9-1-19

Trust Board
There will be a meeting of the Trust Board on Thursday 10 January 2019 at 10:00 in Crompton Rooms A&B, Charles Hastings Education Centre, Worcestershire Royal Hospital, Worcester.

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

Sir David Nicholson
Chairman

	Agenda		Enclosure
	Patient story		
1	**Welcome and apologies for absence**		
2	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
3	**Declarations of Interest** *To declare any interest members may have in connection with the agenda.*		
4	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **9 November 2018** as a true and accurate record of discussions.*	*For approval*	**Enc A**
5	**Action Log**	*For noting*	**Enc B**
6	**Chairman's Report**	*Verbal*	
7	**Acting Chief Executive's Report**	*For noting*	**Enc C**
8	**Board Assurance Framework and Corporate Risk Register** Acting Chief Executive	*For approval*	**Enc D**
9	**Integrated Performance Report**		**Enc E**
9.1	**Introduction** Acting Chief Executive	*For assurance*	
9.2.1	**Section 1 – Quality Performance Report** Chief Nurse/Chief Medical Officer		
9.2.2	**Quality Governance Committee Assurance report** Quality Governance Committee Chairman		

9.3.1	**Section 2 – Operational & Financial Performance Report** Interim Chief Operating Officer/Chief Financial Officer		
9.3.2	**Finance and Performance Committee Assurance Report** Finance and Performance Committee Chairman		
9.4.1	**Section 3 – People and Culture Performance Report** Director of People and Culture		
9.4.2	**People and Culture Committee Assurance Report** People and Culture Committee Chairman		
10	**Governance**		
10.1	**Financial Forecast** Chief Financial Officer	*For approval*	**Enc F1**
10.2	**National Quality Board Mortality Metrics** Chief Medical Officer	*For assurance*	**Enc F2**
10.3	**Report on Nursing and Midwifery Staffing Levels – October 2018** Chief Nurse	*For assurance*	**Enc F3**
10.4	**Service Reconfiguration Plan** Acting Chief Executive/Chief Operating Officer	*For assurance*	**Enc F4**
11	**Assurance Reports from Board Committees**		
11.1	**Audit and Assurance Committee Report** Audit and Assurance Committee Chairman	*For assurance*	**Enc G1**
11.2	**Charitable Funds Committee Report** Charitable Funds Committee Chairman	*For approval*	**Enc G2**
11.3	**Remuneration Committee Report** Chairman	*For assurance*	**Enc G3**

Any Other Business *as previously notified*

Date of Next Meeting
The next public Trust Board meeting will be held on 14 February 2019 in the Board Room, Alexandra Hospital, Redditch

Public Q&A session

Enc A

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON FRIDAY 9 NOVEMBER 2018 AT 10:00 hours
Crompton Rooms A&B,
Charles Hastings Education Centre, Worcestershire Royal Hospital

Present:

Chairman:	Sir David Nicholson	
Board members: (voting)	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Michelle McKay	Chief Executive
	Jill Robinson	Chief Financial Officer
	Philip Mayhew	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Bill Tunnicliffe	Non-Executive Director
	Steve Williams	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications
	Tina Ricketts	Director of People and Culture
In attendance:	Cathy Geddes	NHS Improvement Director
	Graham James	Deputy Chief Medical Officer
	Cathy Garlick	Senior Manager, Local Maternity Service *(item 100/18/1)*
	Kimara Sharpe	Company Secretary
Public Gallery:	Press	1
	Public	4
Apologies:	Suneil Kapadia	Chief Medical Officer
	Julie Moore	Associate Non-Executive Director
	Richard Oosterom	Associate Non-Executive Director
	Sarah Smith	Director of Strategy and Planning

89/18 **WELCOME**
Sir David welcomed everyone to the meeting.

90/18 **Staff story**
The meeting was informed that unfortunately Miss Blackwell was unable to attend but that she would be invited to attend another meeting.

Sir David reported that he had attended a meeting of the local medical committee where working arrangements around junior doctors and the alleged bullying of junior doctors was raised. Mrs Morris confirmed that Miss Blackwell had raised with her concerns about how nurses were speaking to junior doctors.

Mrs Morris reported that she had met with FY1 and FY2 trainee doctors. She understood their workload concerns and the conflicting priorities that they manage. She discussed with

them the action needed for a deteriorating patient. She recognised that nurses could be more helpful when contacting junior doctors and she has re-instigated the SBAR process (situation, background, assessment and response) to ensure that junior doctors are fully aware of the issues and why referral to a doctor has been triggered.

Mr James confirmed that he was putting in place more robust guidelines for escalation to senior doctors by juniors, particularly in respect of volume of work.

Dr Tunnicliffe reflected that allegations of bullying is an indication of a system under pressure. He felt that using the Guardian for Safe Working was not an appropriate use and would have preferred issues to have been raised via the senior medical team. He was pleased to hear of the senior doctor involvement as escalation in respect of a deteriorating patient should not be wholly dependent on a junior doctor. He advocated more multidisciplinary learning and more utilisation of the simulation ward at Kidderminster.

Mr Yates confirmed that Miss Blackwell attended the People and Culture Committee on a quarterly basis. The Committee were keen to ensure that the experience of junior doctors was positive so that they returned to the Trust when they were qualified.

Ms Ricketts reported that she will present to the People and Culture Committee a framework for standards that the Trust should have in place for junior doctors. Mr Yates confirmed to Mr Williams that the Committee is looking holistically at the experience of junior doctors including the role of consultants.

Mrs Morris confirmed to Ms Day that she is working with nurses to ensure that they are not experiencing inappropriate behaviour from junior doctors.

Mr James stated that better information technology would help smarter working, particularly in respect of the electronic discharge system and electronic prescribing. He confirmed that bids have been put in for better systems.

In response to Sir David, Mrs Morris stated that the Trust could undertake more multidisciplinary working. Ms Ricketts was taking this through the education, learning and development group.

Mrs Morris also confirmed that Dr Kapadia was undertaking more work on out of hours working such as the role of night practitioners, in respect of support to junior doctors.

Mr James confirmed to Dr Tunnicliffe that the Trust was working with the University of Worcester in respect of the role of the physician associate which will support junior doctors.

Sir David thanked members for the discussion. He would feed the initiatives back to the Local Medical Committee. He reflected that people do work differently when under pressure, but the Trust needed to be focussed on improving services for patients. Information technology can aid this, but crucial is listening to people and creating an environment of trust between the disciplines.

91/18 **ANY OTHER BUSINESS**

There were no items of any other business.

92/18 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interest. Board members were reminded that the Register is on the website.

93/18 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 13 SEPTEMBER 2018**

RESOLVED that:-

- The Minutes of the public meeting held on 13 September 2018 be confirmed as a correct record with the addition of *due to a national shortage* at the end of paragraph 2 on page 3.

Sir David asked for an update on international recruitment. Mr James confirmed that the Trust was well advanced in developing proposals for secondment or exchange programmes with consultants in Australia.

94/18 **MATTERS ARISING/ACTION SCHEDULE**

Mrs Sharpe reported the following:
65/18: A report had been considered by the Quality Governance Committee at its October meeting which showed embedding of the lessons learnt.
74/18/1: The national report had been considered. It showed no further lessons to learn from deaths of people with learning disabilities.

All other actions had been completed.

95/18 **Chairman's Report**

Sir David outlined the emergency powers that had to be taken in respect of the PFI contract and energy management. This was to reduce the cost to the Trust.

RESOLVED that the Board:-

- Noted the use of emergency powers

96/18 **Chief Executive's Report**

Mrs McKay highlighted the external recognition of staff. The areas were broad, both clinical and non-clinical. A case study had been included in a national report about end of life care.

She went on to state that the national planning guidance would be published in December. In the meantime, she outlined the timetable and suggested that the Finance and Performance Committee oversaw the detail.

Mrs McKay explained that the Trust is required to review all contracts to plan in case of a no Brexit deal and deliver a report by the end of November. Ms Robinson was the Senior Responsible Officer and the Finance and Performance Committee was overseeing the issues.

Mr Mayhew stated that there was an opportunity for more engagement in the planning process and requested assurance on this area.

Ms Ricketts confirmed to Mr Mayhew that the Trust was not affected by any staffing issues due to Brexit. National guidance is in place and the Trust is in contact with the appropriate staff members.

Sir David was pleased to see the recognition being given to the staff and the services offered. He requested that the Trust reviews its policy on European nationals and considered whether to pay for the staff to go through the national scheme.

Sir David highlighted the extended service of the Mental Health liaison team – an extremely important service and he was pleased to see the team now taking referrals from all wards and the extended hours.

Sir David then asked whether the trust was applying for money for prostate cancer

treatment. Mrs McKay confirmed that this would be reviewed.

Sir David then asked for a local Trust planning summary document. It was important to build a plan from front line staff upwards. He would be looking to the Finance and Performance Committee to ensure that this was undertaken.

Ms Robinson and Mr James confirmed that the process had commenced.

ACTION:

- **Review whether the Trust should pay for EU nationals to register post Brexit (Ms Ricketts)**
- **Explore applying for prostate cancer monies (Mr Brennan)**
- **Assurance that the Trust Plan has clinical staff engagement (Finance and Performance Committee)**

Resolved that:-
The Board

- Noted the report
- Noted that Ms Robinson was the Senior Responsible Officer for Brexit planning
- Agreed that the detailed work on the 2019/20 and beyond plans is undertaken through the Finance and Performance Committee.

97/18 **INTEGRATED PERFORMANCE REPORT**

97/18/1 **Executive summary**

Mrs McKay introduced the report. She highlighted the revised quality and safety metrics which had been changed to reflect that some previously monitored indicators had achieved sustained improvement. She expressed grave concern with the financial report and whilst the operational performance remained challenged, she was pleased with the improvement in cancer two week waits. She also highlighted the low turnover rate within the workforce report.

97/18/2 **Quality Performance/Quality Governance Committee Assurance Report**

Mrs Morris focussed on infection, prevention and control (IPC). She continued to be concerned about the outbreaks of CPE (Carbapenemase Producing Enterobacteriaceae). The management and support for patients was of paramount importance. Hand hygiene is key to managing patient safety. This was a national issue and CPE was resistant to antibiotics.

Mrs Morris then went onto *c difficile* which shows the Trust is slightly above trajectory. This is also affected by antibiotic prescribing.

She reported a drop in basic hand hygiene compliance which was very disappointing. The Trust Infection, Prevention and Control Committee are focussing on this issue.

There has been an improvement in pressure ulcer outcomes and falls have slightly decreased.

Mr James reported that VTE (venous thrombolytic embolism) screening has significantly improved over the previous 12 months. Whilst sepsis 6 has a disappointing performance, he was keen to differentiate between the elements. Administration of antibiotics within 1 hour was above trajectory. He accepted that performance in relation to mortality reviews could be improved.

Mr Williams asked about progress with the Friends and Family indicator. Mrs Morris stated

that there was a lot of work being undertaken and that the focus needed to be on out patients. Mrs Geddes confirmed that local data from other trusts has been shared with the patient experience lead and that other A&E departments perform better than the trust. Lessons will be learnt from them.

Sir David asked for the Chairman of the Quality Governance Committee to comment.

Dr Tunnicliffe stated that the Committee are working to develop leading not lagging indicators. He was pleased with the sustained performance of responding to complaints and investigations into serious incidents. He was delighted with the away day and the improvements made to the Committee agenda and dashboard. The Committee continued to be supported by SQUID and urged members to view this.

He then went onto areas of concern. He stated that sepsis 6 was chosen as this allowed a focus on outcomes. Infection prevention and control were of serious concern. He was working with Dr Kapadia in respect of the bereavement service and mortality reviews. He was pleased that the Trust was developing a Digital Strategy to support clinicians to deliver better care.

Dr Tunnicliffe then turned to medical devices. QGC had been concerned that this area was not within the corporate risk register. There was no dedicated training manager. He had no assurance that maintenance of equipment was being undertaken in a timely fashion. Ms Robinson confirmed that this area was under her remit. The PFI were responsible for maintenance on the PFI site and estates and facilities for maintenance on the other two sites. She was working closely with Mrs Morris to identify the actions needed and the lead to undertake those actions.

Ms Robinson confirmed to Mr Mayhew that P2G has been asked to undertake a governance review of the PFI contract, including contract monitoring. This report will be ready in the next two weeks.

Mr Mayhew requested a meta-analysis in relation to lessons learnt from complaints and incidents. This was agreed.

ACTION: To undertake a meta-analysis of lessons learnt, report to QGC and then to Trust Board (Mrs Morris/Dr Kapadia)

Ms Ricketts asked about the electronic staff record and mandatory training. She was aware of issues in respect of safeguarding and the hierarchy, but was unaware of other issues. Dr Tunnicliffe stated that hand held records were still being kept by staff as they had felt that ESR did not reflect the accuracy of the data. Ms Ricketts agreed to discuss this with the divisions.

Finally, Dr Tunnicliffe was concerned that there was inadequate engagement at divisional level with the CQC must and should dos. He has requested a full report into the issues for the next meeting.

Resolved that
The Board

- Received the report for assurance
- Noted the concern in relation to the management of medical devices.

97/18/3 **Financial Performance/Finance and Performance Committee Assurance Report**
Ms Robinson presented the month 6 report. This shows a negative variance to operating

plan of £4.5m. The challenges are predominately around activity and delivery against activity. Income is behind prediction. Elective work cannot be delivered due to bed pressures with non-elective patients. She was pleased that the theatre productivity was gaining traction.

Expenditure plans are in line but continued use of escalation beds and high use of premium rate agency staff means that the spend reductions are not being seen within the cost improvement plans.

The cost improvement plan is ahead of the operating plan by £900k. However, it is not in line with the forecast if the Trust expects to meet the full year plan. She stated that additional resources have been spent to achieve some cost improvement plans e.g. theatre productivity.

Ms Robinson is now reviewing the full year forecast. She will present this to the Finance and Performance Committee. The draft shows significant variance to the operational plan, primarily due to the use of escalation areas. The winter plan has a negative variance of £1.5m, due to the agency spend and no improvement on the 11% vacancy rate.

Sir David invited Mr Mayhew to comment, as Chairman of the Finance and Performance Committee.

Mr Mayhew stated that the finances remain challenging. There is now better understanding of capacity and demand. He was looking forward to the production of the medium term financial strategy. He concluded by stating that there are three areas which need traction, theatre productivity, workforce and procurement.

Mr Williams stated that the discussions in the previous year mirrored those of this year. The Clinical Services Strategy was a key enabler and he wished to see progress on this.

Mrs McKay was pleased that the divisions were now being held to account as there was more granular information available on demand and capacity. The recent NHS Improvement deep dive was complimentary about the grip and control. She concurred that the medium term financial strategy was essential to be able to progress the work further.

Dr Tunnicliffe was sceptical about the clinical engagement. Theatre productivity has only had a 12% improvement in the utilisation of theatre slots. Numbers of stranded patients remained high.

Ms Robinson admitted that the theatre productivity work was only recently showing traction. However this was now progressing well. Mr James agreed and reminded members that this work has taken over 12 months to develop. Dr Tunnicliffe agreed but expressed disappointment that not more senior clinicians were identifying areas for improvement.

Mr Mayhew reminded members that the model hospital showed areas for improvement.

Ms Ricketts stated that that the strategic workforce plan is critical to success. The Trust is reactive to the staff required. This work will look at demand and capacity and match the workforce accordingly.

Following a comment from Sir David, Ms Robinson agreed to share with the Finance and Performance Committee the underlying run rate.

ACTION: Share the underlying run rate with the F&P Committee. (Ms Robinson)

Dr Tunnicliffe asked for more clarity in relation to the provider sustainability fund (PSF). Ms Robinson confirmed that the Trust will be unable to achieve the performance targets so will not receive PSF. She stated that guidance was awaited in respect of the PSF and 2019/20.

In response to Mr Yates, Ms Robinson confirmed that of the £20m forecast deficit, half was due to income.

Sir David wondered whether the Trust was able to forecast correctly. Figures discussed at the Board to Board confirmed a risk of £10-15m. There was now an additional £7m. He requested the Audit and Assurance Committee to oversee an audit into this area. He did not wish this to happen in future years.

ACTION: Audit and Assurance Committee to review the forecast figures (Mr Williams)

Sir David was concerned about the potential £62m deficit. However he was pleased that there was a grip on the run rate. He was adamant that work on the quality and safety agenda and on workforce and culture would ensure that the financial performance would improve.

Sir David then invited Mr Brennan to talk on operational performance.

Mr Brennan stated that the emergency access standard, diagnostics and referral to treatment times were below target. There had been improvement in cancer waiting. All cancer targets should be met by January 2019.

He then turned to the detail. The four hour standard included the minor injury unit activity. The paper was not clear the actions being taken to drive the improvement in performance. He was also concerned that the data being shown was for September.

With respect to length of stay, Mr Brennan reported that when zero length of stay is removed, there is a difference of two days. This would indicate that patients are being admitted and then being discharged rapidly. He would be undertaking more work in this area.

Sir David concurred with the timeliness of the information presented and also requested actions to be shown.

ACTION: Review timeliness of data and insert actions being undertaken (Ms Robinson)

Mr Mayhew was pleased with the progress made on cancer targets. He reminded members that the Trust had the second highest number of referrals in the area. He stated that there needed to be a review of diagnostics. Mr Brennan confirmed that there was a deep dive being undertaken. He is also reviewing the incomplete RTT pathway.

Resolved that:
The Board were assured that

- The CIP programme will be on track to deliver against target during the latter part of the financial year.
- The Trust continues to focus on improving operational performance and has made good progress in cancer services.
- Plans around winter planning are progressing

97/18/4 **People and Culture Performance/People and Culture Committee Assurance Report**

Ms Ricketts stated that the Trust remained in the bottom quartile for the people and culture metrics. There was a continued focus on culture to embed the 4ward programme in everyday activity. Only 70% staff have had an appraisal which was disappointing. Mandatory training also needed improving. She was also focussed on recruitment and retention and the strategic workforce plan was being developed.

Mr Yates stated that recruitment and retention was key. He recognised that compared to other trusts, the Trust had a low vacancy rate. However he was disappointed that this rate had not decreased, despite all the work being undertaken. He acknowledged that recruitment for winter would not match the required numbers and there would be a reliance on agency staff.

Mr Yates was pleased that a leadership faculty was being developed. Development programmes are in place for the leaders. However, there was no budget for backfill for staff to attend the leadership courses. This was of great concern.

He went onto state that there was a need to refocus on the 4ward programme to bring momentum behind it.

Mr Williams was surprised about the huge number of staff who were approaching possible retirement. He wanted to know what the Trust was doing to encourage them to stay. Ms Ricketts stated that the age profile of the trust staff was similar to that of other organisations. Conversations were taking place with staff to attract them back into the Trust with part time or step down work. This work needed to be developed.

Mr Williams asked whether there was the same issue with medical staff. Mr James confirmed that this was a different situation and consultants came back after taking retirement at the age of 58-60. He explained the process.

Dr Tunnicliffe asked why the PDR compliance was so low. Ms Ricketts confirmed that staff did not see the value of the process and the culture needed to be changed to value the interaction.

Sir David expressed concern that this was a crucial element for the Trust. The December development day will focus on the issues.

Resolved that:
The Board:

- Received the Committee report for assurance.

98/18 **STRATEGY**

98/18/1 **People and Culture Strategy - refresh**

Ms Ricketts presented the annual refresh of the People and Culture Strategy. She outlined the two changes made to strengthen the Strategy – the governance structure, to ensure the right oversight and a delivery section.

Mr Yates confirmed that the recent People and Culture Committee had considered the refresh and were assured with its contents.

Mr Mayhew cautioned against undertaking in Investing in People due to the significant resource requirement. Ms Ricketts stated that IIP had recently been reviewed and she considered it to be a worthwhile investment for the future. It helps to demonstrate that the systems are best practice to the regulators.

Resolved that:-
The Board:-

- Approved the People and Culture refresh

100/18 **STAKEHOLDERS**

100/18/1 **Local Maternity System (LMS)**

Sir David welcomed Mrs Garlick to the meeting.

Mrs Garlick outlined the history of the LMS and stated that it formed part of the Sustainability and Transformation Plan. The LMS also reports to NHS England through the Maternity Alliance, the Midlands and East Maternity Board to the national Maternity Board.

She described the Board which is driving the LMS and was pleased that the Director of Public Health would be chairing the Board when Mrs McKay leaves.

The progress to date includes a signed off Plan and agreed trajectories to meet national expectations for the reduction in still births, neonatal deaths, maternal deaths and neonatal brain injuries. There have been additional national trajectories added including reduction in smoking at delivery (2% by 2022) and a reduction in premature births by 2025. These targets are extremely challenging. Currently there is a smoking rate at delivery of 13%. Additional funding has been secured in respect of the Saving Babies Lives Care Bundle.

Mrs Garlick then highlighted the next steps. Work streams are in place with reporting and monitoring mechanisms in place. A maternity ultrasound strategy is being developed and a perinatal mental health service has been commenced in Hereford following a bid for additional monies. Maternity hubs in Leominster, Kidderminster and the Alexandra Hospital have opened. Newly qualified midwives will now be offered LMS wide contracts across both counties and ambulance response times have been agreed.

Sir David complimented the work of the LMS. He asked where the governance is with respect to the Trust. Mrs Garlick confirmed that Mrs Morris is the Trust Maternity Safety Champion and the internal working group reports to Mrs Morris and then through the Women and Children Division.

Mrs Garlick confirmed that a challenge for the LMS was scanning as required under Saving Babies Lives. Two midwives are in training but there is a shortage nationally. She also stated that Continuity of Carer, where the aspiration is for a mother to have contact with only four midwives during her pregnancy has a cost implication. Midwives will be expected to work differently. A business case is in development.

Dr Tunnicliffe complimented the work that has been undertaken.

Sir David asked for a review of the governance and assurance around the LMS. This was agreed.

ACTION: Review the governance and assurance with respect to the LMS. (Mrs Sharpe)

RESOLVED that:
The Board

- Noted the report and the progress made to date

98/18 **STRATEGY (continued)**

98/18/2 **Digital Strategy**

Ms Robinson presented the progress report on the development of the strategy. She explained that the focus was on how to support the transformation of the Trust to help address the key challenges and improve the quality of care for patients.

She explained that a number of site visits have been undertaken to Dudley, University Hospitals Birmingham and University Hospital Coventry and Warwickshire.

A self assessment was undertaken in 2017 around digital maturity. This showed a variable performance. She outlined the six work streams to provide high quality patient care and improve outcomes and patient experience.

Finally Ms Robinson asked the Board to support a formal steering group, accountable to the Strategy and Planning Group.

Mr James stated that a lot had been achieved in a short time. He advised that the Steering Group would need adequate resourcing and should include clinicians.

Mr Mayhew emphasised the necessity to involve patients with the ultimate aim for them to manage their own records. Ms Robinson confirmed that HealthWatch was actively involved.

Ms Day asked for confirmation that social care was involved with the work. Mr James stated that all the health economy was involved as the flow of information needed to be across all organisations.

Dr Tunnicliffe stated that the vision should be broader and the strategy should be more ambitious. He requested that the document should reflect the patient at the centre.

Sir David was pleased to see the document. He urged the strategy to fit with the People and Culture Strategy. Ms Day, Mr Oosterom and Dr Tunnicliffe offered to be part of the steering group.

It was agreed to have a six monthly update on progress to the Board.

Resolved that:-
The Board:-

- Noted the progress made and the next planned phase for the Digital Strategy
- Agreed to establish a Digital Steering Group.

99/18 **GOVERNANCE**

99/18/1 **Report on Nurse Staffing Levels – August to September 2018**

Mrs Morris confirmed that the Report had been presented to the People and Culture Committee on 23 October.

She confirmed to Sir David that the paper shows how the Trust monitors staffing levels on a day to day basis. It also reviews any impact staffing levels have had on harming patients.

Ms Day asked about the mitigation for vacancies as there appeared to be a correlation between vacancies and harm. Mrs Morris confirmed that there is a biannual review of staffing levels which reviews acuity which will feed into the workforce plan. Additional healthcare assistants are also being recruited.

Ms Day issued caution in respect of spending time tracking data rather than strategically reviewing.

RESOLVED that:-
The Board:

- Noted the findings of the report and mitigations to address areas of concern, specifically in relation to staffing shortfalls and incidence relating to patient safety and quality.

99/18/2 **System Resilience Winter Plan**

Mr Brennan referred members to pages 16 to 23 of the report. This showed a range of actions to be implemented and managed through the winter period. He then turned to the analysis of demand undertaken by Carnall Farrar. This shows a baseline shortfall of 89 beds across the system. A further 20 would include the patients waiting in the A&E corridor. He explained the graphs on page 32. If the number of stranded patients was reduced to the national average, 22 beds would be released. The second and third graphs show the impact for the two sites of Worcester and Redditch – a 41 bed deficit for Worcester and 46 bed surplus for Redditch. He will be taking a paper to the Finance and Performance Committee at the end of November which explores this differential in more detail and will give options to even out the bed numbers.

Mr Brennan praised the health economy wide work that has been undertaken. There is focus on more cross working and work within the community. This is supported by the Health and Care Trust.

Sir David sought clarification on the bed numbers. Mr Brennan agreed that they were bed equivalent. He gave an example whereby due to the increased length of stay within the community, 16 community beds have the net impact of five beds within the acute trust.

Mrs McKay confirmed to Mr Yates that the neighbourhood teams have targets for admission reduction and these are measured.

Dr Tunnicliffe was delighted to see the model but the numbers were different to the Trust model. Mr Brennan stated that the Carnall Farrar model did not include beds closed for infection control issues. He confirmed that the assumptions can be changed and the model is dynamic.

Sir David requested that the bed numbers needed to be re-worked and re-presented to the Finance and Performance Committee.

ACTION: Review the bed numbers and present a revised position to the Finance and Performance Committee

RESOLVED that:-
The Board:

- Noted the progress in the Worcestershire System Resilience Winter Plan.

99/18/3 **Flu Campaign - staff**

Ms Ricketts stated that the Board needs to have an oversight of the staff flu vaccination campaign. Lessons were learnt from last year and the Trust is on track to achieve 76%, the same as last year. The national target is 100%. She explained that some staff do not wish to have the vaccine and it is difficult to track those staff members who have a vaccination elsewhere e.g. the GP.

Mrs Morris stated that occupational health has been very active and have targeted 85%. Sir David informed Mr Yates that there is evidence that the flu vaccine contributes to a

reduction in infection.

RESOLVED that:-
The Board:

- Delegated responsibility to the People and Culture Committee to approve the Trust's self-assessment for publication by 31st December 2018.
- Noted the actions being undertaken to improve compliance of staff flu vaccinations.

99/18/4 **Freedom to Speak Up (FTSU) Guardian**

Ms Ricketts presented the report which went to the People and Culture Committee in October. The Trust benchmarks well against other trusts. Changes have been made to the recruitment process as a result of feedback and issues relating to on call are being dealt with by Mr Brennan.

ACTION: Mr McGinity and FTSU Champions to attend a Trust Board meeting. (Mrs Sharpe)

Mr Mayhew asked whether the Trust has communicated to staff about the work of the FTSU Guardian. Mrs McKay agreed that the themes need to be identified and feedback given.

ACTION: Feedback themes to staff in relation to the FTSU Guardian's work. (Mr Haynes/Ms Ricketts)

RESOLVED that:-
The Board:

- Noted the themes of the issues raised through the Freedom to Speak Up Guardian.

100/18 **STAKEHOLDERS**

100/18/2 **Communications and Engagement Update**

Mr Haynes presented his report. He has set out the work undertaken with respect to culture change and recruitment and retention. Measurement of effectiveness is also detailed.

Mr Yates remained concerned about engagement with consultants. He felt that this needed to be more proactive.

Dr Tunnicliffe agreed with this. He also requested that the communication between committees and the rest of the organisation be reviewed. This was agreed.

ACTION: Develop communication to the rest of the Trust from the sub committees. (Mr Haynes)

Mr Mayhew asked whether the Trust was clear in the unique selling point in relation to recruitment and retention. Mr Haynes stated that targeted recruitment was being undertaken and he gave an example of the recent theatre campaign. Recruitment packs were clear about the benefits of living and working in Worcestershire. He is working with human resources through the 4ward programme to ensure that staff are the best advocates for working at the Trust.

RESOLVED that:
The Board

- Noted the report

101/18 **ASSURANCE REPORTS FROM COMMITTEES**

101/18/1 **Audit and Assurance Committee Report**

Mr Williams presented the report. He was concerned about the number of outstanding internal audit recommendations. Further work is being undertaken on this.

Sir David asked about the declaration of interests and the disappointing response rate from consultants. Mrs Sharpe confirmed that the consultant appraisal process will now include declarations of interest and that she is working with Human Resources on reviewing other staff with external employment.

RESOLVED that:
The Board
- Approved the terms of reference
- Noted the report for assurance.

101/18/2 **Charitable Funds Committee Report**

Mrs Ricketts expressed concern about the policy in respect of retirement gifts. Mr Yates explained that the charitable funds handbook detailed the use of the funds and this area did not fall into the remit. Ms Robinson stated that the policy was not being changed; it was just the use of charitable funds. Mr Mathew expressed concern that public money should not be used for this purpose.

