank and agency) 6126.08 wte	6050	6050	6022.98 (funded establishment)	6022.98 wte plus 33 beds for Avon 5 tbc

How have we been doing?	What actions are being taken to make the improvements?
• Our total hours worked have increased by 23 wte this month and 172.35 wte from same period last year • This is partly due to 3 new wards (66 additional beds) and increased fill rates through NHSP interface. • We usually have seasonal variation in our sickness rates in January which will have impacted on additional hours worked this month together with the extra capacity in ED • Our total hours worked are 103 wte above our funded establishment this month for the first time which will be partly due to extra hours in ED not being funded • The total hours worked are expected to increase next month due to the opening of a further 33 beds	• Review of NHSP bookings to ensure that backfill is only requested to cover vacancies, as sickness and training are already in the headroom on the establishment • Business plans in development to move payment for all additional hours for all staff groups through NHSP, to move WLI payments onto Allocate system • Business plans in development to resource implementation of Allocate Clinical Activity Manager module which will give greater grip and control of outpatient clinics and theatre activity • Further rollout of Medics on duty to improve utilisation of medics, including better governance on leave booking and backfill
Assurance level – LEVEL 2	**SRO: Tina Ricketts (DPC)**

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8. Sickness Absence Rates – Ensure that sickness absence is managed and that our staff are supported to maintain their health and wellbeing at work

Strategic Objective: Best Use of Resources

Current performance (January) against local target of 4%	February trajectory	Year end trajectory	19/20 Year end target	April 2020 target
Monthly Absence rate 5.06%	5%	4.8 %	4%	3.5%

How have we been doing?	What actions are being taken to make the improvements?
• Our monthly sickness absence rate has increased by 0.19% to 5.06% this month compared to 4.93% for same period last year • Latest Model Hospital average is 4.35% (September 2019) at which point we were reported as 4.23% • HEE Regional average is 5% • Short term sickness has increased by 0.02% to 2%; Long term sickness has remained higher than target at 2.38% this month • Main increase in long term absence is due to stress/anxiety	• Support from Occupational Health available to support all staff • Specific support for those reporting stress anxiety or depression and musculoskeletal issues • Publicity for flu vaccination ongoing with take up currently 1.4% short of 80% national CQUIN target (79 vaccines short) • Sickness absence rates are discussed in Divisional PRM meetings but will require more focus to reach new stretch target • Target to be reduced to 3.5% from April 2020
Assurance level – LEVEL 4	**SRO: Tina Ricketts (DPC)**

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9. Agency Spend as a % of gross cost – Ensure that we have enough of our own substantive and bank staff to reduce reliance on agency spend

Strategic Objective: Best Use of Resources

Current performance (January) against local target of 7%	February trajectory	Year end trajectory	19/20 Year end target	April 2020 target
Monthly Agency spend as a % of gross cost 9.65%	9.5%	9%	7%	7%

How have we been doing?	What actions are being taken to make the improvements?
• Our agency spend had been showing improvement since the implementation of Allocate suite of solutions and NHSP interface • However, during January 2020 our use of agency has increased by 0.65% to 9.65% of gross cost • This is mainly due to the increased capacity in ED following the unannounced CQC inspection • Seasonal variation in our sickness rates in January will have impacted on additional hours worked this month booked at short notice which would make it less likely to fill on the bank • The total hours worked are expected to increase next month due to the opening of a further 33 beds on Avon 5.	• Review of NHSP bookings to ensure that backfill is only requested to cover vacancies as sickness and training are already in the headroom on the establishment • Further rollout of Medics on duty to improve utilisation of medics, including better governance on leave booking and backfill • Continuation of both domestic and international recruitment • Work with NHSP to increase the Nurse and Medic banks so that we can avoid agency spend wherever possible • Embedding of 12 week roster lockdown to improve opportunity of bank cover
Assurance level – LEVEL 2	**SRO: Tina Ricketts (DPC)**

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10. Bank Spend as a % of gross cost – Ensure that we have enough of our own substantive and bank staff to reduce reliance on agency spend

Strategic Objective: Best Use of Resources

Current performance (January) against local target of 7%	February trajectory	Year end trajectory	19/20 Year end target	April 2020 target
Monthly Bank spend as % of gross cost 6.93%	6.95%	7 %	7%	7%

How have we been doing?	What actions are being taken to make the improvements?
• Our bank spend had been relatively stable at just over 7% but had an increase in March 2019 which is likely to be due to staff taking annual leave at the end of the leave year. • Use of bank was improving upon implementation of the Allocate suite of solutions and NHSP interface, until September • During January our use of bank has increased by 0.2% to 6.9% of gross cost • The total hours worked are expected to increase next month due to the opening of a further 33 beds (Avon 5)	• Review of NHSP bookings to ensure that backfill is only requested to cover vacancies as sickness and training are already in the headroom on the establishment • Work with NHSP to increase the Nurse and Medic banks so that we can avoid agency spend wherever possible • Embedding of 12 week roster lockdown to improve opportunity of bank cover
Assurance level – LEVEL 3	**SRO: Tina Ricketts (DPC)**

Appendix - Assurance Levels

RAG Rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all the agreed actions, with clear evidence of the achievement of desired outcomes over defined period of time i.e. 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of the desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of the desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of the desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

The table above provides the detail in relation to the assurance levels being applied in the improvement statements shown earlier in this report