Sir David requested that a review of this are be undertaken and an update presented to the Board with a solution to retirement gifts.

ACTION: Review the source of funding for retirement gifts (Ms Robinson)

RESOLVED that:
The Board noted the report

101/18/3 **Remuneration Committee Report**

RESOLVED that:
The Board
- Approved the terms of reference
- Noted the report for assurance.

101/18/4 **Quality Governance Committee Report**

RESOLVED that:
The Board
- Approved the terms of reference

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held on Thursday 10 January 2019 at 10:00 in the Crompton rooms A&B, Charles Hastings Education Centre, Worcestershire Royal Hospital. .

The meeting closed at 13:29 hours.

Signed _____ Date _____

Sir David Nicholson, Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – JANUARY 2019

RAG Rating Key:

Completion Status	
	Overdue
	Scheduled for this meeting
	Scheduled beyond date of this meeting
	Action completed

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
9-11-18	CEO report	96/18	Explore applying for prostate cancer monies	PB	Jan 2019		Transferred to the Deputy CMO. Options being reviewed.	
9-11-18	FTSU Guardian	99/18/4	FTSU guardian and champions to attend TB	KS			Programmed for May 2019.	
9-11-18	CEO report	96/18	Review whether the Trust should pay for EU nationals to register post Brexit	TR	Dec 2018		The Trust will be reimbursing the £65 fee for the 223 members of staff that this affects. Action closed.	
9-11-18	Local Maternity System	100/18/1	Review governance arrangements	KS			Governance arrangements are through the division and twice yearly reports to TB. Quarterly reports from the Maternity and Newborn Safety Champion to QGC have been instigated. Action closed.	
9-11-18	FTSU Guardian	99/18/4	Feedback to staff themes within the FTSU report	RH/ TR			This will happen via the Chief Executive's message. Action closed.	
9-11-18	Charitable funds	101/18/2	Review source of funding for retirement gifts	JR	Jan 2019		See Charitable Funds report. Action closed.	

9-11-18	IPR	97/18/3	Review timeliness of data and insert actions to the IPR	JR			The last Trust Board took place on Friday 9th November. Papers were submitted on Friday 2nd November. Therefore Month 7 (October) performance data was not available for the Board to review, and could not have been added to the IPR in time. The Month 7 data would also not have been reviewed in the sub committee meetings. The timing of the performance data was consistent with the timing and reporting of the financial data (i.e. Month 7). In future, a verbal update will be available on request for the most recent data. However, this will be largely unvalidated, and will not be included in the IPR itself. Action closed.	
9-11-18	System resilience winter plan	99/18/2	Review bed numbers and represent to F&P	PB			Transferred to F&P.	
9-11-18	CEO report	96/18	Assurance that the Trust Plan has clinical engagement	F&P			Transferred to the F&P committee	
9-11-18	IPR	97/18/2	To conduct a meta-analysis of lessons learnt, report to QGC then Trust Board	VM/ SK			Transferred to QGC	

9-11-18	IPR	97/18/3	Share the underlying run rate with F&P	JR			Transferred to F&P	
9-11-18	IPR	97/18/3	Auditors to review forecast figures	SW			Transferred to A&A Committee	
9-11-18	Comm and engagement update	100/18/2	Develop communications from sub committees to staff	RH	Jan 2019		Summaries from committee as within the IPR will be trialled in January 2019. Action closed.	

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	C

Acting Chief Executive's report

For approval:		For assurance:		To note:	x

Accountable Director	Paul Brennan Acting CEO		
Presented by	Paul Brennan Acting CEO	**Author**	Kimara Sharpe Company Secretary

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

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

Recommendations	The Board is requested to • note this report

Meeting	Trust Board
Date of meeting	10 January 2019
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Executive Summary

Appointment of the Chairman

I am delighted to report that Sir David has been appointed substantively to the position of Chairman. His term of office expires on 13 May 2023.

Strategy Development/Business case development

The Trust is currently developing the following strategies:

Theme	People & Culture	Quality Improvement	Clinical Services	Estates	IT/ Digital	Finance	Comms & Engagement
Executive(s) Responsible	D of P&C	CNO/ CMO	CNO/ CMO	CFO	CFO	CFO	D of Comms
Strategy status	Year 2 of strategy	Launched in May 2018	1 March 2019	31 March 2019	1 March 2019	MTFS – 31 Jan 2019	31 March 2019
Review date	Nov 2019 (reviewed Nov 2018)	April 2019	Tbc	Tbc	Tbc	Tbc	tbc

As each strategy is developed, a communication plan is also developed for communicating to the organisation.

The following business cases will be presented to the Board as follows:

Business case	Date
Acute Services Reconfiguration (full business case)	March 2019
Breast screening reconfiguration	Date to be confirmed
Electronic prescribing	31 Jan 2019

2019/20 Operational Planning Guidance

Attached is the initial version of the Operational Planning Guidance for 2019/20. The full guidance will be published in January and will set out the full trust financial regime for 2019/20, alongside control totals and indicative CCG allocations. The version published today gives an overview of system planning, the financial settlement and operational plan requirements. The guidance also includes a timetable as follows:

- 14 January - initial plan submission (activity focused)
- 12 February – draft 2019/20 organisation operational plans
- 19 February – draft aggregate system 2019/20 operation plan submission, system operating plan overview and STP led contract/plan alignment submission
- 21 March – deadline for 2019/20 contract signature
- 29 March – organization board approval of 2019/20 budgets
- 4 April – final 2019/20 organization operational plan submission

- 11 April – final aggregate system 2019/20 operation plan submission, system operating plan overview and STP led contract/plan alignment submission
- Autumn 2019 – 5 year system plans to be signed off by all organisations

I will update the Trust Board once the full guidance is published later this month alongside the NHS Long Term Plan.

Clinical research showcased at awards evening
Over 100 health professionals from across Herefordshire and Worcestershire attended a special event at Sixways Stadium in Worcester at the end of November to celebrate the achievements of clinical trials and research in the two counties. The event showcased the best of the clinical research that has taken place in the last year, with awards being handed out for some of the most impressive schemes to help benefit patients.

Clinical research is carried out by the Herefordshire and Worcestershire Research Consortium, based at Worcestershire Acute Hospitals NHS Trust. The team is made up of consultants, specialist nurses and midwives as well as support staff. So far this year, the group has recruited over 1,100 patients into more than 80 different research trials. These have involved everything from filling in questionnaires or providing blood samples to attending an educational programme or trying new types of medicines.

Urology - recognition

- Specialist Registrar Mr Ameet Gupta was awarded the Peter Ryan presentation prize at the Annual West Midlands Regional Urology Meeting held in Birmingham. His work with the Trust's Urology team outlining the impact of modern techniques in prostate biopsy for men with suspected cancer was judged the winner out of 15 papers by a panel of Consultant Urological Surgeons.
- Dr Rachel Cichosz, was awarded the Health Education England West Midlands Foundation Year One Trainee Open Award. Her paper '*Centralisation of Paediatric Services: A Comparative Service Evaluation on Suspected Testicular Torsion Outcomes'* was selected as best submission in 2018 by unanimous decision.
- Dr Lucie Spooner, Urology Core Surgical Trainee presented at the British Association of Urological Surgeons Annual Oncology Meeting in York on improving the clinical management of patients with blood in their urine.

Bessie Ellis wins national award
Senior Clinical Coder, Bessie Ellis ACC, has been awarded the national Chairman's Merit Award by the Institute of Health Records & Information Management (IHRIM). Bessie was given the honour after recently achieving 100% in her Clinical Coding Qualification practical exam.

Tesla Cars
I should like to thank the Tesla Owners Group UK for their donation of two model cars to the paediatric department to enable young people to drive themselves to the operating theatre.

Lithoview Workstation donated
The Alexandra Hospital League of Friends has donated a piece of camera equipment for use

in hysteroscopy and colposcopy procedures. It provides high resolution digital images, and is used by urologists for kidney and ureter procedures. Because of the significantly improved vision with the Lithoview Workstation, cancer can be detected more easily and more complex and large stone work can be performed more safely and accurately. Patients benefit from having better cancer detection and clearance of complex stones.

Sign language courses
Sign language courses for staff will commence at the Alexandra Hospital in January. The League of Friends has donated the cost of the 10 week course being run by Steve Hartman, a British Sign Language tutor who became deaf 16 years ago due to a virus. Thirty staff have already learnt basic sign language at the Worcestershire Royal Hospital.

Brexit preparations
The Secretary of State for Health and Social Care wrote to all trusts on 7 December in respect of a possible 'no deal' Brexit. Within the letter, assurance was given with respect to the movement of medicines and medical products to ensure that the flow of these products will continue unimpeded after 29 March 2019. Assurance was also given with respect to pharmaceutical companies ensuring at least 6 weeks' additional supply of prescription only or pharmacy medicines from the EU or EEA. Arrangements are also in hand for the air freight of medicines with a short shelf life such as medical radioisotopes.

The letter gave a clear message:
the Department will continue to develop the UK-wide contingency plan with pharmaceutical companies. May I therefore take this opportunity to restate my message from August: UK health and social care providers – including hospitals, care homes, GPs and community pharmacies – should not stockpile additional medicines or medical devices beyond their business as usual stock levels. There is also no need for clinicians to write longer NHS prescriptions.

NHS England Board member
Professor Sir Munir Pirmohamed has been appointed to the Board of NHS England. He is the David Weatherall Chair of Medicine and NHS Chair of Pharmacogenetics at the University of Liverpool, and Director of the MRC Centre for Drug Safety Science and Wolfson Centre for Personalised Medicine.

NHS England and Improvement Regional Executive Teams
The joint directors of the new NHS England and Improvement regional teams have been confirmed and they are:

- South West – Elizabeth O'Mahony, currently NHSI's chief financial officer.
- South East – Anne Eden, already joint NHSE and I regional director for the South East.
- Midlands – Dale Bywater, currently NHSI's regional director for the Midlands and East.
- East of England – Ann Radmore, currently Kingston Hospital Foundation Trust chief executive.
- North West – Bill McCarthy, currently deputy vice chancellor at Bradford University and chair of Bradford Teaching Hospital Foundation Trust and a former NHS England and Department of Health executive director.
- North East and Yorkshire – Richard Barker, currently NHSE's director for the North of England.
- London – Sir David Sloman, currently Royal Free London Foundation Trust.

Meeting	Trust Board
Date of meeting	10 January 2019
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Background
This report is to brief the board on various local and national issues.
Issues and options
None
Recommendations
The Board is requested to • note this report
Appendices – Planning Guidance

Preparing for 2019/20 Operational Planning and Contracting

December 2018

Preparing for 2019/20 Operational Planning and Contracting

Version number: 1.0

First published: 21 December 2018

Updated:

Prepared by: NHS England and NHS Improvement

NHS England Publications Gateway Reference: 08660

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net

1 Introduction

The Government announced a five-year funding settlement for the NHS in June 2018. The new settlement provides for an additional £20.5 billion a year in real terms by 2023/24. In response, the NHS has developed a Long Term Plan, which will be published early in the new year. 2019/20 will be the foundation year which will see significant changes proposed to the architecture of the NHS, laying the groundwork for implementation of the Long Term Plan.

To secure the best outcomes for patients and the public from this investment, we will be setting out a bold set of service redesigns to reduce pressure across the NHS and improve care access and quality. We are also conducting a clinically-led review of standards, developing a new financial architecture and introducing a more effective approach to workforce and physical capacity.

The long-term financial settlement will help put the NHS on a sustainable financial footing, moving away from a system in which deficits have become widespread, with the prospect of delivering financial balance for many organisations seemingly unachievable. Instead, the new financial framework will give local organisations and systems the space and support to shape their operational and financial plans to their circumstances, whilst reducing deficits year-by-year. We want to move away as swiftly as possible from individual organisational control totals, to support system working, reward success, and reduce uncertainty.

For 2019/20, every NHS trust, NHS foundation trust and clinical commissioning group (CCG), will need to agree organisation-level operational plans which combine to form a coherent system-level operating plan. This will provide the start point for every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) to develop five-year Long Term Plan implementation plans now, covering the period to 2023/24.

This is the first part of planning guidance. The full guidance will accompany five-year indicative CCG allocations in early January and will set out the trust financial regime for 2019/20, alongside the service deliverables including those arising from year one of the Long Term Plan, which will also be published in January.

2 System planning

This guidance describes a single operational planning process for commissioners and providers, with clear accountabilities and roles at national, regional, system and organisational level.

2.1 System leadership and system working

All STPs/ICSs will produce a system operating plan for 2019/20 comprising a system overview and system data aggregation. STPs/ICSs should convene local leaders to agree collective priorities and parameters for organisational planning. We expect systems to agree realistic shared capacity and activity assumptions from the outset to provide a single, system-wide framework for the organisational activity plans. These should be based on local trends derived from recent activity within a system. Ambition to contain growth should be collectively agreed and must be realistic. These plans need to be demonstrably aligned across providers and commissioners. Partners should adopt an 'open book' approach, sharing assumptions and plans with each other.

The organisations within each STP/ICS will be expected to take collective responsibility for the delivery of their system operating plan, working together to ensure best use of their collective resources.

The system operating plan will have two elements:

1. an overview setting out how the system will use its financial resources to meet the needs of its population and what the system will deliver in 2019/20, which should include specialised and direct commissioning as well as CCG and provider plans. The plan should make clear the underlying activity assumptions, capacity, efficiency and workforce plans, transformation objectives (including clinical and provider strategy), risks to delivery and mitigations; and

2. a system data aggregation (activity, workforce, finance, contracting), demonstrating how all individual organisational plans align to the system plan. Activity volumes in CCG plans must be matched to the volumes in their STP/ICS provider plans and vice versa. Activity volumes for CCGs with significant out of area flows will also need to be aligned.

We will set out the key features of a high quality system operating plan overview in the supporting technical guidance. We will provide an aggregation tool to support the system data submission, and further details of the options for the aggregated data submission will be described in the technical guidance.

Our joint regional teams will have a key role in ensuring local accountability and will work in partnership with system leaders to jointly review draft and final system operating plan overviews and aggregate submissions, including the alignment of

provider and commissioner plans and realistic phasing of non-elective and elective activity across the year. These should ensure that as much of the annual elective activity – particularly inpatient elective activity – occurs in the first half of the year, before winter. They should also contain effective winter plans, profiling additional winter activity, and the necessary capacity. NHSI/E Regional Directors will assure plans against delivery priorities with the support of the National Director for Emergency and Elective Care.

2.1.1 January checkpoint

Our joint regional teams will work with leaders from all organisations to facilitate the January checkpoint process, taking a collaborative approach that prioritises system-wide alignment and encourages providers and commissioners to work together to solve system challenges.

Prior to the provider and commissioner submissions on 14 January 2019, STPs/ICSs should convene local provider and commissioner leaders to collectively agree planning assumptions on demand and capacity, from which the system can agree how the available resources in 2019/20 will be used to meet the needs of the local population.

2.1.2 System control totals

We will set a system control total for each STP/ICS which will be the sum of individual organisation control totals. All STPs/ICSs will have the opportunity to propose net-neutral changes, agreed by all parties, to organisation control totals ahead of the draft and final planning submissions. These proposals will be subject to approval by Regional Directors. This flexibility is intended to support service improvement and collective financial management; we will not accept proposals designed to exploit technicalities in the flexibility offered. Systems that intend to propose any control total changes should engage with their regional team at an early stage, as these will need to be finalised in line with the timetable.

ICSs will be expected to link a proportion of their Provider Sustainability Fund (PSF) and any applicable Commissioner Sustainability Fund (CSF) to delivery of their system control total. The full financial framework for ICSs will be communicated separately. STPs will also be allowed to do this if all parties agree to manage their finances in this way. This will be an important marker of system maturity and readiness to develop as an ICS.

2.1.3 Inclusion of providers and commissioners in a system control total

All NHS providers and CCGs must be included in a system operating plan and system control total. We expect all CCGs and most providers to be included in only one system. Ambulance trusts should be included in the system with their host commissioner. Where a significant proportion of a provider's clinical income flows from organisations within another STP/ICS it may be included pro-rata in more than one system if agreed by the provider, the relevant STP/ICS leaders and the relevant

Regional Director. Providers and commissioners can still be a partner in an STP/ICS, even if they are not included in the system control total, and are encouraged to do so by agreement where this is appropriate. The organisations to be included in each system must be finalised before final system operating plans are submitted.

Whilst we are not yet in a position to reflect specialised commissioning funding flows in system control totals or system aggregate financial plans, we will still expect system operating plans to include agreed local specialised service priorities.

2.1.4 System efficiency

STPs/ICSs are increasingly finding efficiency opportunities that can only be delivered through their combined efforts. These include providers working together to improve productivity and clinical effectiveness, CCGs commissioning at-scale and sharing corporate services, and providers and commissioners working together to design more effective models of care. STPs/ICSs should focus on the cost-effectiveness of the whole system, not cost-shifting between organisations.

2.2 Brexit

The Department for Health and Social Care (DHSC) is issuing further operational guidance to assist NHS organisations with their business continuity planning for a no-deal EU Exit scenario. NHS organisations should follow the instructions contained in this document, and further guidance will be issued to support operational readiness for EU Exit as the situation develops.

3 Financial settlement

3.1 Financial architecture

The Autumn Budget 2018 confirmed additional funding for the NHS of £20.5 billion more a year in real terms by 2023/24. NHS England will receive rebates to help offset drugs spending growth funded by the Branded Health Service Medicines (Costs) 2018 Regulations deal agreed with the pharmaceutical industry.

The 2018/19 Agenda for Change pay deal funding will form part of NHS England's budget for 2019/20. This is a change in source of the £800m funding which is being paid directly to providers by DHSC in 2018/19 and will form part of the tariff uplift for providers in 2019/20.

3.2 Payment reform and national tariff

In October we published *'Payment system reform proposals for 2019/20'*[1] setting out proposed reforms to the payment system for 2019/20.

Subject to consultation, the uplift in the national tariff will be set at 3.8% for 2019/20. The cost uplifts include the costs of Agenda for Change pay awards that were paid directly to relevant providers in 2018/19. Clinical Negligence Scheme for Trusts contributions for 2019/20 have been updated for the relevant national and local prices. The 3.8% cost uplift excludes the transfer into national prices of a proportion of the PSF and the transfer into national and local prices of 1.25% from CQUIN and the pensions impact. The tariff efficiency factor for 2019/20 will be 1.1%. National and local prices will be reduced to cover the costs of the new centralised procurement arrangements. The transfer from the PSF and CQUIN will reduce the tariff scaling factor.

We intend to set a new default approach for payment of CCG commissioned emergency care activity. This will apply where the expected annual value of a CCG's emergency activity with a provider is above £10m, aimed principally at those systems that are still following a Payment by Results reimbursement model. The 'blended payment' model will cover non-elective admissions, A&E attendances and ambulatory/same day emergency care, and comprise two elements:

- a fixed element based on locally agreed planned activity levels; and
- a variable element, set at 20% of tariff prices.

A 'break glass' clause will apply if actual activity is significantly different from the planned level. Should this level be reached, providers and commissioners will need to agree how to revise the fixed payment.

[1] https://improvement.nhs.uk/resources/201920-payment-reform-proposals/

The marginal rate emergency tariff (MRET) and the 30-day readmission rule will be abolished as national rules for 2019/20, on a financially neutral basis between providers and commissioners.

We intend to implement an updated Market Forces Factor (MFF) for 2019/20. The MFF has not been updated for almost 10 years and is currently based on Primary Care Trust (PCT) boundaries, and out-of-date underlying data. The updated MFF would mean a significant change in income for some providers, so we are planning to implement the changes over five years. We will reflect the revenue impact in provider control totals for 2019/20. Commissioner target allocations will also be updated for the updated MFF values (phased over five years), with actual allocations subject to pace of change rules.

The sector largely sets local prices based on the local cost of services, already taking account of unavoidable cost differences, therefore we would not expect the full impact of changes to the MFF to immediately or automatically affect local prices.

We propose to make the maternity pathway tariffs non-mandatory, but we still expect these prices to be used for contracting in 2019/20.

Further details of the changes outlined above can be found in the technical guidance.

3.3 Financial framework for CCGs

Allocations for 2019/20 are being set to fund a stretching but reasonable level of activity, the impact of the 2018/19 pay awards and the changes to national tariff. Allocations will also ensure CCGs are able to meet commitments to the mental health investment standard, and the Prime Minister's commitment that funding for primary medical and community health services should grow faster than the overall NHS revenue funding settlement.

We are making a number of improvements to the formulae which determine target allocations. This includes changes to the way population data is used, new need-indices for community, and mental health and learning disability services, and changes to our approach to health inequalities, making the formula more responsive to extremes of health inequalities and un-met need, and increasing the fair share of resources targeted at those areas.

The Commissioner Sustainability Fund (CSF) was established in 2018/19 to support those CCGs that would otherwise be unable to live within their means to achieve in-year financial balance. The changes to the financial framework including to CCG allocations mean that in future we expect that all CCGs will be able to balance their financial position each year without additional support, and therefore the CSF will be phased out. We are taking the first step towards this in 2019/20 by reducing the CSF from £400m to £300m.

CCGs will be expected to plan against financial control totals communicated during the planning process. CCGs collectively will be expected to deliver a breakeven position after the deployment of the CSF, and control totals will be set on this basis. Therefore, it is essential that CCGs plan for and deliver their control totals for 2019/20 to contribute to delivering financial balance across the NHS.

Any CCG that is overspending in 2018/19 will be expected to improve its in-year financial performance; those with longer standing and/or larger cumulative deficits will be set a more accelerated recovery trajectory.

In line with the 2018/19 financial framework for commissioners, CCGs will not be required to contribute to a national risk reserve, nor to spend any element of their recurrent allocation non-recurrently. Decisions on how allocations are committed are for local prioritisation and must, in line with best practice, include an assessment of the risks to plan delivery alongside a robust risk mitigation strategy, and must deliver the Mental Health Investment Standard.

3.4 CCG administration costs

2019/20 running cost limits will be issued as part of CCG allocations. CCGs must ensure that they do not exceed their management costs allowance in 2019/20.

CCGs are asked to deliver a 20% real terms reduction against their 2017/18 running cost allocation in 2020/21, adjusted for the recent pay award. To ensure that full, recurrent savings can be made from the beginning of 2020/21, CCGs must ensure they are planning for and taking actions to achieve these reductions during 2019/20. CCG admin allowances will therefore be maintained in cash terms in 2019/20, using savings achieved during the year to fund any necessary restructuring costs.

NHS England will support CCGs that want to work collaboratively with their local system or with each other to make faster progress on improving our collective efficiency and effectiveness. We would like to hear from CCGs that want to pilot new approaches or have already achieved efficiencies that they think could be adopted more broadly across England.

3.5 Mental Health Investment

CCGs must continue to increase investment in mental health services, in line with the Mental Health Investment Standard (MHIS). For 2019/20 the standard requires CCGs to increase spend by at least their overall programme allocation growth plus an additional percentage increment to reflect the additional mental health funding included in CCG allocations for 2019/20. The minimum percentage uplift in mental health spend for each CCG will be shown in the financial planning template. CCGs will also need to increase the percentage of their total mental health spend that is spent with frontline mental health provision. As in 2018/19, each CCG's achievement of the mental health investment standard will require governing body attestation and be subject to independent auditor review.

The level of investment required by CCGs in mental health will be significant. It is important that commissioners achieve value for money for this investment, and so contracts must include clear deliverables supported by realistic workforce planning. Commissioners and providers will need to work together, supported by STPs/ICSs, to make sure that these deliverables are met and to agree appropriate action where they are not.

STP/ICS leaders, including a nominated lead mental health provider, will review each CCG's investment plan underpinning the MHIS to ensure it covers all of the priority areas for the programme and the related workforce requirements. Any concerns that proposed investments will be inadequate to meet the programme requirements should be escalated to the regional teams.

Where a commissioner fails to achieve the mental health investment requirements, NHS England will consider appropriate regulatory action, including in exceptional circumstances imposing directions on the CCG.

To support the assessment of mental health investment plans, NHS England will also look at mental health spend per head, and as a percentage of CCG allocations.

We will continue to develop prevalence indicators and performance data to measure outcomes that can be monitored alongside financial investment levels to give a more rounded picture of improvements in mental health. Providers should make full and timely returns to the Mental Health Services Data Set to support this.

Spend on Children's and Young People's (CYP) mental health must also increase as a percentage of each CCG's overall mental health spend. In addition, any CCGs that have historically underspent their additional CYP allocation must continue to make good on this shortfall.

3.6 Underlying Financial Assumptions

3.6.1 Productivity and Efficiency

The NHS has consistently improved productivity over time and in recent years these improvements have outpaced the wider economy. However, both commissioners and providers have the opportunity to go further. The minimum efficiency ask of the NHS in the next five years is 1.1% per year. We expect that efficiency plans are appropriately phased and not back-loaded.

There remains significant variation in efficiency both within and across the different types of services that the NHS provides. Delivering at least 1.1% efficiency per year will require a renewed and intensified focus on enabling greater staff productivity, including through investment in new digital technology and wider infrastructure and through transformative models of delivering services to patients.

Systems should work together to support the improvement of the NHS estate through the development and delivery of robust, affordable local estates strategies that include delivery of agreed surplus land disposal ambitions across all STP and ICS areas.

All systems will work with the NHS RightCare programme to implement national priority initiatives for cardiovascular and respiratory conditions in 2019/20. They will also be expected to address variation and improve care in at least one additional pathway outside of the national priority initiatives. CCGs yet to implement a High Intensity User support offer for demand management in urgent and emergency care will be required to establish a service in 2019/20. CCGs have made great progress working with GPs to reduce unnecessary referrals into hospital. They will continue this work using RightCare data to identify opportunities and outliers and increase the focus on the development of primary care service to further reduce referrals and follow-ups.

In December 2017, NHS England and NHS Clinical Commissioners (NHSCC) issued guidance for CCGs on 18 items which should not be routinely prescribed in primary care. We expect this to save CCGs up to £114 million per year by 2020/21 compared to 2017/18.

In March 2018 NHS England and NHSCC published further guidance for CCGs on conditions for which over the counter items should not be routinely prescribed in primary care. We expect this to save CCGs £93 million per year compared to 2017/18.

In November 2018, NHS England – in partnership with Academy of Royal Medical Colleges, NICE, NHS Improvement and NHS Clinical Commissioners – published '*Evidence-Based Interventions: Consultation response'* which includes statutory guidance on 17 clinical interventions that are divided into two categories:

- Four Category 1 interventions not to be commissioned by CCGs or performed unless a successful Individual Funding Request (IFR) is made because they have been shown to be appropriate only in exceptional circumstances e.g. adult snoring surgery (in the absence of obstructive sleep apnoea);
- Thirteen Category 2 interventions not to be commissioned by CCGs or performed unless specific clinical criteria are met because they have been shown to be appropriate in certain circumstances e.g. ganglion excision.

CCGs and STPs/ICSs should consider how to implement this guidance by 1 April 2019, when national performance monitoring will begin. Activity reduction numbers by CCG and ICS were included in the consultation response document.

All providers, working with their systems, will develop robust efficiency plans taking account of the opportunities identified in the Model Hospital and outlined in published Getting It Right First Time (GIRFT) reports and Lord Carter's reviews *'Operational productivity and performance in English NHS acute hospitals: unwarranted variations'*; '*Operational Productivity: unwarranted variations in mental health and community*

health services'; and *'Operational Productivity and performance in England NHS ambulance trusts: unwarranted variations*.'

We expect a particular focus on key areas where the reviews identify that further savings should be generated across all sectors.

Category 1 – transformative action required from providers in 2019/20:

- Work across the STPs/ICSs to develop proposals to transform outpatient services by introducing digitally-enabled operating models to substantially reduce the number of patient visits.
- Improve quality and productivity of services delivered in the community, across physical and mental health, by making mobile devices and digital services available to a significant proportion of staff.

Category 2 – action required from providers to accelerate ongoing opportunities

- Focus on concrete steps to improve the availability and deployment of clinical workforce to improve productivity, including a significant increase in effective implementation of e-rostering and e-job planning standards.
- Accelerate the pace of procurement savings by increasing standardisation and aggregation, making use of the NHS's collective purchasing powers. Providers should make regular use of the NHS Benchmarking tool (PPIB) to support this work.
- Make best use of the estate including improvements to energy efficiency, clinical space utilisation in hospitals and implementation of modern operating models for community services.
- Improve corporate services, including commissioners and providers working together to simplify the contracting processes and reducing the costs of transactional services, for example through automation.
- Support and accelerate rollout of pathology and imaging networks.
- Secure value from medicines and pharmacy, including implementation of electronic prescribing, removal of low value prescribing and greater use of biosimilars.

In addition to efficiency savings, providers have opportunities to grow their external (non-NHS) income. This provides extra revenue and benefits for local patients and services. It is expected that the NHS will work towards securing the benchmarked potential for commercial income growth and overseas visitor cost recovery identified in the Model Hospital.

3.6.2 Specialised Services and other Direct Commissioning

The direct commissioning of specialised services will focus on delivering the following priorities over the next two years:

- Helping people with **cancer** to benefit from innovative, specialised cancer treatments that will extend and improve quality of life, including the latest NICE-approved drugs, new genomic testing, cutting-edge radiotherapy techniques such as proton beam therapy, implementation of eleven new radiotherapy networks, and new service specifications for children, teenagers and young adults. We will also look to streamline cancer pathways across specialised and non-specialised services.
- Providing high quality specialised **mental health** services that are integrated with local health systems and are delivered as close to home as possible, driving further reductions in inappropriate out-of-area placements.
- Reducing the number of people with **learning disability and autism** who are treated in inpatient settings and supporting local health systems to manage the learning disability and autism care of their whole population.
- Improving **cardiovascular** services by ensuring that specialised vascular services are meeting national standards 24 hours a day, seven days a week, expanding access to mechanical thrombectomy for certain types of stroke, and improving access to non-surgical specialised cardiac interventions for those patients who could benefit.
- Improving outcomes and reducing mortality rates for **babies, children and young people** who are critically ill, and ensuring they are treated in the most appropriate environment for their needs.
- Supporting patients with a range of **long term conditions**, including those with Hepatitis C, where we aim to eliminate this disease ahead of World Health Organisation goals, and those accessing specialised neurosciences services, where we aim to reduce variation.
- Improving **equity of access** to services, including, for example, delivering faster access to high quality gender dysphoria services.
- Enabling patients to benefit from the latest advances in **genomics and personalised medicine**, including reducing the time it takes to receive a diagnosis for a rare disease and improving survival outcomes for those with aggressive cancers, as well as embedding whole genome sequencing as part of routine care.

In addition, the development of ICSs presents further opportunities to integrate the planning and delivery of specialised services into locally-commissioned services and move to a whole pathway-based approach to planning care for our populations. Further detail is contained in the technical guidance.

Specialised commissioning budgets are currently set on a provider rather than a population basis. NHS England and NHS Improvement will work with local systems in 2019/20 to explore how integration of specialised services within local systems could create greater opportunity and incentive for joint service planning, and what supporting governance arrangements would be required. Specialised commissioning budgets will therefore not be reflected formally in system control totals in 2019/20, but it is important that income and expenditure assumptions between specialised commissioners and

providers align at a system level to give a complete view of the resources available to the system. We will therefore again be including specialised commissioning in the plan and contract alignment process (on a provider level) supported by STP/ICS leaders.

This guidance and the approach outlined in recent contracting intentions letters sent to providers separately, will also apply to health and justice services, and services for the armed forces, which are also the responsibility of NHS England.

3.7 NHS Standard Contract

NHS England is publishing a draft NHS Standard Contract for 2019/20 for consultation. The final version of the Contract will be published in February 2019. NHS commissioners must use the NHS Standard Contract when commissioning any healthcare services other than core primary care.

The national deadline for signature of new contracts for 2019/20 (or agreement of variations to update existing non-expiring contracts) is 21 March 2019. Where NHS commissioners and providers cannot reach agreement by this date, they will enter a nationally coordinated process for dispute resolution. Details of this process will be covered in the '*Joint Contract Dispute Resolution'* guidance. Given the focus on closer system working, NHS England and NHS Improvement will view any requirement to enter these national dispute resolution processes as a failure of local system relationships and leadership.

Extremely long waiting times for elective treatment lead to poorer quality of care, are frustrating for patients, and present patient safety risks. Subject to the outcome of the Standard Contract consultation, we propose that new arrangements would apply for 2019/20 in respect of sanctions for 52-week breaches. The new approach would involve 'mirroring' financial sanctions for providers and commissioners of £2,500 per breach from each organisation. Alongside other contract sanctions, the use of withheld funding will be determined by regional teams. Further details will be set out in the Contract and technical guidance.

3.8 Incentives: Commissioning for Quality and innovation (CQUIN), Quality Premium

3.8.1 CQUIN

From 1 April 2019, both the CCG and Prescribed Specialised Services (PSS) CQUIN schemes will be reduced in value by 50% to 1.25% with a corresponding increase in core prices through a change in the tariff uplift. The CQUIN scheme will also be simplified, focusing on a small number of indicators aligned to key policy objectives drawn from the Long Term Plan.

In recent years CQUIN has secured improvements across a diverse range of goals, including treatment of sepsis, venous thromboembolism management, Hepatitis C

treatment and staff flu vaccinations. It has worked well where used to accelerate the uptake of known interventions which are clearly defined and widely supported.

Recognising that some areas have not been suitable for in-year incentivisation through CQUIN, there will be a renewed focus on the types of change where CQUIN has consistently demonstrated success. Each proposal has been subjected to five tests. The indicator must: support proven delivery methods; cover relatively simple interventions; not add separate cost requirements; be aided by explicit national implementation support; and command stakeholder confidence.

A portion of the CQUIN monies will be dedicated to sustain and expand the work of Operational Delivery Networks (ODNs) in ensuring consistency of care quality across the country. In addition, recognising the ongoing commitment to the elimination of Hepatitis C, ODN leads for Hepatitis C will, alongside mental health providers, continue to be eligible for a higher CQUIN allocation when compared to other acute providers of specialised services. Across both CCG and specialised commissioning CQUIN schemes, local indicators will be developed for providers for which national indicators are not available.

The tests to which CQUIN proposals have been subjected will ensure that those interventions supported by the scheme will deliver real benefits to patients and providers. They will be straightforward to implement, aligning with our goal that CQUIN is 'realistically earnable', and therefore deliverable for a significant majority of providers. Where the total value of CQUIN has not been earnt, the use of the resultant funding will be subject to sign off by the joint NHS England/Improvement regional teams.

Full details of the 2019/20 indicators will be published in separate CQUIN guidance.

3.8.2 Quality Premium

The 2019/20 Quality Premium scheme will retain a similar structure to the 2018/19 scheme, including a significant incentive for non-elective demand management, and a set of clinical quality indicators.

Earnings through the scheme will continue to be moderated through the 'gateways'. However the gateway criteria will be reviewed with a view to simplifying them, addressing concerns over low 'earnability' of the scheme for some CCGs. Further details of changes to the scheme will be published shortly.

3.8.3 NHS Resolution (NHSR) Maternity Incentive Scheme

NHSR has confirmed that for the second year running it will be collecting an additional 10% of the maternity contribution from providers that provide maternity services to create a fund for the Maternity Incentive Scheme. We encourage providers to review the relevant detailed guidance and consider how they can deliver the 10 safety actions. The 2019/20 scheme will operate in the same way as the 2018/19 scheme, providers

will be required to meet all 10 safety actions by the deadlines set to earn the maternity incentive.

4 Operational plan requirements

Detail on operational plan requirements are provided in this section. Further detail on other delivery areas will follow in the new year.

4.1 Primary Care

The continued investment in primary care as set out in the Spending Review and underpinning the commitments in the General Practice Forward View provides local systems with both the means and the focus for delivery over the remaining two years of the transformation programme (2019/20–20/21). This investment enables local systems and providers, wherever they are on their current journey, to increase their resilience and sustainability at a practice level and transform the care and services provided to their local population. Building on the £3/head CCG investment in primary care transformation during 2017/18 and 2018/19, we will be requiring CCGs to commit a recurrent £1.50/head recurrently to developing and maintaining primary care networks so that the target of 100% coverage is achieved as soon as is possible and by 30 June 2019 at the latest. This investment should be planned for recurrently and needs to be provided in cash rather than in kind.

STPs/ICSs must have a Primary Care Strategy in place by 1 April 2019 which sets out how they will ensure the sustainability and transformation of primary care and general practice as part of their overarching strategy to improve population health; and which engages CCGs and primary care providers in its implementation. This must include specific details of their:

- local investment in transformation with the local priorities identified for support;
- PCN development plan; and
- local workforce plan which supports the development of an expanded workforce and multidisciplinary teams and sets out the strategy to recruit and retain staff within primary care and general practice.

Where primary medical care commissioning has been delegated, CCGs are required to undertake a series of internal audits[2] that will provide assurance that this statutory function is being discharged effectively. This in turn will provide aggregate assurance to NHS England and facilitate engagement on improvement, including support through STPs/ICSs, who are expected to have oversight of this function and ensure that delegated CCGs are compliant and effective in discharging their responsibilities for:

- primary care commissioning and procurement activities;
- primary care contract and performance management;
- primary care financial management; and
- governance of all primary medical care delivery.

[2] https://www.england.nhs.uk/publication/internal-audit-framework-for-delegated-clinical-commissioning-groups/

STPs/ICSs must ensure that Primary Care Networks are provided with primary care data analytics for population segmentation and risk stratification, according to a national data set, complemented with local data indicator requirements, to allow Primary Care Networks to understand in depth their populations' needs for symptomatic and prevention programmes including screening and immunisation services.

4.2 Workforce

Provider workforce plans will need to consider the significant workforce supply and retention challenges in the NHS. For 2019/20, providers are expected to update their workforce plans to reflect the latest projections of supply and retention, taking into account the supply of staff from Europe and beyond, pay reforms and expected reductions in agency and locum use.

Plans should specifically detail the steps that providers will take during 2019/20 to move towards a 'bank first' temporary staffing model and identify opportunities for improved productivity and workforce transformation through new roles and/or new ways of working. 'Unnecessary' agency staffing spend should be eliminated – that being shifts procured at above agency price caps or off-framework, unless there is an exceptional patient safety reason to do so. Providers should also demonstrate how they will further bear down on the per shift prices paid to procure all temporary staffing resources, and describe the specific actions that will be taken to secure cost reductions compared to the latest 2018/19 outturn. Financial plans should also include an accurate estimate of the split between substantive, bank and agency spend based on these outturn figures.

Providers should ensure they have systems in place to offer full time employment to all student nurses trained locally, where they are suitably qualified and pass assessment centres. Providers should collaborate to ensure that 100% of qualified nurses are able to find NHS employment where they wish to work.

Workforce plans should include actions to improve retention of staff, linked to the rapid improvement areas identified by the national retention programme being rolled out in 2019/20.

Providers should also include within plans a focus on health and wellbeing, mechanisms to address bullying and harassment, consideration to the improvement of diversity amongst staff, and mitigations to address risks associated with EU Exit.

It is important that workforce plans are detailed and well-modelled, phasing in any workforce changes within the year. Workforce plans must also align with finance and activity plans, ensuring the proposed workforce levels are affordable, efficient and sufficient to deliver safe care to patients.

4.3 Data and Technology

From April 2019, providers should submit all commissioning datasets to the Secondary Uses Service (SUS+) on a weekly basis. This will be mandated by NHS Digital in due course, but, in the interim, commissioners should make weekly submission a local requirement within their contracts. More frequent SUS data is a prerequisite for us to move towards a standardised, single version of hospital activity for performance and reconciliation of payments. All providers must also submit the emergency care dataset on a daily basis as currently mandated. In addition, Patient Administration Systems and Electronic Patient Records must enable providers to maintain high quality data to enable accurate reporting, including on available and occupied beds on a daily basis.

We will continue to expand the Global Digital Exemplar and Local Health and Care Record Exemplar programmes with more organisations and localities coming on-stream and in 2019. In addition, in 2019, we will be mandating core standards (across interoperability, cyber security, design, commercial etc.) for all technology across the NHS and introducing additional controls to ensure that all new technology and systems meet these mandated standards.

The NHS App, complemented by NHS Login, will provide a secure way for citizens to access digital NHS services. Initially, it will provide citizens with access to 111 online and their GP record, and the ability to book appointments, set their data sharing preferences and register for organ donation. We ask STPs/ICSs, providers and commissioners to support us to increase uptake, enabling more people to manage their interactions with the health service digitally. By October 2019 100,000 women across 20 accelerator sites will be able to access their maternity records digitally and we expect other organisations to follow their lead on route for universal coverage in future years. We will also enable digital access for all to the successful Diabetes Prevention Programme and ask providers and commissioners to support people to use this.

5 Process and timescale

5.1 Submission of organisational operational plans and system plans

Systems and organisations are asked to develop plans in line with the national timetable below.

These plans need to be the product of partnership working across STPs/ICSs, with clear triangulation between commissioner and provider plans to ensure alignment in activity, workforce and income/expenditure assumptions, evidenced through agreed contracts. System leaders are asked to help ensure plans and contracts are aligned and should convene local leaders as early as possible to agree collective priorities and parameters for organisational planning.

In addition to organisational plan submissions, we request system-level operating plan submissions including an accompanying overview. The detail of what is expected will be set out in the technical guidance.

Boards need to be actively involved in the oversight of operational planning to ensure credible, Board-approved plans, against which in-year performance can be judged.

5.2 Timetable

Milestone	Date
Publication of: • Near final 2019/20 prices • 2019/20 standard contract consultation	21 December 2018
2019/20 deliverables, indicative CCG allocations, trust financial regime and control totals and associated guidance for 2019/20	Early January 2019
NHS Long Term Plan	January 2019
2019/20 CQUIN guidance published	January 2019
2019/20 Initial plan submission – activity focused	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
STP/ICS net neutral control total changes agreed by regional teams	By 1 February 2019
Draft 2019/20 organisation operational plans	12 February 2019
Aggregate system 2019/20 operating plan submissions, system operating plan overview and STP led contract / plan alignment submission	19 February 2019
2019/20 STP/ICS led contract / plan alignment submission	19 February 2019
Final 2019/20 NHS Standard Contract published	22 February 2019
Local decision whether to enter mediation and communication to NHSE/I and boards/governing bodies	1 March 2019
2019/20 STP/ICS led contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Parties entering arbitration to present themselves to the Chief Executives of NHS Improvement and England (or their representatives)	22-29 March 2019
STP/ICS net neutral control total changes agreed by regional teams	By 25 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Submission of appropriate arbitration documentation	1 April 2019
Arbitration panel and/or hearing (with written findings issued to both parties within two working days after panel)	2-19 April 2019
Final 2019/20 organisation operational plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions, system operating plan overview and STP/ICS led contract / plan alignment submission	11 April 2019
2019/20 STP/ICS led contract / plan alignment submission	11 April 2019
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 30 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Autumn 2019

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	D

Board Assurance Framework and Corporate Risk Register

For approval:	x	For assurance:		To note:	

Accountable Director	Paul Brennan Acting CEO		
Presented by	Paul Brennan Acting CEO	**Author /s**	Kimara Sharpe Company Secretary

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome
People and Culture Committee	December 2018	Approved
Quality Governance Committee	December 2018	Approved
Finance and Performance Committee	December 2018	Approved
Executive Management Team	December & January 2019	Discussed

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

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

Recommendations	The Board is requested to: • Approve the Board Assurance Framework • Note the Corporate Risk Register

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	D

Executive Summary

The Board Assurance Framework is presented quarterly to the Trust Board, after being considered by the respective Committees. The Committees have approved the changes as outlined below:

- Increase to the risk rating to 16 of risk no 1 (3927)
- Decrease is risk rating to 12 of risk no 2 (3930)
- Decrease in risk rating to 15 of risk no 5 (3933)
- Increase in risk rating to 20 of risk no 6 (3934)

Additionally, each committee has considered the BAF risks aligned to that committee and have approved the actions as identified.

Each BAF risk is now part of the Datix database in order to streamline the administration.

The Corporate Risk Register (CRR) is also presented to the Board. Risks have been considered by the respective Committees. There is further work to be undertaken on the process for updating the CRR. Additionally, during the next quarter, risk registers will be developed for IT and Estates and Facilities. These will be overseen by the F&P Committee.

The Risk Management Group is being reviewed by the Executive Team. Changes to this will take place by March 2019.

Background

The BAF was approved by the Board in September 2018.

Issues and options

None.

Recommendations

The Board is requested to:

- Approve the Board Assurance Framework
- Note the Corporate Risk Register

Appendices

Appendix 1 – BAF (as at 31 December 2018)
Appendix 2 – Corporate risk register (as at 2 January 2019)

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

RISK RATING 1-3 Low risk | 4-6 Low risk | 8-12 High risk | 15-25 Extreme risk

RISK NUMBER	DATIX REF	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			PROPOSED			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					LIKELIHOOD	CONSEQUENCE	RISK RATING[1]	LIKELIHOOD	CONSEQUENCE	RISK RATING				
3	3931	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	4	4	16	4	4	16	⇔	Nov 2018	Feb 2019	11
4	3932	IF we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning THEN we will fail the national quality and performance standards RESULTING IN a negative patient experience and a failure to exit special measures and to attain STF funding	Chief Operating Officer	Finance and Performance	4	5	20	4	5	20	⇔	Nov 2018	Feb 2019	14

RISK NUMBER	DATIX REF	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			PROPOSED			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					LIKELIHOOD	CONSEQUENCE	RISK RATING[1]	LIKELIHOOD	CONSEQUENCE	RISK RATING				
5	3933	IF there is a lack of a strategic plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a major impact on the trust's ability to deliver safe, effective and efficient care to patients	Chief Operating Officer	Finance and Performance	4	5	20	3	5	15	⇩	Nov 2018	Feb 2019	16
6	3934	IF we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfill our financial duties RESULTING IN the inability to invest in services to meet the needs of our patients.	Chief Financial Officer	Finance and Performance	3	5	15	4	5	20	⇧	Nov 2018	Feb 2019	18
7	3941	IF we are not able to unlock funding for investment THEN we will not be able to modernise our estate, replace equipment or develop the IT infrastructure RESULTING IN the lack of ability to deliver safe, effective	Chief Financial Officer	Finance and Performance	3	4	15	3	4	15	⇔	Nov 2018	Feb 2019	20

RISK NUMBER	DATIX REF	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			PROPOSED			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					LIKELIHOOD	CONSEQUENCE	RISK RATING[1]	LIKELIHOOD	CONSEQUENCE	RISK RATING				
		and efficient care to patients												
8	3936	IF we do not have effective IT systems which are used optimally THEN we will be unable to utilise the systems for the benefit of patients RESULTING IN poorly coordinated care for patients and a poor patient experience	Chief Financial Officer/Chief Medical Officer	Finance and Performance/ Quality Governance Committee	4	4	16	4	4	16	⇔	Nov 2018	Feb 2019	22
9	3937	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	4	4	16	4	4	16	⇔	Nov 2018	Feb 2019	24
10	3938	IF we do not deliver a cultural change programme. THEN we may fail to attract and retain staff with the values and behaviours required RESULTING IN lower quality care for our patients	Director of People and Culture	People and Culture	3	5	15	3	5	15	⇔	Nov 2018	Feb 2019	26

RISK NUMBER	DATIX REF	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			PROPOSED			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					LIKELIHOOD	CONSEQUENCE	RISK RATING[1]	LIKELIHOOD	CONSEQUENCE	RISK RATING				
11	3939	IF are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU THEN there is a risk to the sustainability of some clinical services RESULTING IN lower quality care for our patients	Director of People and Culture	People and Culture	4	4	16	4	4	16	⇔	Nov 2018	Feb 2019	28
12	3940	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	4	4	16	4	4	16	⇔	Nov 2018	Feb 2019	30

Glossary – page 31

BAF RISK REFERENCE *Summary for Datix entry*	1 Lack of robust clinical governance	**DATE OF REVIEW**	November 2018
DATIX REF	3927 (Linked to corporate risks 3946, 3325)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Medical Officer
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

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

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Gaps in central and divisional governance teams	Recruitment into key posts	Sept 2018 April 2019	3/5 div gov leads in place Risk manager starts Jan 2019 Head of Risk Management and Clinical Governance starts March 2019 Interim Head of Risk Management in place All divisions to have a governance lead
2	Consistency of engagement of clinicians in governance process	Support to governance leads - work needed with individual directorates in respect of governance	Dec 2019 Jan 2019	Metrics show overall improvement. Consistent governance agendas across all divisions
3	Consistency and effectiveness of appraisal of medical staff	Development and maturation of the quality assurance process for medical appraisals Recruitment to gaps in structure	April 2019	
4	Lack of attendance at Mortality Review Group	Review attendance to ensure consistency of attendance	Feb 2019	
5	Lack of compliance with mandatory training (medics)	• Raise at PRM • Raise at CGG • Write to governance leads • No study leave unless mandatory training complete • No application for CEA unless mandatory training complete		Ongoing Ongoing Dec 2019 In place In place

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**	November 2018
DATIX REF	3930 (linked to corporate risks 2873)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Nurse
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

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

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Quality Improvement Plans - Divisional trajectories	Divisional trajectories to be developed	Oct 2018	Presentation at CGG 6-8-18. Completed
2	Improvement training in place	Health Education England supporting improvement training	Dec 2018 tbd	Funding and project plan agreed Quality Improvement training role & Matron/Manager to support improvement training
3	Improvement training in place	Appointment of dedicated staff within the Project Management Office	Dec 2018	Completed.
4	Harm reviews reporting robustly Cancer harm reviews	Report developed and presented Process to be embedded with quarterly reporting to QGC and CGG Cancer harm reviews to be linked to divisions using same format	Sept 2018 Feb 2019 Mar 2019	Report to CGG in September followed by QGC
5	Ward accreditation	Framework for ward accreditation to be agreed Roll out	Sept 2018 Jan 2019	Presentation to Sept QGC/Nov QGC. Pilot – Nov 2018

REF	GAP	ACTION	BY WHEN	PROGRESS
6	Embedding the risk management strategy	Joint training undertaken by Head of Risk Management and Health and Safety Advisor and follow up review of risk maturity by Oxford University Hospitals NHS Trust	Oct 2018 Jan 2019	Report to QGC November Revised date due to staff long term sickness
7	Corporate teams use of RAIT	Ensure rolled out and embedded in corporate teams (e.g. medicines management)	Jun 2019	
8	Lack of a surgery QIP	Development of a surgery QIP	Jan 2019	

BAF RISK REFERENCE *Summary for Datix entry*	3 Lack of delivery of statutory requirements of the Hygiene Code	**DATE OF REVIEW**	November 2018
DATIX REF	3931 (linked to corporate risks *to be developed*)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Nurse
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Enhance monitoring of environmental cleanliness at ward, divisional and corporate levels	Deputy CNO to lead the coordination of environmental cleanliness reviews and escalate failures to CNO	Daily	Weekly review with divisional director of nursing and ISS/Engie
2	Review audit tools and inspection methodology for clinical practice and environmental cleanliness	Revised audit tools to be used for inspections and standard operating procedures (SOP) in place to escalate any environmental and clinical practice failures	Aug	In place and report to QGC – August. Complete
3	Escalation and performance management of PFI contractor to ensure sustained improvement in environmental cleanliness	• Monthly meetings to be held with national and regional PFI contractors until sustained improvement • Formal contractual report	Monthly On-going	Report to QGC monthly until de-escalation Discussions underway Action superseded with PFI monitoring review (see action 6)
4	Clarify and reinforce the accountability framework for Divisional teams to ensure sustained clinical standards and environmental cleanliness is consistently maintained	• Escalation SOP in place from mid August to ensure Divisional Directors of Nursing and PFI contractor held to account for sustained clinical standards and environmental cleanliness within 24 hours (working day) timescale	End Aug	In place. Reports to QGC monthly. Complete
5	Ensure consistent and sustained compliance with universal precautions including bare below the elbows, hand hygiene and Trust dress code	• 100% compliance with hand hygiene audit • Multidisciplinary team showing consistent application of universal precautions • Clear expectations with respect to 10 key standards	Monthly Completed	Monthly reporting to TIPCC/CGG/QGC Explicit in DDN objectives
6	Contractual monitoring of PFI contract	• Governance review commissioned, reporting to F&P January 2019	Jan 2019	
7	Lack of hand washing	• Automatic disciplinary process when reported to	On going	2 consultants undergoing disciplinary

REF	GAP	ACTION	BY WHEN	PROGRESS
		CMO/CNO • Signage on floor		process. In place Complete

BAF RISK REFERENCE *Summary for Datix entry*	4 The Trust is unable to ensure efficient patient flow through our hospitals	**DATE OF REVIEW**	November 2018
DATIX REF	3832 (linked to corporate risks 3946, 2709, 3325, 3482, 3483, 3646)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Capacity constraints – physical and staffing	ASR programme implementation/workforce strategy	~~Mar~~ Feb 2019	Bridge opening 16 Jan 2019 90 ID medical nursing staff confirmed Capacity service reconfiguration (see below)
2	Lack of capacity within the out of	A&E delivery board system wide	On-going	Multi agency stranded patient meetings on both sites. Assessment of capacity for pathways 1&2 underway via

REF	GAP	ACTION	BY WHEN	PROGRESS
	hospital pathways	planning		A&E Delivery board
3	Failure to adhere to professional standards	Enforcement by divisional directors	On-going	Embedded process of on call consultant attendance at lunchtime bed mtgs, non-compliance escalated to divisional directors
4	Lack of capacity across AH and WRH	Service reconfiguration	28 Jan 2019	#NOF transfer from WHR to AH, 17 Dec 2018 Frailty transfer to AH – 21 Jan 2019 Boundary changes re Droitwich – 28 Jan 2019 Bridge opening 16 Jan 2019 Extensive clinical engagement Actions agreed at F&P Committee/TLG/HOSC/Trust board

BAF RISK REFERENCE *Summary for Datix entry*	5 Lack of a strategic demand management	**DATE OF REVIEW**	November 2018
DATIX REF	3933 (linked to corporate risks 2709, 3482)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	STP wide plan incorporating the increase in population over the next 5 years	Input into a system wide plan through an established provider board	March 2020	On going work through the STP

REF	GAP	ACTION	BY WHEN	PROGRESS
2	Confirmed winter plan in place	Winter plan developed	Oct 2018	Final plan presented to trust board in November 2018. Completed
3	Communications during Winter	Setup Winter Room	Oct 2018	Completed.
4	Staff and physical capacity	ASR programme – bridge built, extra wards staffed	March 2019	Progress to Trust board, Sept 2018
5	Lack of capacity to meet demand	Trust-wide reconfiguration under emergency powers	Jan 2019	Proposal discussed by Trust Board Oct/Nov 2018. Support from partners for frailty and #NOF moves.
6	Lack of provider board	Work with healthcare partners to develop a provider board	Mid 2019	

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**	November 2018
DATIX REF	3934 (linked to corporate risks 3768, 3792)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Lack of predictive information in reporting	Development of flash and trajectory reporting Development of detailed financial forecast	Sept 2018 On-going	In test mode. Complete In development. On-going
2	Capacity to support individual programme	Identification of resources for the PMO	Sep 2018	Resources being identified. Completed
3	Operational capacity to develop and deliver necessary programmes	SRO for work streams identifying resources needed	Dependent on work stream	Continually under review
4	Maintenance of cash liquidity	Apply for cash to the Department of Health and Social Care to ensure that the Trust remains a going concern	Monthly	On-going
5	Medium Term Financial Strategy (MTFS)	Develop a MTFS	Dec 2018 Jan 2019 Feb 2019	Process agreed at F&P Aug 2018. Update to Nov 2018
6	19/20 CIP	Develop CIP	March 2019	In development. Divisions met 12 Dec.
7	19/20 operational plan	Develop plan	March 2019	
8	Demand and capacity plan	Development of modelling	Jan 2019	First draft – end Nov

BAF RISK REFERENCE *Summary for Datix entry*	7 The Trust is unable to ensure financial viability and make the best use of resources for our patients.	**DATE OF REVIEW**	November 2018
DATIX REF	3941 (linked to corporate risks 3772)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Inadequate liquidity	Restructuring of balance sheet	On-going	In discussions with NHS I/Department of Health
2	Mechanism in place to fund priorities across the STP	Work with STP to pool capital resource for STP priorities	On-going	In discussions with STP partners
3	Area specific funding required	Access national targeted funds as become available	On-going	Project dependent

REF	GAP	ACTION	BY WHEN	PROGRESS
4	Robust capital prioritisation process	Further refine and implement a capital prioritisation process to ensure limited resources used to best effect in the medium term	March 2019	Part of budget setting process
5	Investment funds	Explore all avenues to unlock access to investment funds including bidding for ad hoc national funding	On-going	Discussion with STP partners

BAF RISK REFERENCE *Summary for Datix entry*	8 Ineffective IT systems	**DATE OF REVIEW**	November 2018
DATIX REF	3936 (linked to corporate risks tbc)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Lack of a Digital ICT strategy which includes working across the STP area	Digital Strategy to be developed	Oct 2018 ~~Jan 2019~~ Mar 2019	Draft in place. Final to be presented to Trust Board
2	NED involvement in Strategy development	NED to be contacted	Sept 2018	NED being contacted. Completed
3	Implementation of agreed strategy	Action plan to be developed	~~Dec 2018~~ March 2019	
4	Lack of transparency in relation to reporting to Board Committee/Trust board on reading of results	Include monitoring in integrated performance report	Nov 2018 On-going	Completed On-going development
5	Risks associated with cybersecurity	Cybersecurity action plan implemented	On-going	On-going. Escalated to Information Governance Steering Group
6	Resources (people and finance) to implement the cybersecurity action plan	Discussions held with SIRO	On-going	Resolved/on-going
7	Training in ICE/bluespier	Staff fully trained	On-going	Reviewed through SQUID & divisional performance reviews
8	Development of templates	Templates developed.	On-going	Compliance monitored through SQUID & divisional performance reviews
9	Funding	Application to funding streams as and when required	On-going	Funding successful for HSLI which includes Badgernet (for maternity)

REF	GAP	ACTION	BY WHEN	PROGRESS
			Jan 2019	Applying for e-prescribing funding

BAF RISK REFERENCE *Summary for Datix entry*	9 Inability to sustain our clinical services	**DATE OF REVIEW**	November 2018
DATIX REF	3937 (linked to corporate risks to be developed)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Lack of clinical services strategy	Strategy being developed	~~Oct 2018~~ Feb 2019	Early draft presented to Trust board, September Progress report - October
2	Specialised Commissioning support for strategic partnership proposals	Escalation to CEOs & STP Clinical Reference Group	Dec 2018	Memorandum of understanding in place. Partnership sub groups established.

REF	GAP	ACTION	BY WHEN	PROGRESS
3	Specialised commissioning support for service sustainability proposals	STP/WM cancer support for proposals	On-going	Chairman spoken to Spec Com CEO

BAF RISK REFERENCE *Summary for Datix entry*	10 Failure to deliver cultural change programme	**DATE OF REVIEW**	November 2018
DATIX REF	3938 (linked to corporate risks tbd)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Raise awareness about issues relating to bullying and harassment	Communication campaign on Bullying and Harassment	~~Dec 2018~~ March 2019	Currently being planned. Delayed due to capacity issues Less bullying reported by FTSU Guardian
2	Raise net culture scores and participation rates in key areas across the Trust	Further engagement sessions to be undertaken. Roll out of 'we do this by'	Feb 2019 Feb 2019	Net culture score reduced. Review and further work to be undertaken to embed 4ward in the fabric of the trust
3	Low scores in staff survey	Raise staff engagement	Feb 2019	

BAF RISK REFERENCE *Summary for Datix entry*	11 Failure to recruit, retain and develop staff	**DATE OF REVIEW**	November 2018
DATIX REF	3939 (linked to corporate risks 2873, 3650)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	No agreed Education, Learning and Development Plan in place	Further work needed on the Plan	Nov 2018	Work complete
2	Further work on flexible working	Implementation of Timewise flexible working programme	Dec 2018	OD work started.

REF	GAP	ACTION	BY WHEN	PROGRESS
			Jan 2019	
3	Lack of national trust wide accreditation programme	Consider implementing Investors in People (IIP)	March 2020	
4	Review support for EU staff during transition phase	Utilise the HR employer support model for Brexit	March 2019	Tool has just been released. Currently reviewing how to roll out.
5	Health Education England reduction of funding for learning beyond registration	Comprehensive paper to the People and Culture Committee outlining the implications and opportunities for alternative funding	~~October 2018~~ tbd	National funding not agreed.
6	Joined up approach to education, learning and development	Implement education, learning and development plan	March 2020	Report to P&C Dec 2018
7	Lack of nurses to staff the winter requirements	Contract with agency Targeted campaigns Review skill mix	On-going	Agency confirmed 130 wte Theatre undertaken Weekly review
8	50% nursing staff could retire within 5 years	Strategic workforce plan Career conversations	Dec 2018 tbd	Plan presented to P&C

BAF RISK REFERENCE *Summary for Datix entry*	12 Reputational damage	**DATE OF REVIEW**	November 2018
DATIX REF	3940 (linked to corporate risks 3482)	**NEXT REVIEW DATE**	February 2019

RISK DETAILS

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

CONTEXT

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

ACCOUNTABILITY

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

CONTROLS AND ASSURANCE

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

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Positive news stories	Proactive media management	On-going	
2	Better use of social media	Active use of social media channels	On-going	
3	Lack of stakeholder awareness	Regular stakeholder briefing	On-going	
4	Use of all possible communication channels	Continuous review of communications and engagement channels	On-going	
5	Lack of awareness about job opportunities	Targeted recruitment campaigns	On-going	

Glossary

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

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3325 There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.			
Date Opened	26/10/2016			
Initial Risk Level	Catastrophic	Likely	20	Extreme
Risk Owner	Mrs Jo Kenyon			

Director/Committee	Chief Operating Officer / Quality Governance Committee
Description/Impact	RISK There is a risk that patients presenting with stroke patients may not receive a timely assessment, diagnosis and treatment. CAUSE Not all patients are pre alerted to ED Not all potential stroke patients are screened using the established ROSIER score CT Scans when requested for potential thrombolysis patients may not always occur in a timely manner, ideally within 60 minutes. Specialist (medical)stroke assessment is only available during working hours and 5 days a week. Cover for stroke outside of these times is managed by the duty medical registrar. Out of hours assessment is by non-specialist medical registrars. Most of whom have not had any specialist training in hyper acute stroke assessment and the use of thrombolysis. Support out of hours is via offered by the (Avon, Gloucester and Wiltshire Stroke Network) Beds are not always available on the Stroke or Hyper Acute Stroke unit, due to hospital wide capacity issues. (DTA) Decision to Admit TIA Clinics only available 5 days per week Use of assessment bay as surge capacity, which increases the ward bed stock from 29 beds to 30. Lack of 7 day access to Allied Health Professionals Insufficient SALT input, which places patients at risk or may delay decisions concerning enteral feeding and other SALT assessments. Non stroke patients occupying beds within the stroke unit either because of incorrect initial diagnosis or overall placement by the clinical capacity team. EFFECT They may not receive optimal care which may lead to long term disability and increased mortality. They may have increased length of stay They may have an increased risk of early complications Delays in diagnosis of Stroke Patients at risk of not being given Thrombolysis in a timely manner Higher risk of short term complications on non stroke wards Patients managed in a non-specialist environment High length of stay in acute stroke unit and fragmentation of ongoing care Patients develop a long term disability High mortality of acute stroke patients Lack of supporting information to GP's to provide ongoing continuity of care, possible increase in re-attendance as a consequence. Lack of follow up letters impact on follow up clinics/consultant not aware of reason for attendance. IMPACT Breach of same sex accommodation policy Delays in accessing specialist care Failure in Stroke National Audit Standards (SSNAP) Damages the reputation of the service and the Trust Poor patient experience and potential increase in complaints and litigation Increased safety risk to patient.
Key Controls	Stroke dashboard populated waith validated information wich aligns Trust performace with SSNAP Member of Avon/Glos Stroke network which provides out of hours Thrombolysis support All medical Regs offered training in administering Thrombolysis and can contact the network for out of hours support. All network consultants have remote access to PACS and CT scans. Patients undergoing Thrombolysis currently managed within ED resus area Patients brought by WMAS with an onset time are pre-alerted to ED Therapy outreach provided to outlying pts Clinical guideline on administration of Thrombolysis available New consultant clinical lead appointed June 2017 Member of Avon/Glos Stroke network which provides out of hours Thrombolysis support SOP developed Production of business case to expand MDT Collaberative working with Health Economy Partners
Sources of Assurance	Self-assessment against standards-Self-assessment against standards-Monthly Stroke Data validation Internal Audit-Internal Audit-Re started monthly stroke meetings aligned to Trust template Review-External-Review-External-Monthly stroke strategy forum led by commissioners External Audit-External Audit-SSNAP

	Management Assurance-Internal reports to the Board-Internal Stroke dashboard Peer Review-Peer Review-Avon/Glos stroke network membership

Performance Monitoring	SSNAP - see attached documents Swallow assessments - see attached email with report 21/11/17 reviewed at RMG and escalated to the CRR
Gaps in Control	Limited CNS in reach into ED Data collected to measure our performance against national standards is retrospective Posts may not be filled in a timely manner There is no SOP currently developed and in use - to be reviewed and implemented
Gaps in Assurance	Lack of resilience and issues around validation process

Current Risk Level Major Likely 16 Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Service reconfiguration as detailed in Trust Board paper Jan 2019	Jo Kenyon Divisional Director of Operations	31/01/2019		
Relocate stroke service to smaller area as part of the internal ward moves at WRH	Jo Kenyon Divisional Director of Operations	28/02/2019		
Contact WMAS identify FAST+ to CT pathway and develop a pathway	Trevor Hubbard Deputy Divisional Director of Operations Medicine (Interim)	28/10/2016	M Brotherton (WMAS)contacted 26/10	26/10/2016
Protect a stroke bed and have available 24/7	Stephen Jezard Divisional Director of Nursing - Medicine Division	16/11/2016	Discussed at Trust board 25/10 with agreement to protect the HASU bed and provide 2 assessment trollies on ASU.	07/11/2016
Develop and implement SOP Hyperacute Sroke Unit	Ana Garcia Consultant Neurologist and Stroke Physician	29/12/2016	SOP drafted - going to Stroke directorate meeting on 16th November for approval SOP approvied at Divisional Governance meeting 29/11/2016.Scheduled for discussion at Medicine DMB for final approval.	19/12/2016
Convene a Task and Finish Group to develop early assessment and diagnostics to improve the Acute Stroke pathway	Stuart Cannonier Directorate Manager for Stroke	25/01/2017	Work remains in progress Meetings taking place with Consultant paramedic and visit external trust Visit to Dudley on 13th Feb 2017	14/02/2017
Scope and review the patient pathway for the on going care following an acute stroke	Juliet Hawkesford-Barnes Matron	25/01/2017	19/4/17 Stroke Speciality meeting requested that this action be closed as this work was completed as part of the Stroke Strategy work.	19/04/2017
Agree stroke metric trajectories	Jo Kenyon Divisional Director of Operations	19/07/2017	Completed - sent to CEO and COO for WAHT and COO at CCG for agreement	17/07/2017
Ensure backlog of follow up letters is cleared (letters sent out)	Jo Kenyon Divisional Director of Operations	30/05/2017	help offered ? Band 3 Support for Geriatric Medicine being recruited, ? 1 day a week. Agency typist CV's to be scanned for possible candidates.	19/07/2017
Recruitment of additional CNS	Jane Rutter Matron for Medicine	02/05/2017	Advert out internally and externally 25/10 closing date 8/11 19/4/17 Closing date 19/4, 6 applicants, interviews scheduled shortly ? date.	19/07/2017
Recruitment process for additional Stroke Consultant post ongoing	Jo Kenyon Divisional Director of Operations	02/05/2017	Job description at Royal College for approval. Stroke work force group with H&CT and CCG to develop countywide service. Locum to replace existing vacancy recruitment in progress Interviews scheduled for post 19/4/17 - Update from Stroke Speciality meeting - 1 part time consultant recuited and due to commence in June 17. Recruitment strategy to continue as 1 Consultant post will become vacant shortly.	19/07/2017

Band 6&7 Nurses to undertake swallow screens on Acute Stroke patients	Morag Inglis Speech and Language	30/09/2017	10/10/2017 - action completed Training being devlivered by SLT. Competency review to be completed. To be included in new Band 6/7 induction programme.Competencies completed awaiting sign off by SLT. 19/4/17 - Update at Speciality meeting today. Majority of staff now trained. Morag Inglis to provide current status and update action. Email sent. Email and report attached to documents. Trajectory requested	26/10/2017
Develop Full Stroke business case to provide 24/7 services	Jo Kenyon Divisional Director of Operations	08/09/2017	Approval to proceed to develop business case required first Duplicated action 9057	26/10/2017
Recruit six month temp stroke operational manager	Jo Kenyon Divisional Director of Operations	30/11/2017	Commences 12th Feb 2018	18/12/2017
Review, update and implement TIA referral form	Neil Baldwin Consultant Stroke Physician	30/11/2017	Signed off 11/12/18	18/12/2017
Develop and implement process for clinical sign off of SSNAP data	Neil Baldwin Consultant Stroke Physician	31/01/2018	Rachel Dunne from CCG leading a task and finish group to support improved SSNAP data collection and sign off processes. Will be complete in January 2018	07/02/2018
Develop, seek ratification and implement stroke services business plan	Stuart Cannonier Directorate Manager for Stroke	31/03/2018	Please review this risk action previously assigned to Jo Kenyon. Action superseded by service reconfioguration	02/01/2019
Review, update and implement SOP	Juliet Hawkesford-Barnes Matron	30/11/2018	Being progressed with lead CNS and stroke directorate manager. This is being delayed due to vacancy in post and staffing issues. Action superseded by service reconfiguration	02/01/2019

Target Risk Level	Moderate	Unlikely	6	Moderate

Progress	see actions and controls 19/4/17 Risk and actions reviewed and updated during Speciality meeting today. Remaining meeting to define direction and any potential risks that are identified. Jo Kenyon to review risk following meeting. 27/7/17I Faye Knowles SLT has met with SSNAP inputter today. Trust overall are rated an E for stroke care SLT have progressed from an E rating to a D rating. Targets related to SLT are: 4 hours swallow screen 72 hours assessment of swallow and /or communication to be completed 45 Minutes of therapy daily Issues highlighted Swallow screen with 4 hours -Delay in swallow screen as patients are not being pulled through to ASU where trained stroke nurses are located. -Specialists stroke nurses do not have the capacity to review outliers and complete screen. Measures to improve -ED & MAU training in screens-ongoing -Increase in specialists nurses now seeing outliers and completing swallow screens -80% target of stroke nurses trained in screens by end of Sep 17-achieveable -Education and training to ED & MAU staff- importance of prompt referral to SLT if suspected stroke, challenges-pressured ward -Add time slot to swallow screen paperwork Advanced swallow screen seen to improve 72 hours swallow assessment target Measures to improve - Education and training on admissions unit regarding stroke target and prompt referrals for swallow and communication - Add time slot to advanced screen paperwork –when was screen completed - Completing advanced screen training to senior nurses on stroke. Morag Inglis Business case approved in principle - awaiting outcome of discussions with Commissioners re payment of BPT. COO update, 28/06/18 Business case finalized and approved and funding allocated in specialty medicine budget.

	Recruitment has commenced with planned delivery of KPIs from October 18 onwards. 01/10/18 - DCCO update - Update received from Directorate manager for stroke services. Ongoing vacancies of trained nurses (currently 14 wte) active recruitment ongoing. Ward swap planned with MSSU to reduce bed base and mitigate staffing gaps. Ongoing activity to recruit stroke consultants, locum stroke consultants shortlisted for interviews. Latest SSNAP performance = D

Next Review Date 28/02/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3482 There is a risk that patient safety, effectiveness and management may be compromised in ED due to exit block.			
Date Opened	24/04/2017			
Initial Risk Level	Major	Almost certain	20	Extreme
Risk Owner	Paul Brennan			

Director/Committee	Chief Operating Officer / Finance and Performance Committee
Description/Impact	RISK There is a risk that patient safety, effectiveness and management may be compromised in ED due to exit block. This is a continuation of the corporate risk 1941 which has been RED on the risk register 2010 which has hundreds of linked incidents/complaints and serious incidents related to the overcrowding of the ED. The ED has only 20 adult cubicles but often has over 30 patients waiting for hospital beds. This leads to over 20 patients waiting in the corridor and an inability to off load ambulances. Sick patient might no even have trolleys and have to stay in the waiting room. When the department is overwhelmed it leads to increased mortality and morbidity. Also it leads to difficulty in retaining staff due to an environment where one can not give the best care to patients. There is also a financial cost as patients spend so long in the ED they are never admitted. An estimation of £250 000 is lost every month on tariffs CAUSE This could be caused when patient clinical demand in ED department exceeds capacity; ED becomes overcrowded and overwhelmed due to long delays in patient flow to inpatient facilities admission leading to chronic overcrowding within the department. EFFECT Local and international evidence identifies that an overcrowded Emergency department leads to increased in length of stay, morbidity and mortality. Inability to offload from ambulances leading to delays in triage. Delay in diagnosis and treatment. Patient privacy and dignity is being affected as patients are managed in non-clinical areas such as corridors and an overriding negative impact on the patient experience. Staff working under extreme pressure and has a negative influence on morale. IMPACT Increased patient safety risk Increased likelihood of 4 and 12 hour breaches Reputation al damage Increased media attention Increased likelihood of incidents, complaints and litigation. Difficulty in recruitment and retaining staff. Poor patient experience
Key Controls	Escalation policy for when department reaches capacity Clinical teams escalate appropriately according to policy in order to manage patient care Safety briefings/handover Bed meetings Safer staffing app Escalation matrix as part of the full hospital protocol Trialling the bed meetings in the ED department. Plus one process now in palce Clinical teams escalate appropriately according to policy in order to manage patient care Cultural change programme commenced, signature behaviours launched.
Sources of Assurance	Management Assurance-Escalation Matrix as part of FHP Management Assurance-Weekly perfomance dashboard monitored and presented to exec team Management Assurance-Staffing app- staffing safety monitored through board and chief nurse Management Assurance-EAS is monored locally and via system wide with CGG daily

Performance Monitoring	Monitoring of compliance with escalation policy through the bed meetings Reduction in 12 hour trolley breaches. Monthly directorate performance reviews Weekly Board dashboard of key metrics. Monthly WRH senior ED departmental meetings. Bed reports 4 times per day to senior operational teams/on all teams. Friends and family, compliments/complaints. Quality audits undertaken by Matrons and reported to chief nurse. Clinical audits co-ordinated by Consultant and represented departmental meeting and recorded to trust data base. 06/03/2018 Reviewed at the WRH ED Senior Departmental Meeting. We have had 55 patients in ED this week waiting for specialty beds. There are not enough nurses for these numbers and definitely not enough space. 4 hour targets is at 54%. When the department is that full it slows everything thing down. eg a man who was stable, had to wait 2 hours to get into resus for a cardioversion and the only trolley in the whole department for resus was from the minors plaster room. This is also leading to reduced morale and increase fatigue in the staff with the loss of staff and difficulty in recruitment. The

	consultant have written a letter to the exec. board and have met with the medical director to raise their concerns about safety. Ian Levett 02/10/2018 Reviewed at the WRH senior departmental meeting. No change despite all the efforts. regularly unable to off load ambulances. Ian Levett
Gaps in Control	Demand and capacity mismatch, particularly on WRH site Corpotate Risk 3485 - The trust is unable to deliver safe and effective care due to nursing and medical vacancies.
Gaps in Assurance	Further focus on early discharge is required Need to provide clarity of professional accountability in achieving improved flow Requirement to embed improved process regarding bed managment and communication

Current Risk Level Major Almost certain 20 Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Service reconfiguration as per paper to Trust Board Jan 2019	Jo Kenyon Divisional Director of Operations	31/01/2019		
Professional standards agreed with all staff	Jules Walton Consultant	18/10/2017	Professional standards have been mandated trustwide	18/10/2017
Recruitment	Jules Walton Consultant	11/04/2018	Middle grade recruitment identified 4 new doctors. Successful business case for further 2 wte to increase doctors overnight from 3 to 4. Advert due November 17 Consultant advert due November 17 Developmental consultant advert due November 17	23/10/2017
Plus one pull from the wards		17/01/2018	Early pull from wards implemented (plus one)	30/11/2017
bed meetings	Stephanie Beasley Divisional Director of Nursing	21/11/2017	Re structure the bed meetings toe sure consistency and structure.	23/02/2018
To provide Sonia Lloyd with an update on the implementation of the work relating to Carnell Farrer	David Burrell Divisional Director of Operations	23/03/2018	Email via Datix and outlook to update on progress.	23/02/2018
Workstreams to improve flow	Stephanie Beasley Divisional Director of Nursing	30/03/2018	Intervention 1.1 Reduce ambulance waiting times and improve ambulance data 1.2 Support Clinical leadership with this priority A&E related project 1.3 Improve speed of assessment by specialities and time to admission / discharge 1.4 Improve GP and other service streaming at the Emergency Department front door 1.5 Improve flow through MAU and all assessment units 1.6 Capital business case delivers acute capacity 1.7 Work with Pulse team to help embed culture change programme with ED & Trust leadership team 1.8 Develop a Demand and Capacity Planning tool 1.9 Improve A&E operational data and recording 1.10 Design and Implement A&E Performance Management System	16/04/2018
ED specific internal profesional standards agreed within the division	James France Consultant - A&E WRH	11/09/2018	As part of the external Carnell Farrar work within the organisation an agreed work streams are agreed to dovetail with the existing actions. These workstreams led by the DMD for the division will be monitored through the ED workstream meetings.	16/04/2018
Monitoring of performance against worksreams	Jules Walton Consultant	11/09/2018	Workstreams identified PMO project plan in progress. Meetings agreed. Leads for each workstream agreed. DMD active member of steering group. DOPs identified as lead for workstream 1 and member of operational group.	25/10/2018

Target Risk Level Major Unlikely 8 High

Progress	This new risk is replacing risk 1941 - at a corporate level. Please see this risk for historical detail. Moving forward this risk will be updated. Working with NHSI in progressing the issues of flow and capacity. External visits have taken place. 26/10/2017 Step-down delays continue. Trust is committed to improving patient flow across hospitals including step-downs from critical care. Main workstreams are: Countywide frailty model at Alexandra hospital site - in place from 16/10/2017 Front door streaming at WRH - from 01/12/2017 mandated internal professional standards. Re-focused bed meetings. 07/11/2017. Reviewed at the WRH ED Senior Departmental Meeting. Still this is a serious risk. We have now lost CDU so we are having more than 30 patients in the ED waiting for beds. We will see how many patients the AEC will pull through. Ian Levett 17/01/18 COO update. Evergreen 2 opened to full capacity (28 beds) as part of the winter plan. GP out of hours co-located with AEC as from Mid December 2017. Work on-going with Health economy to reduce DTOCs and improve flow. 15/02/18 COO update, Improvement work commenced with Carnall Farrar. Diagnostic stage completed, implementation stage in progress. UEC steering committee to have first meeting on 20/02/18. 05/06/2018 reviewed at the WRH ED Senior departmental meeting. Things are getting worse. This has previously been the less stressful time of year and we are recurrently so full that we cannot offload ambulances for hours. Ian Levett COO update 28/06/18 Ambulance border change pilot for DY10 and DY11 commenced on 18/06/18. Initial impact is positive with significant reduction in over 1 hour handovers and marginally improved EAS at Alex. System wide Right Move event to take place weeks commencing 2/7 and 9/7 with aim to create additional bed capacity and clear assessment areas from inpatients. 01/10/18 - DCOO Update - ambulance border change continues. Trust winter plan presented at September Board. Carnall Farrar commissioned by CCG to do capacity and demand modelling. Internal clinical engagement event happening on 3rd October.

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3483 Patients may be harmed due to delays in treatment/waiting times			
Date Opened	24/04/2017			
Initial Risk Level	Catastrophic	Possible	15	Extreme
Risk Owner	Heather Fleming			

Director/Committee	Chief Operating Officer / Finance and Performance Committee
Description/Impact	RISK There is a risk of inappropriate patient pathway management and extended waiting times CAUSE Poor data quality, lack of training and/ or utilisation of reports by end users EFFECT This has resulted in a historic backlog of non RTT pathways that require significant validation Data quality issues remain on RTT pathways IMPACT Patient treatment can be delayed if the pathways are not managed consistently and to the waiting list rules. This can result in patient harm due to delayed treatment. Also reputational risk to the organisation. This risk is linked to risk 2871.
Key Controls	Weekly Patient Target List meetings to track patients through treatment pathways- head of patient access Non RTT validation workstream tracked through RTT steering group, led by COO Intensive Support Team recommendations have been translated into a project plan, monitored through RTT steering group.
Sources of Assurance	Management Assurance-Project plan monitored through RTT steering group Review-Internal-Validation of Non RTT cases through RTT steering group Review-Internal-Monthly elective access board Management Assurance-Executive led harm review panel

Performance Monitoring	Finance and Performance Committee and Trust Board via Integrated Performance report.
Gaps in Control	Insufficient capacity in key specialties
Gaps in Assurance	Impact of emergency pressures leading to elective cancellations Workforce vacancies in a number of specialties

Current Risk Level	Major	Likely	16	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Risk to be re-written in q4, 2019	Heather Fleming Operations	29/03/2019		
System wide review of the health economies ability to identify an agreed process for all patients waiting longer for their RTT and non RTT appointments, and identify actions to mitigate potential harm with those partners.	Jim O'Connell Interim Chief Operating Officer	31/05/2017	New controls added to ensure a system wide review plan is in place	23/05/2017
Executive led harm review panel to be established to review all breaches of statutory standards	Vicky Morris Chief Nursing Officer	30/11/2017	Harm review panel formed and initial meetings held. Forward plan of the Schedule of meetings confirmed. - Done July 30th. Divisions need to ensure prospective harm reviews continue for review by the panel. Done August 2017. Harm review panel outcomes need to be fed back to Divisions and key issues identified for improved process (capacity/ alternate routes for management) Due 2017.	01/08/2017

To provide a progress report on Datix on the impact experienced due to the national mandate.	David Burrell Divisional Director of Operations	13/04/2018	Progress report provided by COO	28/06/2018

Target Risk Level Major Unlikely 8 High

Progress	New risk added to Corporate Risk Register. Linked with Risk 2871, which is being managed by information team Phase 1 of Non RTT validation project is complete, we have developed a plan for phase 2 and 3 which will take us up to end of March 2018. Issues logs for ICT, Data Quality, Training and Processes has been developed also to help focus on key areas of improvement. 25/10/2017 Dedicated weekly RTT cancer and diagnostic PTL meetings led by deputy COO. Weekly cancer oversight meetings with CCG NHSI and cancer alliance. Capacity and demand modelling undertaken and to be refreshed in October 2018. Joint cancer and RTT action plans agreed with commissioners and regulators (NHSE & NHSI) 7/12/17 review by COO, Additional £50 non recurring funding received from NHSI to support cancer performance. 05/01/2018 Phase 2 of the Non-RTT validation is on track to be completed by the 12/01/2018. Guides have been developed for processes highlighted as issues during the validation process and will be ready for dissemination once they have been approved. 17/01/18 COO update - Updated trajectory for RTT agreed with the commissioners, NHSE and NHSI. The Trust's performance has been above RTT trajectory for 2 consecutive months. There is a risk that performance will deteriorate following the National mandate to cancel non-urgent elective surgery until the end of January. 15/02/18 COO update, RTT trajectory hit for 3 consecutive months. Significant reduction in 52+ week waiters (forecast = 2 for January month end and 0 for February month end). S Lloyd 28/06/18 COO update. We have minimised the negative impact of 52 plus week waits. Whilst Trust reported single figures in April/May the trajectory = 0 by July. Cancer and RTT performance monitored jointly with CCG and NHSI via Elective Care Executive Group. Trajectory to hit 85% cancer standard from end of Q2., RTT trajectory is in line with national planning guidance, nil 52plus week waits and reduction of total WL by March 19 compared to March 18. 01/10/18 - DCOO update - Trust has achieved zero 52+ week waiters for 2 consecutive months and is forecasting sustaining this trajectory going forward. Additional locum appointments in T&O and Gen surgery approved by TLG. Theatre efficiency programme ongoing.

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3768 Cash Flow -There is a risk that the Trust does not generate sufficient cash incomings through contracted services provided			
Date Opened	11/06/2018			
Initial Risk Level	Major	Likely	16	Extreme
Risk Owner	Katie Osmond			

Director/Committee	Chief Financial Officer / Finance and Performance Committee
Description/Impact	Risk There is a risk that the Trust does not generate sufficient cash incomings through contracted services provided to cover cash outgoings each month. In addition, the Trust cannot repay loans due this year, unless re-financed with the DHSC. Cause In recent years the Trust has spent more than it has earned. The Trust has experienced severe affordability challenges in recent years. The Trust's deficit has increased from £14.2m in FY 2013/14 to £52.6m in FY 2017/18 resulting in the accumulated deficit of £199.6m at 31 March 2018. Effect The effect has been that the Trust has had to borrow money from the DHSC to support day to day operations and investment in capital assets. The Trust applies for loans from the Department of Health and Social Care on a monthly basis to manage cash shortfalls, which enables it to pay its creditors within credit terms. Impact The Trust loans totalling to £194.8m at 31 March 2018, £42.4m of which are due for repayment in FY 2018/19, £72.4m in FY 2019/20, £60.8m in FY 2020/21 and the rest is spread until FY 2037/38 Unless the trust returns to surplus there will be a continued reliance on cash support to maintain the business. There is no guarantee that the additional funding will continue to be provided. There is a reputational risk associated with the above.
Key Controls	Monitoring and reporting 12 monthly cashflow forecast review of the daily cash balances and compared to the forecast Monitoring the KPIs and Better payment practice code Internal KPI monitoring, creditor days, inventory days, debtor days Reporting 13-week cash flow to NHSI on a monthly basis. The loan requirement is calculated and applied for with NHSI on a monthly basis. Managing outflow of cash through authorisation levels according to the Trust's SFI's. Large value expenditure is authorised by more senior staff, authorisation limits are given to Budget Holders/Budget Managers only.
Sources of Assurance	Internal reports to the Board-Reports to Board Management Assurance-KPI monitoring External Audit-Going concern assessment Standards-Use of resources liquidity

Performance Monitoring	BPPC target is 95% of invoices paid within credit terms. Current performance 75% Use of resources liquidity metric NHSI, our score is 4 (highest) Debtor days currently 241 days for Non NHS debt and 123 days for NHS debt, target of 30 days. Creditor days currently 44 days, target of 30 days. Drugs Inventory turnover days 26 days, this is required to be reviewed in line with other peer Trusts (15 days) to ensure we don't buy unnecessary levels of stock.
Gaps in Control	There isn't a plan B for repayment of loans due this year, if the DHSC will not agree to re-financing.
Gaps in Assurance	

Current Risk Level	Major	Likely	16	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Effective contract management with CCG's to receive payments for overperformance on a regular basis. Also manage	Christian Stevens Head of Income and Contracts	31/01/2019	11/12/18 £6.4m underperformance estimated as at Nov-18	

underperformance from the cash flow point of view.				
Review Good Received Not Invoiced (GRNI) and close orders that have been paid for but not matched to the order.	Tina Dunne Query Manager	31/01/2019	11/12/18 PO's over 90 days reduced by 472, 1,969 in September to 1,497 in November.	
Review of all large aged non-purchase order invoices on hold to determine whether such invoices are expected to be paid or should be written off.	Tina Dunne Query Manager	31/01/2019		
To work closely with debt managment team (SBS) to taget overdue debt	Lynne Walden Head of Finance Worcester	31/01/2019	11/12/18 % of over 90 days debt of the total debt reduced from 53% in September to 33% in November	
Reporting and monitoring Underlying I&E performance	Faye Richmond Finance	28/02/2019		
Delivery of Financial Sutainability plan (CIP) through cash releasing savings	Jill Robinson Interim director of finance	29/03/2019		
No PO no Pay, only invoices with PO number can be paid, apart those that on the exception list from the procurement.	Tina Dunne Query Manager	29/03/2019	Waiting for an up to date list from Procurement 12/10/18 the NON-PO invoices report is being reviewed against the lis agreed with Procurement.	
Seek formal agreement from DHSC to defer revenue loan repayments in 2018/19	Katie Osmond Assistant Director of Finance	30/09/2018	Formal request to DHSC 16/07/18 - awaiting response. 12/10/18 letter from NHSI received on 20/07/18 confirming that principal repayment of £1334k is delayed into the future years.	12/10/2018
Managing outflow of cash through authorisation levels according to the Trust's SFI's. Large value expenditure is authorised by more senior staff, authorisation limits are given to Budget Holders/Budget Managers only.	Elvira Patrasco Deputy Financial Controller	31/12/2018	SFI's refreshed and re-issued October 2018. Budget Holders / Budget Managers are allocated limits as per SFI's under Financial Recovery mode.	11/12/2018

Target Risk Level Major Possible 12 High

Progress	Risk drafted and awaiting discussion and approval at the July 18 F&P committee. S Lloyd 03/09/18 - risk reviewed and moved to approved. KO 05/10 - risk reviewed by KO / JR - EP to update actions. Agreed to escalate to CRR 08/10/2018 J Pick: Escalated to CRR 11/12/18 - individual actions are updated with progress

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3772 Access to Funding for asset replacement			
Date Opened	13/06/2018			
Initial Risk Level	Major	Almost certain	20	Extreme
Risk Owner	Katie Osmond			

Director/Committee	Chief Financial Officer /
Description/Impact	RISK There is a risk that the Trust is unable to invest in supporting the Estates and ICT infrastructure, Strategic Developments and replacement clinical equipment. Insufficient investment is taking place due to the lack of capital funds available. There is a risk to failure of plant and equipment and a number of clinical systems are coming out of support or will, in the near future, not be supported. In the last capital planning process, the Trust identified circa £54 million worth of capital bids across the Trust against available internal funding of £3.8 million. CAUSE This is caused by a reduction in available internally generated funds caused by PFI and existing capital loan repayments. This situation isn't likely to change until the PFI development is paid off in 2032. Also, if the Trust continues to receive capital loans, repayments will be on-going. The current capital loans outstanding amount to £27m. EFFECT The effect is the inability to maintain the full range of clinical equipment and infrastructure to the required level at the appropriate time resulting in critical and urgent capital schemes being deferred. IMPACT The impact on the Trust is increased patient safety risks, negative impact on the patient experience and increased risk of reputational damage. There is the potential for statutory standards to be breached with potential loss of income and legal penalties due to backlog maintenance not being completed. The revenue position is worsening due to the increased use of leasing solutions and Managed Equipment Schemes when capital funding is not available. The Trust is applying for capital loans on an annual basis to try to reduce the risks affecting the Trust in terms of capital investment. However, there is a lack of capital resource across the NHS financial system. Demand for resources is greater than the capital funding available. It is highly likely this will reduce what the Trust has available to spend on capital projects. This will either reduce the investment that Trust can make in capital to transform services, or if assets are leased as an alternative, then it instead places the revenue control total at risk.
Key Controls	Monitoring and Reporting of the Capital Position showing the Year to Date position and Full Year Forecast. Reporting at Capital Prioritisation Group, Strategy and Planning Group and Finance and Performance Committee Apply for Capital Loans for the highest risk rated capital schemes – the Trust is currently applying for a £5 million capital loan for the red risk rated critical and urgent capital schemes. Risk based capital prioritisation processto ensure limited funds are directed to most significant risks Re-prioritisation of the capital programme in year to focus on highest risk schemes Contingency fund held in 2018/19 to maintrain funds for business critical failed asset replacement
Sources of Assurance	Internal reports to the Board-Capital Reporting is part of Finance reports to Board Self-assessment against standards-Capital Service Cover Rating reported to NHSI External assessment against standards-Monthly reporting to NHSI of performance against capital limits (statutory duty)

Performance Monitoring	Use of resources capital cover metric NHSI, our score is 4 (highest). This is directly linked to I&E performance as the monthly calculation takes the Operating Deficit less the Depreciation divided by the capital funding available. Monthly monitoring of performance against the Capital Resource Limit (CRL) - remaining within the CRL is a statuory duty.
Gaps in Control	The Trust is submitting a capital loan for the highest risk rated items, if this is not approved, all schemes will be deferred into the next financial year.
Gaps in Assurance	The replacement of equipment could be funded through the revenue budgets, however, this will have a knock on effect on the cash available for day to day business.

Current Risk Level	Major	Almost certain	20	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop Medium term Plan, IT and Estates Strategies to support future capital strategy	Katie Osmond Assistant Director of Finance	31/01/2019	Date changed as being considered as part of the development of the aforementioned strategies.	
Review of Medical Equipment (MTS) - what could be funded through	Charlotte Kings Head of Procurement	31/01/2019	Report to be considered at Jan 2019 F&P committee	

long term leases / MES?			
Successfully bid for any other capital funding that the Trust is able to	Julian Turner Financial planning accountant	31/01/2019	05/10 - IT bid completed (HLSI)and submitted 3rd Oct EPMA funding - deadline 31.1.19
Successfully secure capital loan funding with NHSI	Lynne Walden Head of Finance Worcester	31/01/2019	NHSI have provided queries, which Finance are currently working through 05/10 - 2nd set of NHSI queries responded to - expecting regional NHSI to submit to national team for review Jan '19 - being picked up via the performance review meetings

Target Risk Level Major Possible 12 High

Progress	16/07/18 - first draft reviewed and amended by KO. 17/07/18 - risk awaiting discussion and approval at F&P committee. S. Lloyd 17/07/18 - Trust submitted capital loan application amounting to £5.64m 29/08/18 - capital loan queries received from NHSI 03/09/18 - risk reviewed and converted to approved. KO 03/10/2018: J Pick - escalated to CRR on behalf of KO 05/10 - risk reviewed by KO/JR and updated. 11/12/18 - Elvira - actions / dates reviewed 2-1-19 - actions and dates reviewed by JR. Amendments by KS

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3792 Achievement of the Financial Plan (Delivery of the in year Control Total/ Improving the deficit position)			
Date Opened	27/06/2018			
Initial Risk Level	Catastrophic	Likely	20	Extreme
Risk Owner	Katie Osmond			

Director/Committee	Chief Financial Officer /
Description/Impact	RISK There is a risk that the Trust does not achieve its 2018/19 financial plan as agreed with NHSI and that the deficit is greater than planned. CAUSE The cause of the Trust not achieving its financial plans includes: - expenditure increases above plan - slippage in delivery of Trust CIP programme - income decreases compared to plan EFFECT The effect of the Trust not meeting its financial plan is that no Provider Sustainability Funding can be received (£17.8m in 2018/19)which both increases the reported deficit and reduces the cash available to service commitments. IMPACT The impact is likely to be that the Trust would move from Enhanced Financial Oversight into formal Financial Special Measures with NHSI.
Key Controls	Sustainability Plan in place overseen by Turnaround Director Divisional Confirm & Challenge Meetings continue Grip & Control measures in place in line with NHSI best practice guide On-Going finance skills training with Budget Managers / Budget Holders SFI's refreshed and re-launched in May 18, with a requirement for confirmation of receipt / acceptance Enhanced Financial Oversight through the NHSI regime
Sources of Assurance	Internal reports to the Board-Monitoring of development and performance against CIP targets Internal reports to the Board-Monthly finance reports with detailed analysis of performance v control total and actions identified in Financial Recovery plans Independent Assurance-External review through NHSI, internal audit and benchmarking

Performance Monitoring	Compliance with monthly control total CIP delivery in Line with Plan Operational Metrics linked to STF Compliance with Capital Resource Limit (Forecast) Carter productivity data through model hospital Better Payment practice Code
Gaps in Control	Staff Capacity and Capability to deliver CIP The performance management system requires strengthening Finalised project plans for all material elements of the CIP programme Ability to realise savinghs in the face of operational pressures including safety issues and delayed discharges
Gaps in Assurance	Consistency and completeness of QIA process for CIP schemes Agree a longer terms CIP plan (2 to 3 years) Agree medium term financial strategy

Current Risk Level	Catastrophic	Likely	20	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop mitigation plans for key financial risks	Joanne Kirwan Head of Finance	31/01/2019	Risks identified as Winter Planning and contractual position. Work being undertaken as part of financial forecast.	
Deliver 2018/19 CIP programme	Darren Hargreaves tbc	31/03/2019		
Develop robust medical workforce plans to	Tina Ricketts Director of People and Culture	31/03/2019	Strategic workforce plan being developed as part of planning cycle. This includes team job planning linked to	

support recruitment as well as managing temporary costs			the Trust's demand/ capacity model	
Maximise benefit from cap and collar contract	Jill Robinson Interim director of finance	31/03/2019		
Identify key risks to delivery of planned position	Joanne Kirwan Head of Finance	30/09/2018	Forecast outturn paper presented to FPC in September, setting out identified risks to the FOT.	05/10/2018
Develop a recovery plan	Joanne Kirwan Head of Finance	31/12/2018	Presented to F&P, Trust Board. Completed.	13/12/2018

Target Risk Level	Major	Possible	12	High

Progress	Risk Drafted to be presented to FPC week commencing 5/10 - reviewed by KO / JR - to review monthly for next 6 months to ensure delivery. 08/10/2018 J Pick: Escalated to CRR 11/12/2018 - Elvira - reviewed actions/dates

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3831 PC06 Recruitment and Retention			
Date Opened	03/08/2018			
Initial Risk Level	Major	Likely	16	Extreme
Risk Owner	Tina Ricketts			

Director/Committee	Director of People and Culture / People and Culture Committee
Description/Impact	There is a risk that a high number of medical and qualified nursing vacancies may result in the Trust's inability to meet service demands which may have an impact on patient care and safety. Other consequences of high vacancy rates are a negative impact to staff morale, an increase in sickness absence and higher use of bank and agency workers resulting in increased costs.
Key Controls	Trust turnover and vacancy levels monitored through monthly Team Leadership Group meetings, Recruitment & Retention Steering Group and People and Culture Committee.
Sources of Assurance	

Performance Monitoring	Bank and agency spend vacancy rates Staff in post Turnover sickness absence rates
Gaps in Control	High medical and nursing vacancy rates Breaches of safer staffing fill rates Lack of workforce planning to identify future staffing requirements Low completion rate of exit interviews
Gaps in Assurance	

Current Risk Level	Major	Likely	16	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Implemetation of the Recruitment and Retention plan	Tina Ricketts Director of People and Culture	31/05/2019		

Target Risk Level	Major	Unlikely	8	High

Progress	The Trust has a recruitment and retention plan. The Trusts overall turnover rate is at the local target of 12%. The retention rate for qualified nursing, qualified midwives and health care support is better than the Model Hospital average which is a change in trend from 2016. The Trust is above its agency cap for temporary workforce costs. The Trust has seen an increase in the qualified nursing vacancies since August 2018 primarily due to increased budgeted establishment and use of escalation areas which is of serious concern ahead of winter pressures. However, we have a rolling recruitment programme for B5 and B2 and the Chief Nurse has blocked booked 100+ agency nurses for the winter period.

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3832 PC07 Workforce Planning			
Date Opened	01/09/2017			
Initial Risk Level	Major	Likely	16	Extreme
Risk Owner	Tina Ricketts			

Director/Committee	Director of People and Culture / People and Culture Committee
Description/Impact	The Model Hospital indicates that the Trust spends more on staff per unit of activity than a typical Trust. There is a risk that the Trust will be seen as inefficient which may result in an increase in cost improvement requirements by Commissioners
Key Controls	Model Hospital Committee. Cost Improvement Plans
Sources of Assurance	

Performance Monitoring	Pay expenditure Cost per weighted unit of activity Reference costs Model hospital
Gaps in Control	Only 67% of consultants have job plans. Workforce plans do not go beyond 12 months.
Gaps in Assurance	

Current Risk Level	Major	Likely	16	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done

Target Risk Level	Major	Unlikely	8	High

Progress	The Trust is in the process of developing a strategic workforce plan which will be linked to the clinical services strategy and demand/ capacity model. The implementation of the Workforce Transformation Programme which will see an organisation wide solution for job planning, leave management and e-rostering by September 2019. The workforce plan will be used to set establishment levels for 2019/20.

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3833 PC08a Mandatory Training completion rates			
Date Opened	03/08/2018			
Initial Risk Level	Moderate	Almost certain	15	Extreme
Risk Owner	Tina Ricketts			

Director/Committee	Director of People and Culture / People and Culture Committee
Description/Impact	There is a risk that low mandatory training compliance could have a detrimental impact to the Trust's reputation, as an employer of choice and its ability to meet CQC standards.
Key Controls	Monthly compliance reports issued to managers Monthly performance review meetings bi-monthly P&C Committee
Sources of Assurance	

Performance Monitoring	Performance review meetings Confirm and Challenge meetings % of staff completing mandatory training by staff group P&C Committee
Gaps in Control	Target of 92% compliance not achieved in all subject areas
Gaps in Assurance	

Current Risk Level	Moderate	Likely	12	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Mandatory training action plan via MT group	Debbie Drew Human Resources Manager	28/02/2019		

Target Risk Level	Moderate	Unlikely	6	Moderate

Progress	The Trust was subject to a performance notice from CCG regarding data quality for mandatory training. However, significant improvement has been made in this area. Review of content and frequency of mandatory training has been undertaken by the lead specialists.Concerns growing that trajectory not being achieved due to capacity within services to release colleagues for training. Trust Leadership Group to improve performance in their areas of responsibility. Task and finish group set up to remove obstacles to staff completing training.The divisional focus on mandatory training compliance has seen improvement in the majority of subject areas with the overall compliance level being at 80%. Fewer reports of data quality issues.

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3842 PC15 HR / OD Capacity			
Date Opened	22/06/2018			
Initial Risk Level	Major	Likely	16	Extreme
Risk Owner	Tina Ricketts			

Director/Committee	Director of People and Culture / People and Culture Committee
Description/Impact	There is a risk to the successful delivery of the Trust's People and Culture Strategy and Workforce Transformation Programme. There is a risk that the Trust will not deliver the required £2.7m (FYE) CIP savings attributed to this programme.
Key Controls	Strategy Implementation Plan developed. Project Initiation Documents developed for key Workforce Transformation workstreams
Sources of Assurance	

Performance Monitoring	Achievement of workforce CIP savings Delivery of people and culture strategy
Gaps in Control	HR pay budget reduced in 2018/19. Gaps in HR/ OD capacity/ capability to deliver business as usual as well as transformational work
Gaps in Assurance	

Current Risk Level	Major	Likely	16	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
New HR business partner model	Tina Ricketts Director of People and Culture	30/04/2019	Approved by Execs.	
Review of HR function	Tina Ricketts Director of People and Culture	30/11/2018	Completed	30/11/2018
Interim resource	Tina Ricketts Director of People and Culture	03/12/2018	In place.	03/12/2018

Target Risk Level	Major	Unlikely	8	High

Progress	Resource plan developed for priority workstreams of the Workforce Transformation Programme and additional interim resource now in place. Review of HR function has been undertaken with new structure in place from 1st December 2018. Delivery of programme has been impacted by the delay in the contract being signed for a single provider of bank/ agency staff. Furthermore, as the savings were not devolved to budgets at the time the CIP schemes were approved by the TLG the savings made by the divisions are being used to offset other cost pressures or have been accounted for under other divisional CIP schemes. A revised forecast has been undertaken with £1.7m of the savings now deferred to 2019/20. The executive team has supported the recruitment of 3 x Senior HR Business Partners to support the delivery of this agenda. These posts will be advertised in December 2019.

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3844 PC17 Health and Safety capability/ capacity			
Date Opened	22/06/2018			
Initial Risk Level	Major	Likely	16	Extreme
Risk Owner	Paul Graham			

Director/Committee	Director of People and Culture /
Description/Impact	There is a risk that the Trust may not being undertaking all of the required health and safety audits due to the lack of resource. This may result in a serious incident occuring and the Trust being found at fault due to the lack of H&S oversight.
Key Controls	Regular audits undertaken by divisions
Sources of Assurance	

Performance Monitoring	Number of H&S audits
Gaps in Control	Single point of failure - one post covering H&S and security. Lack of clarity between estates and H&S responsibilities
Gaps in Assurance	

Current Risk Level	Major	Likely	16	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Review by Internal Audit	Tina Ricketts Director of People and Culture	29/03/2019		

Target Risk Level	Major	Unlikely	8	High

Progress	The Trust has commissioned internal audit to review the governance structure for health and safety within the Trust. This is due to be completed by 31st March 2019. The audit will also review the effectiveness of health and safety policies and the accountability framework to ensure colleagues are clear on their roles and responsibilities in relation to this agenda. Approval has been given to recruit to a band 6 H&S Manager which will be advertised in January 2019.

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3852 Risk of HCAI due to lack of sustainability in maintaining a safe and clean environment leading to patient harm			
Date Opened	22/08/2018			
Initial Risk Level	Major	Almost certain	20	Extreme
Risk Owner	Emma Bridge			

Director/Committee	Chief Nursing Officer / Trust Infection Prevention & Control Committee
Description/Impact	Risk: The inability to sustain CONSISTENT standards for well maintained and clean environments from which to deliver patient care on all three sites. This risk is increased through inconsistent standards of hand hygiene and use of PPE. Cause: The risk of the previous audits in place not providing an emerging picture of poor compliance to meet the required standards of cleanliness and regulatory requirements set out in the Health and Care act (criterion 2) AND through lack of triangulation of audits between facilities operational teams, IPC audits and facilities compliance audits. Facilities and Estates provision of cleaning resource and standards through the PFI provider (WRH) site and Trust teams on the Alex and Kidderminster site are not robustly performance managed in order to make those improvements. Historical PFI contract does not contain the requirement to meet the hygiene code under the heath and Care act making it difficult to manage poor performance from service provider at the WRH site. Poor understanding of responsibilities under the hygiene act across all responsible groups. Poor escalation practice with regards to environmental concerns. Staff training for IPC at level 2 to ensure awareness of requirements falling below the required 90% level of compliance. Senior staff not challenging non -compliance to hand hygiene and PPE non compliance and ward / Dept staff not feeling confident to challenge. Effect: Inconsistent standards of cleanliness. Inconsistent hand hygiene standards. Inconsistent use of required PPE. spoor provision of service demonstrated by failing audits across all areas of responsibility. Increased surveillance from both internal and external parties. Impact: Clinical areas failing required standards of cleanliness without escalation by ward/ Dept staff to senior nurses. Impact on organisational reputation for providing a safe and clean environment. Potential increase of HCAI and less effective outbreak management. Poor patient experience. Risk to not compliance of the regulatory requirements in line with CQC outcomes, National Standards of Cleanliness and compliance with the Hygiene Code.
Key Controls	Performance review meetings with Divisions to ensure compliance with IPC level 2 training compliant with clear deadlines for achievement. Introduction of a credit for Cleaning (C4C) environmental audit programme, implemented trustwide, to demonstrate triangulated picture of all aspects of compliance. Back to the floor programme introduced to provide weekly oversight of cleanliness whilst working directly with front line teams and direct opportunity to challenge poor hand hygiene standards and PPE issues. Governance and feedback from the “back to the floor” to be provided weekly to Divisions and at a corporate level to triangulate with audit outcomes and actions. A statement of Intent to be signed up to, to ensure that this practice becomes embedded practice. Divisional reports to TIPCC to manage the performance on a range of required standards Professional escalation with Divisional Directors of Nursing/ Divisional medical directors and requirement for holding clinical leaders to account for personal professional practice and those of their colleagues under span of control. Implemented decontamination programme of all trust beds, due to be completed Jan 2019. Introduction of a credit for Cleaning (C4C) environmental audit programme, implemented trustwide, to demonstrate triangulated picture of all aspects of compliance. Full mattress audit and replenishment of mattresses as required (ongoing 6 monthly programme). Monthly meetings with MDs of external contractors SPC & ISS, chaired by CNO NHSI collaborative for improving hand hygiene being piloted across surgical Division to improve compliance MHRA notification in place based on manufacturer’s instructions which limit and do not enable full cleaning to take place- local solutions agreed with manufacturers.
Sources of Assurance	

Performance Monitoring	Weekly escalation meetings for cleaning continue until consistent standards are in place MDT Audit process through C4C TIPCC PRM meetings with Divisions Surgical Division- separate escalation meetings to ensure all actions in NHSI action plan completed and practice embedded. Disciplinary process applied where required Further NHSI inspections

Gaps in Control	Draft key standards need to be launched to ensure all staff understand the expectations for them in professional standards, cleanliness standards and isolation practices. Pilot for zero tolerance "non- compliance slip" to be evaluated by surgery and then applied and rolled out across the Trust. Ward and Dept manager and supervisory roles understanding that the ward controls/ checks needs to evidence sufficient local controls Formal contractual management for PFI agreed to be progressed through F&P COMMITTEE and clinical standards reviewed in QGC Refined performance management of Trust staff employed to supervise and work to the required cleanliness standards
Gaps in Assurance	Insufficient evidence that cleanliness standards are being consistently achieved. C4C Audits

Current Risk Level Major Likely 16 Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Clear plan in place to support the Facilities team to review supervisory arrangements to ensure adequate level of cleanliness consistently achieved	Jill Robinson Interim director of finance	31/01/2019		
Embed the "Back to the floor" programme with feedback into Div governance and corporate meetings	Vicky Morris Chief Nursing Officer	31/01/2019	Will be transferred to be a control at end Jan 2019	
Ensure level 2 training for IPC is at 90% compliance across Divisions	Vicky Morris Chief Nursing Officer	31/01/2019	76% (unvalidated) @31 December. Mainly medics who have not completed training. Email sent to all clinical leads. Raised at DMD meetings. Revised date 31.1.19	
Formal performance management of the PFI contract to support improvements	Jill Robinson Interim director of finance	31/01/2019		
IPC standards and expectations agreed with DDNs/ DMD's and then shared through Divisional professions	Vicky Morris Chief Nursing Officer	31/01/2019		
Launch the key standards for IPC	Vicky Morris Chief Nursing Officer	31/01/2019		
Pilot for non - compliance slips for HH and PPE standards to be rolled out	Vicky Morris Chief Nursing Officer	31/01/2019	Initial concerns voiced by JNCC. Timescale may slip.	
Review of contract failings in line with KPI's for service provider at WRH site	Ray Cochrane Directorate support manager	31/01/2019	P2G have been commissioned to undertake this element of work. Meetings have taken place. Further update in Jan 2019	
Procure computerised audit system	Emma Bridge Interim Head of Facilities	04/07/2018	Purchased and implemented.	28/09/2018
Agree standard audit questions with IPC and operational teams	Helen Mills Facilities	01/08/2018	Questions agreed and added to system	28/09/2018
Agree and implement	Emma Bridge Interim Head of Facilities	04/09/2018	Agreed and cascaded to all clinical teams via DDNs	28/09/2018

escalation procedure for audit process				
Masterclass of audit process to be cascaded to ward managers and Band 6's	Heather Gentry Infection Control Nurse	31/10/2018	Complete. Transferred to be a control.	31/12/2018
Bi-weekly reporting of new audit process whilst baseline audits are being undertaken	Helen Mills Facilities	31/12/2018	Being discussed at escalation meeting. Transferred to a control	31/12/2018
Weekly escalation meetings with operational teams and DDN's chaired by CNO	Vicky Morris Chief Nursing Officer	31/12/2018	Weekly meetings taking place and are ongoing. 02/10/18 - weekly cleaning meetings continue chaired by CNO or Deputy CNO with ISS, IPC and DDN attendance. Complete. Transferred to a control	31/12/2018
Complete base line audits of both inpatient and outpatient areas across all three sites	Helen Mills Facilities	31/12/2018	02/10/18 - currently underway all sites using revised C4C audit tool 31/12/18 - baseline audits completed.	03/01/2019

Target Risk Level	Major	Possible	12	High

Progress

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3877 PC18 Junior Doctor Experience			
Date Opened	25/09/2018			
Initial Risk Level	Major	Likely	16	Extreme
Risk Owner	Tina Ricketts			

Director/Committee	Chief Medical Officer / People and Culture Committee
Description/Impact	There is a risk that the Trust may not being able to recruit to the required number of Junior Doctors due to the poor feedback received from current rotations. This may result in there being insufficient numbers of medical staff to cover services as the reputation of the Trust will be poor within the future medical workforce.
Key Controls	GSW reporting to P&C Committee, quarterly HEE visits Guardian for Safe Working (GSW) in place and reporting
Sources of Assurance	

Performance Monitoring	Number of junior doctors allocated to the Trust Exception reporting Issues raised through Junior Doctor Forums Monitoring of Trust's performance against HEE standards
Gaps in Control	
Gaps in Assurance	

Current Risk Level	Major	Likely	16	Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
HEE action plan	Sandra Berry Training Manager WRH	28/02/2019		

Target Risk Level	Major	Unlikely	8	High

Progress	The Trust has developed a set of standards for Junior Doctors which have been based on HEE and Royal College guidelines. A gap analysis has been undertaken and actions identified to improve the Trust's position. A regular report is submitted to the People and Culture Committee from them Guardian of Safe Working with Junior Doctors being invited to attend the February 19 meeting to provide an overview of their experiences. The Trust has responded to the concerns raised by HEE following their visit in 2018 and this is monitored through the Education, Learning and Development Steering Group.

Next Review Date 31/01/2019

Corporate Risk Report

NHS Worcestershire Acute Hospitals NHS Trust

Risk	3946 There is a risk that the capacity constraints in specific services are leading to delays in follow up appointments/treatments			
Date Opened	09/12/2018			
Initial Risk Level	Major	Likely	16	Extreme
Risk Owner	Tracy Pearson			

Director/Committee	Chief Nursing Officer / Quality Governance Committee
Description/Impact	RISK There is a risk that the capacity constraints in specific services are leading to delays in follow up appointments or diagnostics which may result in harm or reduced clinical outcomes and due to the use of endoscopy/ Theatre recovery for inpatients (at times of surge) there is also the potential risk that in patients may not receive optimum care and furthers the reduced capacity to undertake routine surgery/ diagnostics. Specific clinical risks relating to Ophthalmology, Dermatology and Endoscopy unit (The risk that patients on surveillance pathways may be harmed following a delay in diagnosis due to lack of appointment capacity within the services. Also the endoscopy unit and Theatre recovery unit environment is not designed for inpatient use and there is a potential risk to the delivery of safe and dignified care. The current Informatics system is subject to review to ensure that there are no “Unknown” service areas where constraints with capacity may increase this risk and subject to the outcome of the review, this is included in the level of risk. CAUSE Consultant capacity within specific services is causing the impact on delayed follow up appointments and treatment. Increase in Ophthalmology referrals and follow up demand for required treatments (national profile) An increase in the number of 2ww referrals. The limited bed capacity on the WRH site and the use of the WRH endoscopy recovery areas and Theatre recovery as a surge area for inpatients. EFFECT Delay in being seen in follow up appointments and being provided time critical treatments or diagnostics. Inpatients being cared for in non – inpatient designated areas without designated substantive nurse and medical cover. The potential that we are not able to meet the patient’s privacy/ dignity needs and also their hygiene needs due to restricted/ limited toileting and bathroom facilities. The increased activity has and is affecting surveillance patients, waiting times and JAG accreditation. The effect on specific service areas and the patients on the identified follow up back log list are referenced in Divisional risk registers and attached papers and Corrective action statements and in associated harm review papers (Harm review panel) Impact on recruitment and retention of staff leading to difficulty running Endoscopy services when there is capacity. IMPACT Patients may be harmed due to delay in follow up /review leading to delay in diagnosis/ treatment.(including Increased risk of loss of vision) Potential sub-optimal care and patient experience for those being treated in these surge areas and for those patients who have not been able to receive their surveillance diagnostics or follow up treatments. Additional workforce requirements to cover inpatient care in non -designated inpatient areas and lack of continuity of care with use of agency staff. Theatre and Endoscopy staff are covering some additional shifts to cover care needs when unit opened for inpatients. Weekend WLI lists in addition to normal working week leading to tiredness and possible increased sickness rate and poor retention rates, which in turn is impacting on ability to cover core activity for Endoscopy lists and reduced experienced practitioners to manage the lists. Impact on JAG accreditation following 2 reviews with action plan in place in order to achieve JAG accreditation in 6 month’s time. 2ww, 31/62 day cancer pathway, routine diagnostic and surveillance waiting times. National waiting time standards are not being met. Increased risk of complaints and litigation Increased risk of negative media attention and reputational damage The PTL weekly meetings will review the waiting times and the Divisions maximise the capacity in order to see the patients as quickly as possible in order to minimise any potential harm. Divisional oversight on operational measures to minimize delays outlined in Corrective action statements on divisional risk registers and in monthly harm reviews. A prospective harm review process has been established in Ophthalmology/ Dermatology and Endoscopy services to ensure that any potential reduced clinical outcomes or any potential harms are reviewed and a Duty of Candour discussion held with the patient and their family. A trust wide Harm review panel receives Divisional specific reports (monthly in 2018)- Divisions will continue Divisional level monthly reviews and report to the Harm review panel Quarterly from Dec 2018. Performance monitoring through Divisional meetings and TLG and Operational performance meetings Every opportunity to increase capacity and minimize delays are being reviewed with Health economy work/ reviews/(Ophthalmology &Dermatology) and outsourcing to other providers (QIA) endoscopy insource and outsourcing.

	WLI introduced to address capacity on all 3 sites. Ward environmental risk assessment are in place for Recovery and Endoscopy unit and these are maintained by the Division (these need to be completed and reviewed monthly) to ensure that all mitigating actions are being taken to maximise the patient's care including staffing and the issues relating to continuity / dignity of care. Block booking of agency staff to work with substantive staff to provide continuity of care. Quality audits undertaken to review standards of documentation and gather real time patient feedback. Divisional and corporate evidence of those audit outcomes are in place. Senior Divisional support to the unit to ensure that both medical and nursing staff are briefed on the Recovery plan and plans to maintain capacity across the county. Weekly review of templates to ensure appointment slots are used appropriately. Ongoing advertising- proactive Divisional recruitment for Endoscopy and within Ophthalmology/ Dermatology to vacancies and use of Locums. Divisional review of staffing to ensure safe staffing for Theatre recovery and Endoscopy when in use for Inpatients and for core services. SOP in place to ensure appropriate criteria of patients are placed in Theatre recovery or Endoscopy and a "Plus 1" risk assessment which is undertaken prior to transfer of patients to the unit (evidenced in their notes).
Key Controls	The PTL weekly meetings will review the waiting times and the Divisions maximise the capacity in order to see the patients as quickly as possible in order to minimise any potential harm. Divisional oversight on operational measures to minimize delays outlined in Corrective action statements on divisional risk registers and in monthly harm reviews. A prospective harm review process has been established in Ophthalmology/ Dermatology and Endoscopy services to ensure that any potential reduced clinical outcomes or any potential harms are reviewed and a Duty of Candour discussion held with the patient and their family. A trust wide Harm review panel receives Divisional specific reports (monthly in 2018)- Divisions will continue Divisional level monthly reviews and report to the Harm review panel Quarterly from Dec 2018. Performance monitoring through Divisional meetings and TLG and Operational performance meetings Every opportunity to increase capacity and minimize delays are being reviewed with Health economy work/ reviews/(Ophthalmology &Dermatology) and outsourcing to other providers (QIA) endoscopy insource and outsourcing. WLI introduced to address capacity on all 3 sites. Ward environmental risk assessment are in place for Recovery and Endoscopy unit and these are maintained by the Division (these need to be completed and reviewed monthly) to ensure that all mitigating actions are being taken to maximise the patient's care including staffing and the issues relating to continuity / dignity of care. Divisional oversight on operational measures to minimize delays outlined in Corrective action statements on divisional risk registers and in monthly harm reviews. Quality audits undertaken to review standards of documentation and gather real time patient feedback. Divisional and corporate evidence of those audit outcomes are in place Senior Divisional support to the unit to ensure that both medical and nursing staff are briefed on the Recovery plan and plans to maintain capacity across the county. Weekly review of templates to ensure appointment slots are used appropriately.
Sources of Assurance	

Performance Monitoring	Internal Audit-Waiting list monitored continuously and reported to Monthly Directorate Performance meetings. Integrated performance report to Quality Governance Committee / Finance and performance and Trust Board. Management Assurance-Reduction in number of patients on waiting list without a TCI date. Management Assurance-Evidence that the 2ww standard is being met. Management Assurance-Governance reports – weekly profile Review-Internal-Cancer MDTs Review-Internal-Endoscopy list – diagnostic tracking Harm review panel (Quarterly) Divisional monthly reviews
Gaps in Control	Vacant Nurse Endoscopist post Funding for second locum doctor Effective management of patient flow and bed numbers below that required Agreed operational (service reconfiguration) mitigating plans agreed and commenced but impact will not be realised until early 2019 as a control not yet effective in the reduction of Inpatients to be able to move out of surge areas including Endoscopy Shortfall in resources (staff and equipment) to support Endoscopy capacity Endoscopy Insourcing not able to always support Trust requirements
Gaps in Assurance	Formal reporting of the "Plus 1" risk assessment process and outcomes and corrective actions Divisional triangulation of concerns, SI's, audits, Quality reviews and staff concerns to ensure all mitigation in place needs to be evidenced at Governance meetings and in CGG

Current Risk Level Major Likely 16 Extreme

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Agreed operational	Datix User Datix User	31/01/2019	QGC and Board update on service reconfiguration	

(service reconfiguration) mitigating plans agreed and commenced but impact will not be realised until early 2019			
Carve out extra capacity on Endoscopy Insourcing weekend list	Lynne Mazzocchi General Manager	31/01/2019	
Development of endoscopy recovery plan	Lynne Mazzocchi General Manager	31/01/2019	(13/12/2018 Action ported from risk 2148) 07/09/18 - Recovery plan is being worked through with Corporate team. This is a 10 week programme. This work continues & is not yet complete.
Divisional triangulation of concerns, SI's, audits, Quality reviews and staff concerns to ensure all mitigation in place needs to be evidenced at Governance meetings and in CGG	Julian Berlet Consultant Anaesthetist - Alex	31/01/2019	Divisional Governance review all sources of data but needs further consideration of how this is triangulated to evidence actual impact/ effect on patients and how this has been considered.
IT and informatics review - for organisation oversight and assurance that there are not wider services which have a significant backlog of follow up appointments	Julian Berlet Consultant Anaesthetist - Alex	31/01/2019	Divisional review of this action as no update on Datix regarding other services which have constraints which may impact on this CRR item.
Move to Endoscopy electronic referral	Lynne Mazzocchi General Manager	31/01/2019	(13/12/2018 - ported action from risk 2148) Currently underway- panel being designed by IT. Demo with admin teams was undertaken 27/9/18. Further review has required further minor tweaks to system. Further review meeting scheduled with IT 8/10/18 which will be followed with any testing amendments. To pilot 2/52 with Mr Lovegrove/Dr Gee. with potential go live first week November
To organise endoscopy agency nurses whilst recruiting to substantative	Lynne Mazzocchi General Manager	01/02/2019	
Formal reporting of the "Plus 1" risk assessment process and outcomes of audit to be reported to PRM and CGG Quarterly.	Julie Kite Divisional Director of Nursing - Urgent Care	05/02/2019	Quarterly report to provide assurance and actions required to ensure full controls are evidenced.
Procure Endoscopy capacity at a local private hospital	Lynne Mazzocchi General Manager	28/02/2019	
Report endoscopy surveillance position to JAG at next conference call	Lynne Mazzocchi General Manager	28/02/2019	
Report endoscopy surveillance position at next JAG visit	Lynne Mazzocchi General Manager	28/06/2019	
Continue to utilise	Lynne Mazzocchi General Manager	31/07/2019	

Locum Endoscopist				
Reduce Endoscopy surveillance waiting times	Lynne Mazzocchi General Manager	31/07/2019		
Status for second locum doctor and Nurse endoscopist to be confirmed	Tracy Pearson DDO SCSD	31/12/2018	Divisional review and status to be confirmed. Dec 2018 • The Endoscopy service have recruited to the 8b Nurse post and is progressing with 2 x 8a vacancies for Nurse Endoscopists – this will be advertised imminently at the same as the Consultant posts below • 2 x Consultant posts (substantive) – the service has now received feedback on the JD from the Royal College of Physicians. Amendments have been made and the JD resubmitted to RCP for approval week commencing 31/12/18. Once approved the posts will be advertised (anticipated to be in the next 2 weeks) • The service continues to use Your World for locum Consultant support against the vacant posts.	31/12/2018

Target Risk Level	Moderate	Possible	9	High

Progress	10/12/2018: This revised and updated CRR entry (Risk 3946) cross references with previous CRR entries 2148 and 2299. These have now been archived and are accessible via the archived CRR on Datix. Evidence on Datix to support this CRR will be at a corporate level of evidence and operational detail and evidence will be provided through the Divisional risk registers. Any new Datix incident relating to service capacity, impact on patient care and harm should be considered by the Division against their Divisional risks and escalated if this impacts on this current CRR and actions planned and assurances required. 17.12.2018 (LMahachi)- Feedback from Endoscopy JAG visit on 04-05 Dec 2018, stipulated the immediate need for the organization to reduce the waiting list and priorities those in high risk groups. The WRH unit is planned to be returned from an inpatient surge area to a fully functioning Endoscopy Suite week commencing 4th February 2019. The service is working up staff rotas to return to 'normal' core Endoscopy activity and are interviewing for 7wte general nurse endoscopy staff on 08/1/2019.

Next Review Date 31/01/2019

Enc E

Trust Board

Integrated Performance Report

November 2018
Month 8

10th January 2019

Quality & Safety | Key Messages

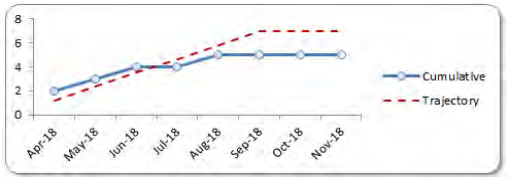
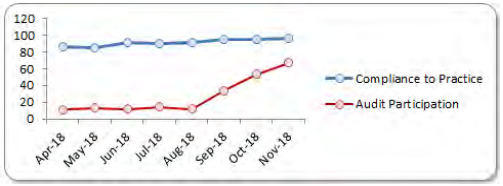
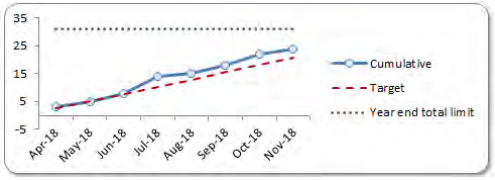
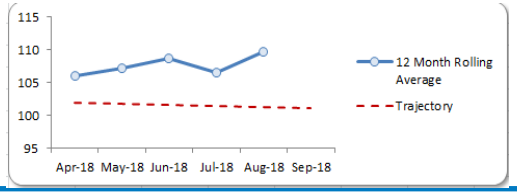
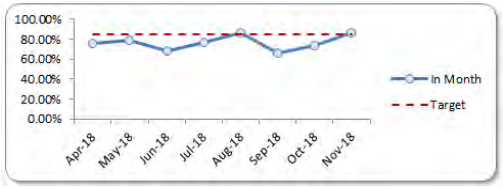
Falls with Harm	The national average is 0.19 falls per 1000 bed days. The Trust November performance is 0.17 per 1000 bed days. A 'falls initiative summit' in Urgent Care will be facilitated in the New Year. Elderly care wards remain an focus for improvement. A shortage of HCA's is a contributory factor. SCSD successful falls round tables to be rolled-out across divisions.
Medicine incidents per 1000 bed days	National average is 4.69 Currently performing well compared to other Trusts (4.41 and 4.25 for November and October 2018). Main areas for further improvement are the Emergency Department and Evergreen. The introduction of Electronic Prescribing System in the forthcoming financial year(s) will reduce errors, although this improvement is reliant on a national funding bid.
% of medicine incidents causing harm	National average is 11.21% Currently reporting more incidents causing harm than national average (21.57% and 18.28% for November and October 2018).
Mixed Sex Accommodation	The QIP plan for this indicator will be reported against picker survey question "Not having to share sleeping areas with opposite sex". The performance remains static with 50 in November 2018 due to ongoing capacity challenges.
Complaints	Baseline position 78% Trajectory is >80% of complaints within 25 days of receipt. The Trust had been above 80% between May and September 2018, performance dropped below 80% in October and November's performance has declined further to 71.43%.
Mortality & Morbidity Meetings and Reviews	Executive commitment to renew focus on the continuing inconsistency of Clinical engagement with the M&M process . More consistent engagement is expected to improve shared learning and compliance.
Friends & Family Test	Response rates remain below target in all areas (excluding maternity). Recommended rates remain above 90% across the Trust (excluding ED)
Sepsis screening and treatment	Though improved, screening and treatment compliance remains below target level. Investigation work will be undertaken for patients who are not screened.
Fractured Neck of femur	October's performance was poor at 73.53%. November's position demonstrates significant improvement of end of month position of 86.67%. The Trust is implementing changes to the fractured NOF pathway in December to improve patient care and relieve bed capacity issues at WRH.
Infection Prevention and Control	Trust trajectory >95% in 100% of wards compliance for hand hygiene in inpatient areas. November's performance is 96.79% compliance, with 67% audit participation. Increased level of challenge by senior staff has improved compliance.

Month 8 2018/19: Quality & Safety Summary

RAG rated against Internal Trajectory

Safe
Effective
Patient Experience

Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions
Are we preventing our patients from acquiring pressure ulcers?	To reduce the number of avoidable grade 3 / deep and ungradeable hospital acquired pressure ulcers. **0**	There were no grade 3 hospital acquired pressure ulcers, and the Trust remains below trajectory.		Continue improvement arising from work undertaken as part of national collaborative 'Stop the Pressure' What are we aiming for in Dec? **0**
Are we ensuring that patients receive all elements of the sepsis 6 bundle?	To improve the % of patients receiving all elements of the sepsis 6 bundle within 1 hour. **60.23%**	Compliance with the sepsis 6 bundle remains significantly below target level. Of 88 patients requiring treatment within 1 hour, 35 did not receive it.		Investigation into possibility for outreach to operate from ITU. **>=83.82%**
Are we maintaining the expected standards of hand hygiene?	To improve the compliance with Hand hygiene practice, and participating in audits. **96.79%** **66.94%**	Compliance is at the target level but participation in audit remains significantly below target level – although it has risen significantly in the last 3 months.		Publication of 10 Key Standards. Triumvirate training programme. Disciplinary action for clinical staff transgressing hand hygiene policy. **>=95%**
Are our patients at risk of contracting C.Difficile during their stay?	There should be no more than 31 cases of *C.Difficile* in the year. **2**	There were 2 confirmed cases of hospital acquired C. difficile in Nov-18. The cumulative total of 24 continues to put the end of year target at risk.		Microbiologists to attend divisional governance meetings. Deputy DIPC role to be recruited to. Band 7 development programme underway. **No more than 3**
Are we reducing mortality for patients whilst under our care?	To monitor and seek to reduce mortality for patients using the Hospital Standardised Mortality Ratio. **109.68 August**	HSMR rolling average was 109.68 in **Aug-18**. Performance is moving further away from trajectory and the Trust remains an outlier for the 5th month in a row.		Targeted reviews of respiratory infections group is underway. **<=101.45**
Are we treating our patients in the required timeframes?	To improve the time to theatre for patients with fractured neck of femur (#NOF) **86.67%**	The #NOF metric met target again in November.		Consultant on-call rota now provides county-wide cover. Ambulatory Trauma Pathways in development. Golden Patients programme has been implemented. Quarterly audits scheduled. **>=85%**

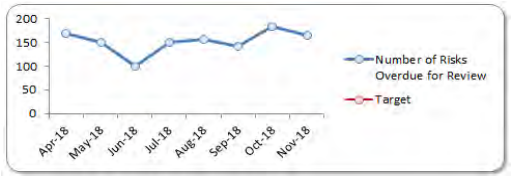
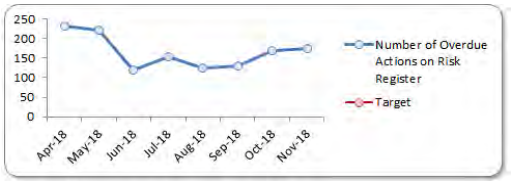
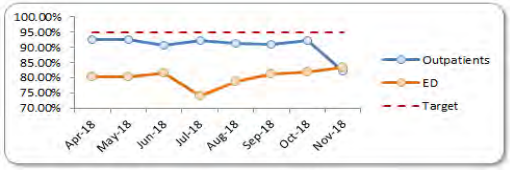
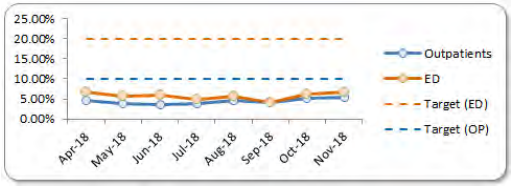
RAG ratings for all metrics except 'Hand Hygiene' indicate performance against trajectory. Hand Hygiene metric is RAG rated against locally agreed threshold. RAG rating on the Dashboards are against national or locally agreed standards.

Month 8 2018/19: Quality & Safety Summary

RAG rated against Internal Trajectory

Safe
Effective
Patient Experience

Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions
Risk				
Are we reviewing risks to ensure patient safety?	To reduce the number of risks overdue a review. **164**	The average number of risks overdue for review each month between April and November 2018 is 152.		What are we aiming for in Nov? Work continues within the divisions to review risk management processes.
Are we managing risks to ensure patient safety?	To reduce the number of overdue actions relating to risks. **175**	The number of overdue actions has remained at over 100 since April 2018. The monthly average is 165		Work continues within the divisions to review risk management processes.
Friends & Family Test				
Are we providing a positive experience for Maternity / Inpatients?	To improve the Recommended Friends & Family Score for Maternity & Inpatients **99.3%** **95.3%**	Both Maternity and Inpatients achieved the target level of recommendation.		November awareness campaign in place. Text messaging service review planned. >=95%
Are we providing a positive experience for Outpatients / ED?	To improve the Recommended Friends & Family Score for Outpatients & ED **82.0%** **83.5%**	Outpatients score dropped this month but ED has remained above 80% for the 3rd month in a row.		November awareness campaign in place. Text messaging service review planned. >=95%
Are we providing a positive experience for Maternity / Inpatients?	To improve the Response Rate for the Friends & Family Test for Maternity & Inpatients. **45.0%** **19.9%**	Both Maternity and Inpatients response rates increased this month		November awareness campaign in place. Text messaging service review planned. >=30%
Are we providing a positive experience for Outpatients/ ED?	To improve the Response Rate for the Friends & Family Test for Outpatients & ED. **5.5%** **6.8%**	Both Outpatients and ED are currently below target.		November awareness campaign in place. Text messaging service review planned. >=95%

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

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

Quality Governance Committee Assurance Report

Accountable Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Bill Tunnicliffe - Non-Executive Director	Kimara Sharpe - Company Secretary

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

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

The Committee met on 22 November and 20 December. The items discussed were as follows:

Item for escalation to the Board

- **Mortality Performance:** the Committee continue to be significantly concerned about the increase in HSMR to 109.5. This is the 4th month in a row that the rate has increased. Actions which were going to be taken included a review in deaths from pneumonia. This was agreed three months ago and the committee has yet to see the report. We are also disappointed in the attendance by clinicians at the Mortality Review Group and whilst we were informed of an in depth review of the attendance and purpose of the group, the Committee was disappointed that no progress on this issue has taken place. We were also disappointed that there is no action plan to address the issues within this area of work. The executive team have not discussed what further action is needed.
- **Mandatory training**: I remain concerned that the mandatory training rates for medics and will pick this up outside the meeting with the Chair of People and Culture.

Other items discussed

- **Board Assurance Framework:** The Committee agreed to an increase in risks for risk 1 and a decrease in risk 2. A request was made to ensure that 'on-going' was removed and a firm date given to the actions. This is an item on the Board agenda.
- **Corporate risk register:** The risks aligned to the Committee were presented. The risks were not fully updated and assurance was given that this would take place by the Board meeting. It is acknowledged that the risk register needs to be used more effectively as a tool within the committee and I intend to take this forward in the new year.
- **Sepsis:** A verbal update was given in relation to the progress made with managing sepsis within the trust. There is much progress and the mortality rate for sepsis has reduced.
- **Clinical Governance Group:** This Group continues to mature. There was medical representation at the December meeting. There is currently a review of medicine incidents and assurance was given on the process for review when an incident takes place. A round table discussion about falls took place on Silver Ward which has resulted in learning about patients undergoing chemotherapy and people falling at night. This will be rolled out across the Trust via the band 7 staff in January. There is sustained improvement in complaints response and I have requested that the dashboard is reviewed to focus on outcomes, not process. **Limited assurance**
- **Radiation incident report:** The Chief Radiographer attended to present the annual report. There had been 55 incidents of excess radiation out of a total of over 400,000 episodes of care. Of the 55, 12 were reportable to the CQC. Six of these were due to the incorrect patient attending for the test and three were due to the radiologist not following the strict checking criteria. The Trust benchmarks well against comparative trusts for reportable incidents. I was concerned that there was no trust response to some of the issues raised, although I do understand that the investigations into the incidents will be presented to the Committee. I was also concerned that there is a huge workload within the radiology department caused by pressures on patient flow.
- **Quality Assurance Visits:** I am pleased that the visits are now robustly managed. I would urge my non-executive colleagues to participate in the visits. Dates have been circulated. **Moderate assurance**

Quality Governance Committee Assurance Report

Accountable Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Bill Tunnicliffe - Non-Executive Director	Kimara Sharpe - Company Secretary

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

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary (cont.)

- **Care in the Corridor report:** I was delighted with the progress made in response to a HealthWatch visit to the urgent care department. The department has changed its approach to the patient experience by ensuring that staff can be identified and signage is clear. It is clear now how long patients are waiting and how long staff take to see patients. Storage of patient property has changed to minimise property loss. I should like to thank Clare Bush for her efforts in driving through the changes. It was clear that simple changes can make a huge positive impact.
- **Winter report:** I was very concerned that the quality impact assessments for the ward moves have not been presented to the Committee. They will be to the next meeting.
- **Serious incident report - quarter 2:** This report showed improvement in the investigation processes for serious incidents. **Moderate assurance**
- **Infection control update:** there have been three cases of c diff on Beech high care which are being investigated as a serious incident. Work continues with the PFI Contractor on estate issues and whilst all beds will have been decontaminated by 31 December, work is on-going with the provider of the beds in relation to accountability. Work also continues with medical staff compliance with infection control training. **Limited assurance**
- **Organ donation:** the Trust has received a complimentary letter from the Blood and Transplant Authority stating that the Trust facilitated 10 people having organ transplants in April to October 2018. I have been asked to bring this to the Board's attention.

Other items discussed:

- Demonstration of the RAIT tool to manage the CQC evidence
- CQUIN
- Ward accreditation
- Patient, Carer and Community Engagement report
- Never event – wrong side block – the final report will be presented to the QGC
- Safeguarding quarter 2
- Patient safety alert
- R&D update
- Mid year annual governance statement

Quality Governance Committee Assurance Report

Accountable Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Bill Tunnicliffe - Non-Executive Director	Kimara Sharpe - Company Secretary

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

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Background

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

Issues and options

None.

Recommendations

The Board is requested to receive this report for assurance and to note the committee's concern in relation to the recent increases in the Trust's HSMR and lack of progress being made with clinical engagement in the mortality review process.

Appendices

- TB IPR Dashboards – M8 2018-19

Finance | Key Messages

Deficit	In Month 8 the Trust is recording a pre Provider Sustainability Fund (PSF) deficit of £6.6m, which is £4m adverse to plan. Inclusion of PSF takes the deficit to £5.8m in month. The cumulative position is a £45.6m deficit against a plan of £33.5m, resulting in a £12.1m adverse variance. As a result of financial and operational performance the Trust has not been able to access PSF of £9.8m.
Income	Patient care income remains behind plan year to date in elective activity, driven by a combination of lower than planned activity volumes and lower complexity activity. The Trust was closer to plan in November following increased volume of Emergency activity, actions undertaken to improve Theatre Utilisation, and the impact of prior months coding. The forecast assumes that the improvements in elective performance over recent months are sustained.
Expenses	Pay costs increased in November, in line with forecast. The majority of the increase related to Nursing, in particular bank costs, driven by increased bed capacity, specialling and vacancy fill. Non-pay expenditure increased in-month, reflecting additional activity across the Trust and non-recurrent items (professional fees / SBS contract changes) within Corporate. The overall position continues to be supported by non-recurrent vacancies and slippage against business cases.
CIP	Year to date, the CIP position has delivered £4.8m in improvements against a planned position of £7.8m. The key areas of slippage are in the workforce CIP and theatre productivity plans. Although elective activity has improved, slippage in recruitment of additional surgeons has impacted delivery of the expected financial improvement to date. This will be partially addressed through the extension of the locums and WLI into Quarter 4.
Cash Balance	The Trust continues to require cash support in line with the planned deficit. The variance to plan has increased the level of cash support required and the Trust continues to work closely with NHS Improvement to ensure access to the cash required to maintain services. The Trust has already received £39.2m in revenue loans and £6.3m in capital loans as at the end of November.
Forecast Update	The Trust year end forecast was reviewed at both Finance & Performance Committee and Trust Board in December. The forecast indicated a base case outturn position of £72m deficit. Two key risks were identified related to the cost of winter and contracts. Further mitigating actions have also been developed, and work continues to finalise the financial impact of these. A formal revision of the forecast can only be made at the quarterly reporting points in the year and therefore the forecast position will be formalised in the Q3 submission in January following review by Trust Board.

Use of Resources | Risk Rating Summary

	Metric Definition	How we did YTD at M8	Risk Rating		Previous Month YTD	Full Year Plan (Forecast)
I&E margin rating	I&E surplus or deficit / total revenue.	(16.50%)	4	Adjusted financial performance deficit of **£39,017k** (£39,017 / total operating income £236,644= **(16.50%).**	4	4
I&E margin: distance from financial plan	YTD actual I&E surplus/deficit in comparison to YTD plan I&E surplus/deficit.	(7.20%)	4	I&E margin YTD actual of **(16.50%)** less I&E margin YTD plan of **(9.30%)** = **(7.20%)**.	4	1
Liquidity rating (days)	Measures the days of operating costs held in cash, cash-equivalent and liquid working capital forms.	(67.687)	4	Working Capital of (£82,591) / YTD Operating Expenditure of £261,119 multiplied by the number of YTD days (214) = (67.687).	4	4
Capital service cover rating	Degree to which the organisation's generated income covers its financing obligations.	(2.212)	4	Revenue available for capital service (£24,464k)/ capital service **£11,062k** = **(2.212)**	4	4
Agency rating	Total agency spend compared to the agency ceiling.	(15.15%)	2	Total agency spend of **£11,615k** less agency ceiling of **£10,087k** / divided by agency ceiling of **£10,087k** = **(15.15%).**	2	1

Operational Performance | Key Messages

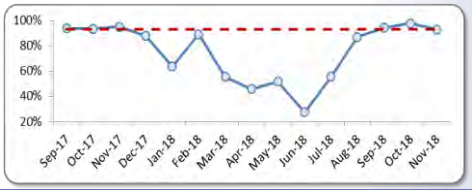
2WW Cancer	Cancer 2WW performance remains above target level for the second month. The 47 lung and urology patients waiting longer than 2 weeks this month represent 36% of all 2WW breaches across the 11 specialties.
2WW Breast S	Performance remains above target level for the third consecutive month though the number of patients with potential breast cancer who waited longer than 2 weeks to see a specialist rose to 12 from 3 in October.
62 Day Cancer	Performance against the 62 day standard remains below target level though fewer patients were treated after 62 days than in October. As the 62+ day and 104+ day patients start their treatments and the backlog reduces however, the impact may cause a slight decline in performance.
EAS 4 Hours	EAS 4 hour performance decreased slightly with an increase in performance at the ALX offsetting the decline at WRH. 34 patients waited longer than 12 hours to be admitted (trolley breach). Ambulance handovers over 60 minutes decreased from 415 in October to 270 in November.
RTT	RTT performance decreased slightly from October and remains lower than trajectory. It is however, expected to stabilise. 5 specialties carry 63% of the >18 week patients (ophthalmology and 4 surgical specialties). There have been no patients waiting 52+ weeks at month end since July.
Diagnostics	The number of patients waiting longer than 6 weeks for a diagnostic test continues to drop from its peak in July-18. The total waiting list reduced by over 1,000 patients with reductions seen in non-obstetric ultrasound, CT scans, DEXA scans and echocardiography. The number of breaches remains significant, with 85% of the breaching cohort waiting for an endoscopy.

Month 8 2018-19 Operational Performance Summary

RAG rated against Internal Trajectory

Worcestershire Acute Hospitals NHS Trust

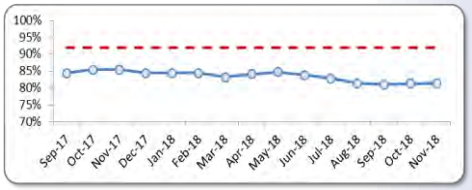
Cancer Waiting Times

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in December?
Did we see urgent cancer patients quickly?	**93%** of potential cancer patients seen by a specialist within **2 weeks**.	93.34% ↓ We saw 93.34% of our cancer patients within 2 weeks. **128** patients waited longer than 2 weeks.		Continue with daily monitoring, recovery plans, maintain additional capacity where required.	93.0% FORECAST STATUS: DECLINE / **STABLE** / IMPROVE
Did we see patients with potential breast cancer quickly?	**93%** of patients with potential **breast cancer** seen by a specialist within **2 weeks**	93.02% ↓ 93.02% of patients were seen within 2 weeks. 12 **patients** waited longer than 2 weeks.		Increased week and weekend slots, enhanced consultant radiology cover.	93.0% FORECAST STATUS: DECLINE / **STABLE** / IMPROVE
How quickly did we start treating cancer patients?	**85%** of cancer patients to start treatment within **62 days** of urgent GP referral.	77.04% ↑ 77.04% of patients started treatment within 62 days. **38 patients waited longer before starting treatment**. There were **23 patients** waiting 104 days or more for treatment at the end of the month.		Cancer pathways continue to be reviewed. On-going discussion with Tertiary Centres to reduce patients delays. Recruitment to vacant consultant posts and investigate use of independe sector.	85.0% FORECAST STATUS: DECLINE / **STABLE** / IMPROVE

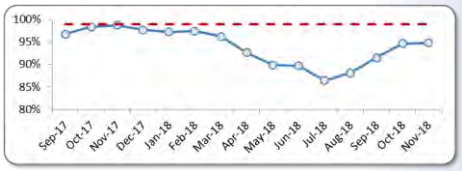
EAS

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in December?
Are we seeing patients with an emergency within 4 hours?	The Trust should see **95%** of patients within 4 hours from arrival to admission, transfer or discharge	74.97% ↓ The Trust performance was **74.97%** with **3,901** patients breaching the 4 hours standard and **34 patients** waiting 12+ hours to be admitted. WRH achieved 56.59% (↓) and ALX 72.03% (↑)		Ward reconfiguration and relocation of #NOF and Stroke from WRH to AGH to equalise ED and capacity pressure. Revised on-call rotas proposed. WRH Discharge lounge opened 10 Dec.	85.0% FORECAST STATUS: **DECLINE** / STABLE / IMPROVE

RTT

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in December?
Did we start treatment within18 weeks?	**92%** of patients on a 'referral to treatment' (RTT) pathway should be seen within 18 weeks.	81.47% ↑ 81.47% of patients are waiting less than 18 weeks for treatment. 6,651 **patients have been waiting longer than 18 weeks,** there are no patients waiting **52 weeks or longer.** The 40-51 cohort **increased to 339 from 337**		Targeted improvements in all milestones: 6ww to first OPA; Diagnostic; 6ww to TCI; FUN ratio; DC rates; LOS; Theatre utilisation	83.98% FORECAST STATUS: DECLINE / **STABLE** / IMPROVE

Diag.

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in December?
When a patient needs a diagnostic test, do we do this within 6 weeks?	A minimum of **99%** of patients who need a diagnostic test should be waiting less than 6 weeks	94.81% ↑ **8,046** patients requiring a diagnostic test were waiting less than 6 weeks for their test. **5.19%** were waiting 6 or more weeks; **that's 440 patients**.		Urology put on WLIs. PET/CT project investigation continues. Business Case with W&C for ultrasound capacity. Options appraisal for radiology in progress.	96.13% FORECAST STATUS: DECLINE / STABLE / **IMPROVE**

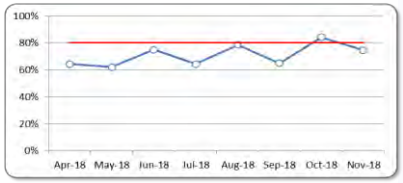
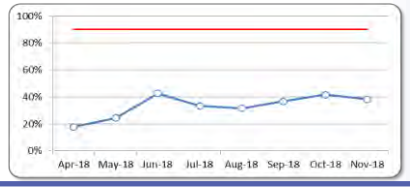
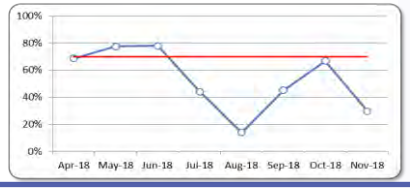
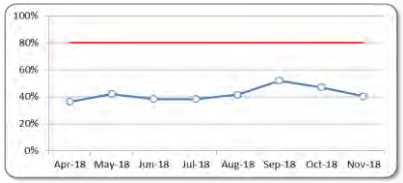
Forecast Status against next month's performance: Decline – expected to worsen. Stable – not expected to change significantly. Improve – Expected to improve.

Month 8 2018-19 Operational Performance Summary

RAG rated against Internal Trajectory

Worcestershire Acute Hospitals NHS Trust

Stroke

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in December?
Are stroke patients spending enough time on the specialist ward?	At least 80% of patients should spend 90% of their stay on the stroke unit.	74.6% 	**44 out of 59** patients spent at least 90% of their time on the stroke ward. **15 patients spent less than 90% of their stay on the ward.**		• New TIA referral form. • Stroke ward swap resulting in 20 protected stroke beds. • Investigate GP training in TIA management. • Implementation of ROSIER tool in ED.	93.0% FORECAST STATUS DECLINE **STABLE** IMPROVE
Are we directly admitting stroke patients to the specialist ward?	At least 90% of patients should be directly admitted to the stroke ward.	38.1% 	Only **16 of 42 patients** were admitted to the stroke ward within 4 hours.			93.0% FORECAST STATUS DECLINE **STABLE** IMPROVE
Are stroke patients seen quickly in specialist clinic?	At least 70% of patients should be seen in TIA clinic within 24 hours.	29.9% 	26 of 87 patients were seen in the TIA clinic within 24 hours. **61 patients were not.**			85.0% FORECAST STATUS DECLINE STABLE **IMPROVE**
Are we scanning stroke patients soon enough?	At least 80% of patients should receive a CT scan within 1 hour of arrival.	40.4% 	Only 23 of 57 patients had their CT scan within 60 minutes. **More than half waited longer** than 1 hour.			85.0% FORECAST STATUS DECLINE **STABLE** IMPROVE

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

Finance & Performance Committee Assurance Report

Accountable Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Steve Williams - Non-Executive Director	Jill Robinson – Chief Finance Officer Thekla Goodman – FPC Committee Administrator

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 (FPC) met on 17 December 2018. Due to timings, the Committee received a summary position on the financial position and an un-validated summary of operational performance. The Committee focussed on the following three areas:

- NHSI Review of the 2018/19 Forecast position
- The Medium Term Financial Strategy
- The Board Assurance Framework

Background

The Finance & Performance Committee (FPC) meets on a monthly basis to gain assurance that plans are in place to achieve the Trust's agreed Operational Performance Targets, Financial Control Total, its Cost Improvement and Financial Recovery Plans.

The Committee met on 26 November 2018 (Month 7) and 17 December (Month 8).

NHSi Review of 2018/19 Forecast Position

Following the Trust's indication that it would not meet its agreed control total for 2018/19, NHSi undertook a 3 day in-depth review in October 2018. The potential failure to achieve the agreed control total is mainly attributable to the non-delivery of CIP and the activity plan. Further testing of the Trust's controls and processes will be undertaken to determine whether or not the Trust should be placed into financial special measure.

NHSi concluded the Trust's finance team was demonstrably robust and able to articulate at granular level the drivers of financial under-performance. There was also evidence of good working relationships with the divisional teams who displayed clear ownership of their budgetary position.

The same level of assurance was not found in the processes around the Trust's Cost Improvement Plan however. NHSi stated the CIP shortfall would likely be higher than the forecast figure and that the Trust must focus on improving the underlying position and monthly run-rate.

The completion of the demand and capacity modelling was deemed crucial in enabling a comprehensive understanding of the Trust's capacity and will support future contract negotiations.

Finance & Performance Committee Assurance Report

Accountable Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Steve Williams - Non-Executive Director	Jill Robinson – Chief Finance Officer Thekla Goodman – FPC Committee Administrator

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	

Medium Term Financial Strategy

The first draft of the Medium Term Financial Strategy was presented. This draft document will be developed further into a 3-5 year rolling plan and needs to be integrated with Trust's evolving strategies (clinical services, workforce, IT and estates).

The executive team will take the STP agenda and commissioning impacts into account when discussing the hierarchy of current proposed strategies. An exercise will need to be undertaken to break down large-scale transformational projects, mapping the resulting annual savings into more tangible, achievable short-term targets.

NHSI reported on the 2018/19 Forecast Position resulting in agreement that the CIP and efficiency savings for 2019/20 would be embedded into the budgets at budget holder level and owned by the budget holders before the start of the financial year. It was noted also that the 2019/20 budget would be integrated with the workforce plan and the demand and capacity plan.

An additional F&P committee meeting is to be scheduled for January to focus on the development of the MTFS.

Finance & Performance Committee Assurance Report

Accountable Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Steve Williams - Non-Executive Director	Jill Robinson – Chief Finance Officer Thekla Goodman – FPC Committee Administrator

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	

Board Assurance Framework and Corporate Risk Register

The committee received the Board Assurance Framework and noted the risks relating to finance and operational performance as follows:

Risk 4: The Trust is unable to ensure efficient patient flow through our hospitals – Risk rating 20 – to stay the same.
Risk 5: Lack of a strategic demand management – Risk Rating 20 recommended reduction to 15.
Risk 6: The Trust is unable to ensure financial viability and make the best use of resources for our patients (income & expenditure structural imbalance) – Risk Rating 15 recommended increase to 20.
Risk 7: The Trust is unable to ensure financial viability and make the best use of resources (unlock funding for capital investment) – Risk Rating 15 – to stay the same
Risk 8: Ineffective IT Schemes – Risk Rating 16 – to stay the same
Risk 9: Sustain Clinical Services– Risk Rating 16 – to stay the same

The Committee gave approval to the BAF risk ratings including the recommended changes.
The Committee noted the finance and performance Corporate Risks (risk rated 15 or above). The Committee requested an additional risk to 3792 be opened for 2019/20 'achievement of the financial plan'.

The Committee approved the CRR submission to the Board in January.

Recommendations

The Board was asked to note that:

- The Trust continues to be under enhanced oversight and has not been placed into special measures.
- The Trust has begun to develop the Medium Term Financial Strategy that will be developed further over the coming months into a robust 3-5 year rolling plan.
- The Committee received, and discussed the pertinent elements of the BAF and recommended changes as detailed.
- The Committee approved the CRR submission to the Board in January.

Appendices

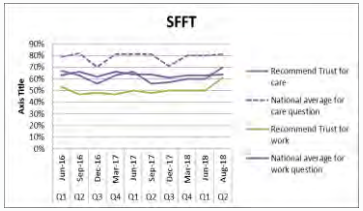
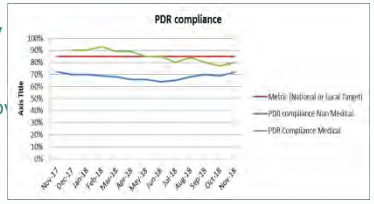
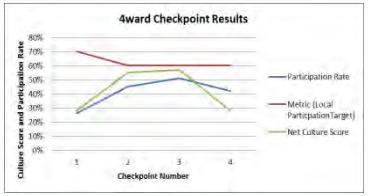
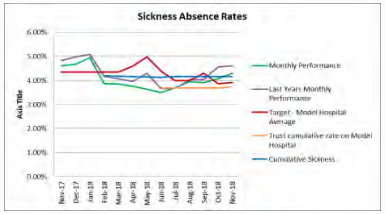
- TB Finance Report – M8 2018-19
- TB IPR Dashboards – M8 2018-19

People & Culture Performance | Key Messages

Job Plans	The Trust is below average for the completion of job plans. This is being addressed through the Allocate suite of solutions which will see team job planning completed for all specialities by 31st March 2019 with individual job plans updated by 30th September 2019.
Appraisals	There has been slight improvement (3%) in both the medical and non-medical appraisal rates this month. Divisional action plans to improve compliance are monitored through the monthly performance review meetings.
Mandatory Training	The Trust continues to see improvement in the compliance rates for mandatory training and has now reached overall performance of 80% across all 11 topics.
Sickness Absence	Sickness absence rates have remained consistent since last month and are slightly lower than the same period last year. Urgent Care and Surgery have the highest rates and are being supported by HR to undertake back to work interviews and formal sickness absence management meetings.
Turnover	The overall staff turnover rate is higher than this time last year but continues to be in line with the national average at 12%. Of concern is the increase in turnover for healthcare assistant and clinical support workers which is being addressed through the Nursing, Midwifery and AHP workforce group.

Month 8 (Nov-2018) Engaged Workforce Summary

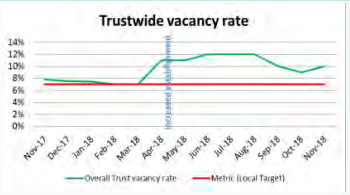
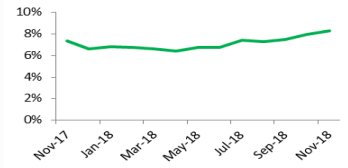
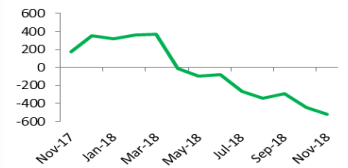
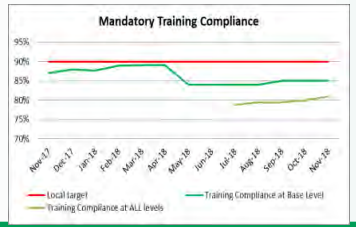
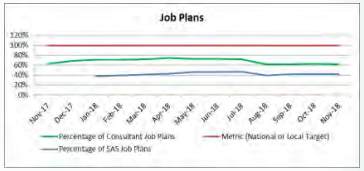
Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	
Staff Friends and Family Test Results	National quarterly measure of whether staff would recommend Trust for treatment (T) or work (W)	70% (T) 61% (W)	Q2 SFFT postcards resulted in 10% improvement on the number who would recommend for Treatment, and 11% improvement for work. We had 15% response rate (241 out of the1600 sample) National average has improved by 1% on each criteria.		Improve culture, retention and staff experience so that staff report higher satisfaction. National Staff Survey has been issued as paper questionnaire in attempt to improve response rates with results due in February	What are we aiming for in Dec? Improved position to National average – 81% (T) & 64% (W)
PDR Compliance	All staff should have an annual appraisal/PDR. Separated into Medical (M) and Non-Medical (NM)	80% (M) 75% (NM)	Appraisal rates have improved by 3% for both M and NM although remain below target. Monthly reports continue to be circulated by the Learning and Development team to highlight areas of concern to divisions.		Divisions to be held to account. ESR also automatically notifies staff and managers of expiry dates.	85% target
4ward pulse check results	Summary of results from 4 ward Programme	42% participation 28% net culture	Checkpoint 4 saw net culture score drop to 28% from 57% in checkpoint 3. Participation rate reduced from 51% to 42%.		Communications plan in development to reduce the impact of the fall in net culture score due to changed algorithm which reflected "unable to score" and 'did not participate' rates.	Improving response rate and net culture score
Sickness absence rates	Sickness absence rates measured against National average on Model Hospital	4.29%	Sickness has increased by 0.22% to 4.29% in month. Cumulative sickness for the 12 month period remains at 4.15% . This is lower than the same period last year when we reported 4.47%		Sickness absence to continue to be managed through Divisions with support from HR business partners.	4%

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

Month 8 (Nov-2018) Skilled Workforce Summary

Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	What are we aiming for in Dec?
Vacancy Rates	Vacancies against funded establishment compared to 7% Trust local target	10%	Vacancy rate has increased by 1% from 9% which is due to increased establishment of 75.86 wte.		Implementation of Allocate suite of solutions will give greater transparency of vacancy position. Business case for centralised recruitment to improve governance and timelines. Winter Recruitment Plan developed	9%
Agency as a % of gross payroll cost	Agency spend as a percentage of total substantive and temporary pay spend	8.29%	Agency spend increased in November and was 8.29% of the total pay costs. Agency spend was above forecast as the forecast assumed agency costs would represent 6.76% of total pay costs.		The FRP plan is to improve quality and safety through recruitment of substantive clinical staff.	6.58% (Forecast)
Agency spend v NHSI ceiling	NHSI set the Trust an annual agency expenditure ceiling of £17.3m	(£518k)	Agency staffing costs of £1,959k in month is an increase of £75k on last month and is £518k above the monthly NHSI agency ceiling. Agency costs are above the Trust's internal plan.		As part of the FRP the Trust is strengthening controls across all staff groups requesting agency and engaging with agency suppliers to ensure compliance with capped rates.	Need to reduce run-rate
Training compliance *(statutory, mandatory, and essential to role)*	All staff are required to undertake Mandatory training at the appropriate level assigned by leads in 11 topics	81%	Compliance has increased by 1% across all levels . Only one of the 33 topic levels has declined this month and all clinical divisions have improved by between 1-2%.		Divisions being held to account for their staff compliance. Revisions to be made to SGC L3 are part uploaded at the time of this report.	85%
Percentage of up to date job plans	All consultants are required to have an annual job plan review	62%	Compliance has declined by 1% this month for Consultants and remained unchanged for SAS doctors.		Early Implementers have commenced upload of job plans to Health Medics rostering system. Work on Team job planning has commenced.	65%

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

People & Culture Committee Assurance Report

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

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

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

The Committee met on 18 December 2018. The items discussed were as follows:

Challenges in managing staff pay cost budgets: I was delighted to welcome colleagues from four divisions to understand more about the management of staff and the associated pay budgets within the Trust. There was evidently good understanding of the constraints on pay. The process for business case approval was also explained and it was clear that the divisions were congruent of the importance to constantly test the requirement for expenditure on pay. The numbers of additional staff recruited since April was also explained. The discussions highlighted that further monitoring of establishment levels was needed as these fluctuated each month dependant on the business cases that had been approved. There was also discussion about the future with the use of Allocate to manage e-rostering and annual leave more effectively. It was agreed that the Committee would receive a regular report on staff numbers (direct and non-direct employed) which would include bank and agency costs.

Bank and Agency deep dive: The NHS Professionals contract should achieve £1.46m savings as a full year effect in 2019/20 but will need close monitoring by the Trust to ensure delivery. I was disappointed to learn of the delays in the approval of the business case. We had a discussion with the divisions about the Trust being risk adverse particularly in respect of discharges. It was explained that temporary staff who may be unaware of the services in the community may not be as willing to discharge as substantive staff. Also moving patients causes delays as staff do not know them as well. It was felt that the recruitment lock down in respect of administration staff also cause delays as front line staff end up undertaking work which normally would be for administrative staff.

ESR and Mandatory training: I was pleased that this report received moderate assurance. There has been considerable work on this issue to both improve data quality and compliance levels across the Trust. I congratulated both the central ESR team and the divisions on the rapidly improving position.

Board Assurance framework: The Committee approved the BAF risks aligned to the Committee which are presented in a separate report to the Board.

People and Culture Strategy update: The paper contained an overview of the Trust's pay expenditure along with the underlying reasons as to why the Trust was overspent against budget as at month 8. The report also provided the accountability framework which the Director of People and Culture and the Chief Operating Officer is taking forward with the divisions. A further report will be presented in the new year. I am concerned about the Trust's health and safety internal structures, including governance, which is the subject of an internal audit at the current time. **Limited assurance**

Development of a strategic workforce plan: The progress on the development of this critical piece of work was discussed. It is evident that a considerable amount of developmental work is required with divisions and the Trust is to receive support from Health Education England and NHS Improvement. The ageing workforce is a challenge and there are plans to tackle this by being a more flexible proactive employer. **Limited assurance**

People & Culture Committee Assurance Report

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

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

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary (cont.)

Communications and engagement update: This update showed how much effort is needed to attract and offer jobs to clinical staff. With modest investment, there can be a huge reach to potential staff via social media, but this can translate into small numbers for job offers. I have requested that the next report focuses on the medical workforce engagement activities. **Moderate assurance**

4ward steering group: Concern was raised by members over the recent impact of the change of methodology for the checkpoint results, which the Trust had not been adequately sighted on before they were issued. It was also felt that a stepped change in momentum needed to be given to the programme. This will be further discussed at the 4ward steering group meeting on 21 December 2018.

Education steering group: I was pleased to hear that the apprenticeship levy is being used for leadership development meaning that more resource will be available to the Trust than in previous years. Work is well underway for mentoring training, development of a coaching pool and work with Wolverhampton on the triumvirate leadership programme.

Winter workforce update: There is an item on the agenda in relation to this item which will give the most up to date position statement.

Nursing and midwifery staffing levels: This item is also on the board agenda. The fill rate has fallen to under 90% for the first time. Work is on-going in respect of triangulating any harm events and in particular the effect on the deteriorating patient. There is no evidence that staffing levels caused any harm for the month of October.

Staff flu vaccination: The Committee approved the publication of the checklist. Up to date figures will be available at the Board meeting.

Terms of reference: The Committee agreed to add the Chief Operating Officer as a permanent member. Further amendments are being considered by the CMO.

Other reports received:

- Progress update on the bi-annual patients' acuity and dependency study
- Nursing, midwifery and AHP workforce report
- Medical workforce report
- Guardian for safe working
- People and culture scorecard
- People and culture risk register
- JNCC minutes
- Work plan

People & Culture Committee Assurance Report

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

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

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Background

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

Issues and options

None.

Recommendations

The Board is requested to

- receive this report for assurance
- approve the change to the terms of reference

Appendices

- TB IPR Dashboards – M8 2018-19

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire Acute Hospitals NHS Trust

Reporting Period: November 2018

SAFE

Area	Indicator Type		Indicator	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Current YTD	Prev Year	2018/19 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Incidents	Local	QPS3.3	Number of overdue SIs	7	5	4	1	1	4	0	0	0	0	0	0	1			0	-	>0	CMO	
Falls	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	1	2	0	1	2	2	1	2	2	2	4	2	4	19	24	<=1	-	>=2	CNO	
VTE	National	QPS11.1	VTE Risk Assessment (as recorded in Bluespier and OASIS)	94.30%	89.91%	92.47%	91.98%	90.97%											>=95%	94% - 94.9%	<94%	CMO	
	National	QPS11.2	VTE Risk Assessment (as recorded in OASIS only - Aug-17 onwards)						93.74%	95.13%	94.35%	95.51%	94.67%	94.07%	95.14%	95.33%			>=95%	94% - 94.9%	<94%	CMO	
Never Events	National	QPS4.1	Never Events	1	0	0	0	0	0	0	0	0	0	0	1	1	2	2	0	-	>0	CMO	
Pressure Ulcers	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	1	1	2	2	2	2	1	1	0	1	0	0	0	5	17	0	1 - 3	>=4	CNO	
	Contractual	QPS7.7	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 4 Avoidable (Monthly)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	>=1	CNO	
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	3	0	3	1	3	3	2	3	6	1	3	4	2	24	33	17/18 Threshold < = 32 18/19 Threshold < = 31			CNO	
	National	QPS12.4	MRSA Bacteremia - Hospital Attributable (Monthly)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	>0	CNO	
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective	97.4%	97.6%	95.1%	98.8%	97.3%	96.8%	95.5%	95.6%	97.7%	97.8%	96.5%	95.5%	93.90%	1		>=95	-	<95%	CNO	
	Contractual	QPS12.14	Ecoli Cases (Trust Attributable)	0	4	3	3	4	5	5	6	6	7	3	5	6	43	62	-	-	-	CNO	
C-Sections	Contractual	MCS1.2	Emergency Caesareans	14.90%	17.20%	18.10%	18.90%	15.40%	12.60%	14.10%	12.10%	14.00%	16.20%	15.70%	20.00%	17.00%	15.21%	16.14%	<=15.2%		>15.2%	CNO	
Sepsis 6	National	QEF3.4	% of patients receiving all elements of the sepsis 6 bundle within 1 hour (wards)						65%	44.44%	69.23%	29.17%	46.15%	50.00%	52.17%	60.23%			>=80%	-	< 80%	CNO	
Hand Hygeine	Local	QEF3.5	Hand Hygiene Compliance to Practice				77.38%	88.58%	86.59%	85.55%	91.29%	89.96%	91.48%	95.02%	95.66%	96.79%			>=95%		<95%	CNO	
	Local	QEF3.6	Hand Hygiene Audit Participation				0.79%	6.30%	11.02%	13.39%	11.81%	14.17%	11.81%	33.86%	52.76%	66.94%			100%		<100%	CNO	

EFFECTIVE

Mortality	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months	103.75	104.42	104.67	104.52	104.15	106.09	107.21	108.86	109.55					-	-	<=100	-	-	DPS	
	National	QPS9.1	Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge - rolling 12 months	101.05	103.62			107.15									-	-	-	-	-	DPS	
	National	QPS9.23	% Primary Mortality Reviews returned within 30 days of issue (from month assigned)	51.85%	18.13%	56.28%	52.59%	45.11%	34.16%	58.62%	51.46%	57.24%	58.18%	52.17%	59.89%				>=60%	-	<60%	DPS	
	National	QPS9.25	Number of issued Primary Reviews not completed (backlog - based on month assigned)	235	317	290	335	382	396	382	408	432	440	454	487				-	-	-	DPS	
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	47	59	50	39	32	55	62	62	55	45	55	50	52	436	487	0	-	>0	CNO	
NOF	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	85.19%	81.33%	80.95%	80.65%	81.48%	75.86%	79.10%	68.52%	76.56%	86.54%	66.18%	73.53%	86.67%		81.4%	>=85%	-	<85%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Pts	100.00%	92.42%	94.44%	94.34%	89.80%	86.27%	84.13%	84.09%	87.50%	93.75%	70.31%	80.65%	88.14%		91.9%	>=85%	-	<85%	CMO	
Audits	Local	QR1.9	% Of NICE assessments completed within 12 weeks following publication	78.0%	85.0%	82.0%	84.0%	85.5%											>95%	20% - 94%	<20%	CNO	
	Local	QR1.16	% of NICE assessments completed within 10 weeks (8 weeks wef 1/9/18, 6 weeks wef 1/4/19)						46.2%	74.6%	81.7%	79.4%	80.0%	84.00%	89.00%	90.00%			>=85%	84%- 75%	<75%	CMO	
	Local	QR1.13	Complete an annual programme of local clinical audit						0.0%	1.0%	2.0%	5.0%	9.0%	19.0%	22.0%	28.0%			>=60%	59%- 50%	<50%	CMO	
	Local	QR1.14	Participate in all relevant national clinical audits that the trust is eligible to participate in.						94.0%	95.0%	95.0%	95.0%	95.0%	95.00%	95.00%	95.00%			>=94%	93-90%	<90%	CMO	

* NCEPOD - currently not active as no reports are due

PATIENT EXPERIENCE

Friends & Family	National	QEX2.1a	Friends & Family - A&E (% Recommend)					73.75%	80.13%	80.35%	81.46%	73.93%	78.68%	81.35%	81.70%	83.52%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.2	Friends & Family - A&E (Response Rate %)	4.97%	3.54%	1..3%	6.10%	3.59%	6.64%	5.72%	6.00%	4.86%	5.67%	4.12%	6.30%	6.83%	5.75%	-	>=20%	-	<20%	CNO	
	National	QEX2.61a	Friends & Family - Acute Wards (% Recommend)					93.58%	96.27%	94.45%	94.49%	94.14%	93.65%	92.90%	93.16%	95.47%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.62	Friends & Family - Acute Wards (Response Rate %)	8.63%	5.18%	6.79%	9.30%	5.65%	7.51%	8.69%	17.46%	19.33%	18.26%	16.99%	18.29%	20.30%	16.00%	-	>=30%	-	<30%	CNO	
	National	QEX2.7a	Friends & Family - Maternity (% Recommend)					98.73%	98.68%	98.26%	97.25%	98.60%	95.98%	97.13%	97.88%	99.18%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.8	Friends & Family - Maternity (Response Rate %)	15.38%	19.61%	34.04%	34.93%	19.14%	30.18%	26.56%	22.38%	27.99%	35.97%	21.76%	29.42%	29.37%	27.64%	-	>=30%	-	<30%	CNO	
	National	QEX2.10a	Friends & Family - Outpatients (% Recommend)					92.39%	92.46%	92.51%	90.79%	92.17%	91.40%	91.01%	92.36%	93.32%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.11	Friends & Family - Outpatients (Response Rate %)	2.63%	1.70%	3.67%	5.69%	4.13%	4.72%	3.76%	3.65%	3.80%	4.60%	4.21%	5.11%	5.48%	4.73%	-	>=10%	-	<10%	CNO	
Complaint Management	Local	QEX1.24	Formal Complaints - Received In Month	69	31	62	52	56	55	61	44	58	50	49	56	47	420	607	-	-	-	CNO	
	Local	QEX1.37	Formal Complaints - % responded within 25 days (closed in month)	52.78%	43.18%	42.62%	54.24%	73.21%	76.36%	81.33%	82.00%	86.67%	90.77%	88.57%	76.09%	71.43%			>=80%	70-79%	<=69%	CNO	
	Local	QEX1.41	Formal Complaints - % of further concerns received	1.5%	12.9%	5.0%	4.0%	0.0%	0.0%	3.0%	0.0%	0.0%	8.0%	0.0%	2.6%	2.1%			<10%	-	>=10%	CNO	

* A new electronic mortality review system was introduced at the end on May - this means previous months are not comparable. PMR reporting is based on the month assigned and reported a month in arrears.
** There has been a change in methodology for FFT - the 'score' now represents % recommended (where the response was either extremely likely or likely)

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

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

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire Acute Hospitals NHS Trust

Reporting Period: November 2018

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

Area	Indicator Type	Indicator		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Current YTD	Prev Year	Tolerance Type	2018/19 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Waits	National	PW1.1.3	Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	98.71%	97.73%	97.26%	97.46%	96.20%	92.63%	89.89%	89.69%	86.51%	88.13%	91.52%	94.68%	94.81%			National	>=99%	-	<99%	COO	
	National	CW3.0	RTT - Patients on an incomplete pathway (within 18 weeks)	85.49%	84.45%	84.46%	84.46%	83.24%	84.15%	84.76%	83.86%	82.87%	81.45%	81.01%	81.36%	81.47%			National	>=92%	-	<92%	COO	
	National	CW4.0	RTT - Patients waiting 52 weeks or more for treatment	21	14	3	2	4	3	2	1	0	0	0	0	0			National	0	-	>=1	COO	
A & E	National	CAE1.1a	4 Hour Waits (%) - Trust	80.33%	74.98%	73.28%	72.12%	71.28%	75.34%	78.78%	79.80%	78.01%	76.37%	77.76%	75.02%	75.00%	77.72%	78.91%	National	>=95%	-	<95%	COO	
	Local	CAE2.1	12 hour trolley breaches	17	4	8	24	75	44	28	3	2	10	19	25	34	165	140	Local	0		0	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile	32	41	56	58	59	68	47	40	51	68	73	94	65	65	-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment for All Patients (Mins) - 95th Percentile	29	36	46	49	49	64	55	64	66	69	68	68	57	57	-	National	<=15mins	-	>15mins	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	46.20%	38.10%	33.30%	28.90%	28.60%	33.30%	36.70%	53.60%	51.00%	46.50%	43.90%	39.20%	43.80%	44.50%	46.30%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	80.50%	75.00%	70.40%	67.40%	71.40%	73.80%	78.80%	85.70%	83.40%	80.30%	79.20%	76.20%	81.60%	80.40%	81.20%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes - WMAS data	152	254	372	336	335	263	174	123	210	315	287	415	270	2045	1,992	Local	0		>0	COO	
Cancer	National	CCAN1.0	2WW: All Cancer Two Week Wait (Suspected cancer)	92.75%	85.42%	83.74%	87.79%	77.75%	70.48%	77.49%	65.62%	75.00%	80.58%	88.90%	93.96%	93.34%	81.05%	80.63%	National	>=93%	-	<93%	COO	
	National	CCAN2.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	95.17%	87.91%	63.64%	89.15%	55.65%	45.96%	51.76%	27.66%	55.68%	87.01%	94.20%	97.81%	93.02%	68.61%	71.79%	National	>=93%	-	<93%	COO	
	National	CCAN3.0	31 Days: Wait For First Treatment: All Cancers	98.28%	97.55%	97.24%	97.11%	98.11%	97.39%	97.32%	98.80%	97.82%	98.15%	97.35%	96.73%	96.11%	97.44%	97.63%	National	>=96%	-	<96%	COO	
	National	CCAN7.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	72.76%	71.88%	69.39%	74.06%	82.93%	79.11%	76.01%	72.14%	73.30%	77.96%	70.26%	68.38%	77.04%	74.08%	72.65%	National	>=85%	-	<85%	COO	
	Local	CCAN7.2	62 Days: Wait For First Treatment From Urgent GP Referral: Breast*	93.75%	86.96%	69.23%	90.91%	86.44%	87.50%	85.19%	86.67%	93.55%	89.74%	65.52%	91.49%	83.33%	84.77%	88.59%	National	>=97%	-	<97%	COO	
	Local	CCAN7.3	62 Days: Wait For First Treatment From Urgent GP Referral: Gynae*	57.14%	76.92%	71.43%	0.00%	100.00%	81.82%	55.00%	60.00%	69.23%	90.00%	44.44%	84.21%	100.00%	73.33%	74.12%	National	>=83%	-	<83%	COO	
	Local	CCAN7.4	62 Days: Wait For First Treatment From Urgent GP Referral: Haemotological*	83.33%	77.78%	60.00%	60.00%	76.00%	71.43%	70.00%	75.00%	92.86%	77.78%	100.00%	83.33%	33.33%	77.94%	78.71%	National	>=86%	-	<86%	COO	
	Local	CCAN7.5	62 Days: Wait For First Treatment From Urgent GP Referral: Head & Neck*	44.44%	11.76%	41.67%	26.67%	28.57%	100.00%	71.43%	10.00%	50.00%	20.00%	50.00%	0.00%	50.00%	43.75%	28.79%	National	>=74%	-	<74%	COO	
	Local	CCAN7.6	62 Days: Wait For First Treatment From Urgent GP Referral: Lower Gastro*	60.00%	65.00%	54.55%	51.16%	80.00%	71.43%	70.00%	73.91%	76.19%	80.49%	89.66%	70.00%	84.21%	75.89%	52.19%	National	>=77%	-	<77%	COO	
	Local	CCAN7.7	62 Days: Wait For First Treatment From Urgent GP Referral: Lung*	42.86%	58.82%	28.57%	53.85%	50.00%	57.14%	75.00%	75.00%	56.00%	66.67%	35.71%	52.17%	69.57%	59.75%	56.08%	National	>=81%	-	<81%	COO	
	Local	CCAN7.8	62 Days: Wait For First Treatment From Urgent GP Referral: Skin*	92.86%	98.44%	91.18%	90.63%	97.30%	96.88%	100.00%	100.00%	87.14%	92.68%	83.33%	77.53%	94.74%	90.05%	94.99%	National	>=96%	-	<96%	COO	
	Local	CCAN7.9	62 Days: Wait For First Treatment From Urgent GP Referral: Upper Gastro*	62.50%	76.67%	48.15%	66.67%	90.91%	57.14%	90.48%	53.85%	68.42%	85.71%	92.86%	52.94%	83.87%	73.71%	67.03%	National	>=80%	-	<80%	COO	
	Local	CCAN7.10	62 Days: Wait For First Treatment From Urgent GP Referral: Urological*	60.53%	63.83%	78.48%	83.54%	83.33%	77.14%	59.68%	53.21%	56.86%	67.48%	57.89%	59.57%	59.38%	60.40%	65.16%	National	>=81%	-	<81%	COO	
	Local	CCAN7.11	62 Days: Wait For First Treatment From Urgent GP Referral: Other*	100.00%	0.00%	-	-	-	33.33%	100.00%	100.00%	0.00%	100.00%	100.00%	-	-	72.20%	56.10%	National	-	-	-	COO	
	National	CCAN8.0	62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers (Small numbers)	96.15%	93.10%	76.00%	69.23%	71.43%	85.19%	85.19%	90.00%	90.70%	76.60%	73.21%	65.38%	81.82%	80.17%	87.73%	National	>=90%	-	<90%	COO	
	Local	CCAN12.0	62 Days waits: 62 day treatments waiting over 62 days	101	114	95	73	78	83	93	107	113	135	133	87	102							COO	
	Local	CCAN10.0	104 Day waits : 62 day treatments waiting over 104 days	27	27	26	27	24	15	21	17	20	38	32	25	23							COO	
	Local	CCAN11.0	Cancer Long Waiters (104+ Days) - treated in month	19.0	11.0	12.0	10.0	12.0	7.5	9.5	9.5	12.5	9.5	17.5	18.5	8.5	93.0	127.0	-	-	-	-	COO	
Stroke**	Local	CST1.1	80% of Patients spend 90% of time on a Stroke Ward	75.4%	50.0%	70.0%	59.3%	60.7%	64.3%	62.0%	73.1%	64.3%	78.5%	64.8%	84.3%	74.1%	70.40%	1	Local	>=80%	-	<80%	COO	
	Local	CST2.1	Direct Admission (via A&E) to a Stroke Ward	23.3%	25.0%	32.4%	27.8%	27.3%	17.6%	24.4%	42.5%	33.3%	31.6%	36.7%	41.5%	36.6%	33.00%	0	Local	>=90%	-	<90%	COO	
	Local	CST3.1	TIA clinic within 24 hours	76.6%	55.0%	77.2%	80.5%	85.0%	68.6%	77.6%	77.9%	44.2%	14.1%	45.2%	66.7%	29.9%	56.20%	0	Local	>=60%	-	<60%	COO	
	Local	CST4.0	CT scan within 60 minutes of arrival	28.6%	21.9%	27.1%	37.9%	23.6%	36.4%	42.2%	38.3%	38.3%	41.6%	51.9%	47.8%	41.1%	43.00%	34.90%	Local	>=80%	-	<80%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH	97.1%	97.2%	98.8%	100.2%	99.9%	99.8%	99.8%	98.8%	100.3%	98.3%	96.3%	99.0%	98.8%	98.9%	97.4%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX	85.9%	88.6%	92.3%	91.2%	91.7%	87.2%	87.2%	87.3%	88.1%	87.8%	89.5%	92.5%	97.9%	88.8%	86.8%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN2.3	Beds Occupied by NEL Stranded Patients (>7 days) - last week of month	41.11%	44.44%	47.27%	44.30%	45.12%	40.20%	38.41%	41.18%	39.19%	37.41%	35.18%	41.04%	38.08%			Local	<=45%	-	>45%	COO	
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute	31	54	51	38	25	36	35	40	25	31	27	23	39			Local	<30	-	>=30	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute	936	1,127	1,160	876	923	830	803	713	617	840	622	523	885	5833		-	-	-	-	COO	
Elective	National	PEL3.1	Number of patients - 28 Day Breaches (cancelled operations)	8	16	38	15	19	36	19	34	8	25	16	30	37	205	-	TBC	-	-	-	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	2	1	1	0	1	0	1	1	3	2	1	0	2	10	7	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	4.3	4.5	4.8	5.0	4.9	5.2	4.6	4.6	4.4	4.5	4.5	4.3	4.3	4.5	4.6	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	6.4	6.6	7.0	7.2	7.1	7.5	6.9	6.9	6.6	6.6	6.6	6.4	6.6	6.8	6.6	-	-	-	-	COO	
Dementia	National	QEF1.1	Dementia: Find, Assess, Investigate and Refer (Pt 1 - Find)	95.4%	95.5%	94.3%	91.5%	88.1%	89.9%	88.1%	85.5%	93.6%	94.9%	86.8%	97.9%	93.4%	91.5%	94.1%	National	>=90%	-	<90%	CMO	
	National	QEF1.2	Dementia: Find, Assess, Investigate and Refer (Pt 2 - Investigate)	89.6%	95.6%	96.4%	93.5%	92.2%	93.4%	94.3%	90.5%	93.7%	93.1%	89.5%	93.3%	93.9%	92.8%	92.4%	National	>=90%	-	<90%	CMO	
	National	QEF1.3	Dementia: Find, Assess, Investigate and Refer (Pt 3 - Refer)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	National	>=90%	-	<90%	CMO	

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

*** Stroke metrics are unvalidated for the current reporting month and are subject to change due to coding timeliness*

Data Quality Kite Mark Descriptions

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PEOPLE AND CULTURE ENGAGEMENT SCORECARD FOR TRUST BOARD
AS AT 30 NOVEMBER 2018 v2

Worcestershire Acute Hospitals NHS Trust

DATA FROM OLM - run 11 December 2018

Metric	Description	Mar-16	Mar-17	Mar-18	Sep-18	Oct-18	Nov-18	Target	Trend from last month
Establishment	Trust wide establishment for M8 November 2018				5904.08	5840.14	5916.00		↑ 75.86
Staff In Post (SIP)	Contracted SIP (FTE)	5,080.09	5,104.18	5,199.57	5,299.07	5,292.60	5,303.89	5840.14	↑ 11.29
Vacancy Rate	**TOTAL SUBSTANTIVE VACANCIES**				605.01	547.54	612.11	7%	↑ 64.57
	Overall Vacancy Rate			7%	10%	9%	10%	7%	↑ 1%
	Vacancies increased by 3.72% in May 2018 due to the significant increase in establishment of 212 posts. Establishment increased by a further 75.86 wte this month which worsens the vacancy position.								
Metric	**Description**	**31/03/2016**	**31/03/2017**	**31/03/2018**	**30/09/2018**	**31/10/2018**	**30/11/2018**	**Target**	**Trend from last month**
Staff FFT - Recommend Trust as a place to Work	2017 Staff Opinion Survey results	51%	48%	50%	50%	61%	61%	60 % National average Q1	→ 0%
PDR Compliance	Medical	82%	82%	89%	80%	77%	80%	85%	↑ 3%
	Non Medical	80%	76%	66%	69%	72%	75%	85%	↑ 3%
	Registered Nursing				69%	72%	75%	85%	↑ 3%
	HCA's				66%	68%	72%	85%	↑ 4%
	AHP'S				73%	78%	80%	85%	↑ 2%
	PDR Professional, Scientific and Technical				63%	63%	51%	85%	↓ -12%
	Healthcare Scientists				86%	87%	88%	85%	↑ 1%
	PDR Estates and Ancillary				72%	73%	79%	85%	↑ 6%
	PDR Admin and Clerical				68%	73%	74%	85%	↑ 1%
Up to date Job Plans	All Medical staff	68%	61%	67%	59%	60%	58%	100%	↓ -2%
	Consultants			72%	62%	63%	62%	100%	↓ -1%
	SAS Doctors			41%	42%	42%	42%	100%	→ 0%

Mandatory Training Compliance

Metric	Description	Mar-16	Mar-17	Mar-18	Sep-18	Oct-18	Nov-18	Target	Trend from last month
Overall Mandatory Training Compliance	Overall Training Compliance at Base Level			89%	85%	84%	84%	90%	→ 0.00%
	Overall Training Compliance at **ALL** levels				79%	80%	81%	90%	↑ 1.00%
Mandatory Training Compliance By Topic	Information Governance	87%	90%	94%	86%	86%	90%	95%	↑ 4.00%
	Fire	85%	82%	81%	79%	80%	81%	90%	↑ 1.00%
	Health & Safety	75%	85%	84%	87%	87%	88%	90%	↑ 1.00%
	Conflict Resolution	81%	87%	88%	88%	88%	89%	90%	↑ 1.00%
	Equality & Diversity	74%	69%	69%	73%	74%	75%	90%	↑ 1.00%
	Infection Control L1	85%	77%	89%	90%	90%	90%	90%	→ 0.00%
	Infection Control L2			67%	70%	72%	74%	90%	↑ 2.00%
	Moving & Handling L1	90%	88%	88%	91%	90%	89%	90%	↓ -1.00%
	Moving and Handling L2			77%	74%	76%	76%	90%	→ 0.00%
	Safeguarding Children L1	88%	80%	99%	98%	98%	98%	90%	→ 0.00%
	Safeguarding Children L2			63%	71%	74%	75%	90%	↑ 1.00%
	Safeguarding Children L3			59%	66%	67%	72%	90%	↑ 5.00%
	Safeguarding Children L4			100%	75%	80%	80%	90%	→ 0.00%
	Safeguarding Children L5			0%	100%	100%	100%	90%	→ 0.00%
	Safeguarding Adults L1	96%	96%	87%	91%	92%	92%	90%	→ 0.00%
	Safeguarding Adults L2			59%	70%	73%	76%	90%	↑ 3.00%
	Safeguarding Adults L3			1%	15%	21%	21%	90%	→ 0.00%
	Safeguarding Adults L4			100%	100%	100%	100%	90%	→ 0.00%
	Safeguarding Adults L5			33%	67%	67%	67%	90%	→ 0.00%
	Resuscitation L1			72%	91%	89%	89%	90%	→ 0.00%
	Resuscitation L2 Basic Life Support	85%	85%	86%	79%	79%	79%	90%	→ 0.00%
	NLS L4 Newborn Life Support			58%	85%	89%	100%	90%	↑ 11.00%
	EPLS L4			74%	79%	81%	83%	90%	↑ 2.00%
	ALS L4 Advanced Life Support			63%	74%	76%	79%	90%	↑ 3.00%
	Preventing Radicalisation L1			86%	94%	94%	94%	85%	→ 0.00%
	Preventing Radicalisation L2			89%	90%	89%	90%	85%	↑ 1.00%
	Preventing Radicalisation L3 (WRAP)			52%	67%	69%	72%	85%	↑ 3.00%
	Preventing Radicalisation L4 (WRAP)			100%	100%	100%	100%	85%	→ 0.00%
	Preventing Radicalisation L5 (WRAP)			100%	100%	100%	100%	85%	→ 0.00%
	MCA and DoLS L1			64%	75%	76%	79%	90%	↑ 3.00%
	MCA and DoLS L2			47%	61%	63%	67%	90%	↑ 4.00%
	MCA and DoLS L3			0%	69%	71%	75%	90%	↑ 4.00%
	MCA and DoLS L4			0%	50%	75%	75%	90%	→ 0.00%

Metric	Description	Mar-16	Mar-17	Mar-18	Sep-18	Oct-18	Nov-18	Target	Trend from last month
Turnover	Annual Turnover (FTE)	12.97%	12.57%	11.04%	11.90%	11.98%	12.12%	local target 10-12%	0.14%
	Annual Turnover (FTE) for Consultants				9.53%	9.51%	9.01%	local target 10-12%	-0.50%
	Annual Turnover (FTE) for other Medics				7.09%	8.34%	6.78%	local target 10-12%	-1.56%
	Annual Turnover (FTE) for Registered Nurses				10.42%	10.62%	11.58%	local target 10-12%	0.96%
	Annual Turnover (FTE) for HCA's	12.97%	12.57%	11.04%	14.86%	15.58%	16.39%	local target 10-12%	0.81%
	Monthly Turnover			1.02%	1.41%	0.84%	0.89%	MHB Aug 18 Peers 0.86%	0.05%
Retention Rate/Stability Index	Trust Retention Rate/Stability Index			90.08%	89.55%	89.10%	89.00%	MHB Jul 18 National Median 85.8%	-0.10%
	Consultants retention rate				92.97%	92.62%	92.36%	92.47% (Model Hospital Mar 18)	-0.26%
	Registered Nurses and Midwives				89.70%	89.41%	88.94%	MHB National Median 87.6%	-0.47%
	HCA's				85.99%	86.29%	84.86%	MHB Aug 18 84.3%	-1.43%
	AHP'S (Dietitians, OT's Physio's, Orthoptists and Radiographers				82.07%	81.66%	81.01%	MHB Jul 18 Peers 86.5%	-0.65%
Sickness Absence	Monthly sickness absence	4.06%	4.06%	3.93%	3.91%	4.07%	4.29%	MHB Jul 18 Peers 3.91%	0.22%
	Cumulative Sickness over 12 months			4.17%	4.15%	4.15%	4.15%	MHB Jul 18 Peers 3.91%	0.00%
	Model Hospital Benchmark Sickness as at July 2018					3.67%	3.74%	MHB Jul 18 Peers 3.91%	0.07%

NOTES:

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

KEY TO COLUMN H		KEY TO COLUMN J	
TARGET MET		PERFORMANCE IMPROVED OR TARGET MET	
WITHIN 3% OF TARGET	GREY BOXES ARE NOT APPLICABLE OR NOT AVAILABLE	PERFORMANCE DETERIORATED	
TARGET NOT MET		PERFORMANCE UNCHANGED	
		0	ARROW DEPICTS DIRECTION OF TRAVEL FROM LAST MONTH

PEOPLE AND CULTURE PAYBILL SCORECARD FOR TRUST BOARD
AS AT 30 NOVEMBER 2018 v2

Worcestershire Acute Hospitals NHS Trust

DATA FROM ADI - Month 8 Supplied by Finance

Metric	Description	Mar-16	Mar-17	Mar-18	Sep-18	Oct-18	Nov-18	Target	Trend from last month
Vacancies by Staff Group (Substantive vacancies are calculated in line with the Model Hospital formula : establishment less contracted)	Medics Overall	16%	20%	16.23%	12.42%	13.40%	14.29%	10%	0.89%
	Consultant	11%	15%	14.13%	18.71%	10.89%	10.52%	15%	-0.37%
	Other Medics	20%	24%	19.08%	7.54%	15.36%	17.23%	10%	1.87%
	Registered Nursing and Midwifery	7.13%	8.38%	7.46%	10.68%	8.81%	8.87%	7%	0.06%
	Registered Nursing	7.83%	9.97%	6.94%	11.93%	10.06%	10.50%	7%	0.44%
	Registered Midwifery			-0.48%	-0.63%	-2.86%	-2.43%	7%	0.43%
	HCA's				2.95%	5.90%	5.56%	7%	-0.34%
	AHP'S			4.69%	4.05%	1.95%	2.60%	7%	0.65%
	Scientific, Therapeutic and Technical			4.16%	7.10%	7.27%	6.24%	7%	-1.03%
	Ancillary			10.03%	7.19%	7.41%	6.23%	7%	-1.18%
	Senior Managers			9.37%	6.96%	5.40%	5.36%	7%	-0.04%
	Administrative and Clerical			6.10%	10.76%	11.40%	11.57%	7%	0.17%
	Higher turnover in Senior Managers and Admin and Clerical is indicated as neutral due to Workforce Transformation Programme								

				FUNDED FOR WINTER	OTHER WARD VACANCIES	APPOINTMENTS IN PIPELINE	REMAINING VACANCIES	POSITION LAST MONTH (OCT 2018)	Trend from last month
Additional Staff required for Winter Plan	Registered Nursing (Winter escalation) wards and A&E only			66.56	139.67	88.33	117.90	126.56	-8.66
	HCA's (Wards only plus A&E - winter escalation)			122.64	25.20	88.70	59.14	92.03	-32.89
	Ward Manager			2.00			2.00	1.00	1.00
	Consultant			8.80	42.49	19.00	32.29	28.33	3.96
	Middle Grade			4.40	48.90	22.00	31.30	56.68	-25.38
	Junior Grade			10.00	37.55	5.00	42.55	5.00	37.55
	Allied Health Professions & Pharmacists			14.20	8.85		23.05	17.95	5.10
	Additional Clinical Support staff (therapy Assistants and Pharmacy Technicians)			15.60			15.60	7.80	7.80
*Agency as a % of Gross Cost**	All staff groups	13.12%	9.36%	6.89%	7.52%	8.00%	8.00%	7%	0.00%
*Bank as a % of Gross Cost **	All staff groups	3.56%	4.01%	10.15%	8.25%	7.49%	7.49%	7%	0.00%

	COST PER WAU - latest data from Model Hospital Dec 2018	NATIONAL TOTAL FOR 2017/18	PEER TOTAL FOR 2017/18	TRUST TOTAL FOR 2017/18	TRUST TOTAL FOR 2016/17		TRUST QUARTILE FOR 2017/18	TREND FROM LAST YEAR MHB
Cost per WAU	Medical staff	£535	£570	£616	£542	Cost per WAU is the headline productivity metric used with the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit of clinical output.	4th	£74.00
	Registered Nurses and Midwives	£711	£718	£789	£802		3rd	-£13.00
	AHP'S (Dietitians, OT's Physio's, Orthoptists and Radiographers less Corporate)	£130	£137	£144	£139		3rd	£5.00
	Healthcare Scientists and other Scientific and Technical Staff	£156	£165	£169	£168		3rd	£1.00
	Corporate, Admin and Estates	£359	£321	£306	NEW		2nd	NEW
	Agency staff cost per WAU	£108	£121	£181	£217		4th	-£36.00

NOTES:

Vacancy rate is an in month value only
Gross Pay Costs = Gross Staffing Costs
Registered nursing and midwifery vacancy rate includes Nurses & Midwives Band 5 and above
Agency as a % of gross pay cost = this is all agency for all staffing types

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

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	10th January 2019
Paper number	Enc F1

Financial Forecast Update – 2018/19

For approval:		For assurance:	✓	To note:	

Accountable Director	Jill Robinson – Chief Finance Officer		
Presented by	Jill Robinson – Chief Finance Officer	**Author /s**	Jo Kirwan - Assistant Director of Finance Katie Osmond – Assistant Director of Finance

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Finance and Performance	26th November and 17th December	Reviewed
Private Trust Board	13th December	Reviewed
Trust Leadership Group	4th and 12th December	Reviewed

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

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

Recommendations	The Trust Board is asked to debate and agree the revised forecast outturn for submission to NHSI as part of the Month 9 reporting. The recommendation is that we increase the full year forecast deficit to £72.5m and submit to NHSI on the 16th January in adherence with the NHSI protocol for changes to an in-year financial forecast.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	10th January 2019
Paper number	Enc F1

Executive Summary

Context

In September 2018, the Trust indicated to NHSI that it was not going to meet its financial plan, and based on the forecast it was going to be £20.5m off plan with a deficit of £62m. Given the significance of the variance, NHSI conducted a detailed review of the forecast assumptions. The report concluded that the Trust has a clear understanding of the current financial position and the drivers to the adverse position. The review concluded that a forecast outturn of £62m appeared optimistic and that there was no clear route to the £17.7m of Cost Improvement Programme (CIP) delivery. The NHSI regional team estimated a more likely forecast outturn in the region of between £65m and £72m. As a result of this, the Trust performed a detailed financial review of the CIP.

Baseline Forecast

A forecast refresh was presented to the Board in December 2018. The forecast had been updated to include the actual run rate for M5 through M7. This has since been updated to include Month 8 actuals. An assessment of the underlying run rate was undertaken and rolled forward in order to determine a baseline forecast for the remaining months of the year. The cost of winter has been applied to the baseline forecast consistent with the allocation agreed by the Board at £4.2m. A financial risk assessment of CIP delivery was performed consistent with the underlying methodology detailed above adjusted for any stepped increase in schemes with high confidence of delivery level e.g. Malvern View.

Revised Forecast

The baseline forecast indicates a year end deficit of £71.3m which incorporates further actions to improve the financial position that were agreed were agreed at the Trust Leadership Group in December and are documented on page 10 within the attached presentation.

An assessment of current risks and opportunities has been performed. This results in a deficit range of £71.3m upside to £76.3m downside.

Recommended Forecast

It is recommended that the Trust increases the baseline forecast reflecting an additional £1.2m of expenditure associated with the winter plan, increasing the spend on the provision of additional capacity to £5.4m (see page 7 within the attached presentation).
Contract risks with a downside assessment of £3m require robust management by Executives and escalation to NHSI in order that they do not adversely impact the current year's financial position. We continue to have a dialogue between the Chief Executive and CCG Accountable Officer to resolve this in line with the contract. We have also fully apprised NHSI of the situation and will continue to work closely with them to resolve.

At this point in the process we recommend to the Board that we include the impact of the additional cost to the winter plan in the forecast, but do not include the contract management issues in line with the basis of the signed contract.

Meeting	Trust Board
Date of meeting	10th January 2019
Paper number	Enc F1

This increases the full year deficit to £72.5m.

Issues and options

If an NHS Trust is to reconsider its planned forecast outturn position, the Trust Board's primary focus must be the identification and delivery of a financial recovery plan that demonstrates the mitigating actions being implemented that ensure any proposed revision to forecast outturn is minimised, managed and fully recovered at the earliest possible time.

Revisions to forecast can only be made at the quarterly reporting points in the year and can only be made through the standard NHSI quarterly reporting process.

Recommendations

The Trust Board is asked to debate and agree the revised forecast outturn for submission to NHSI as part of the Month 9 reporting.

The recommendation is that we increase the full year forecast deficit to £72.5m and submit to NHSI on the 16th January in adherence with the NHSI protocol for changes to an in-year financial forecast.

Appendices:

Appendix 1 – 2018/19 Financial Forecast Slides

2018/19 Financial Forecast

Jill Robinson

Chief Finance Officer

Trust Board
January 2019

Contents **Page**

Forecast - Approach

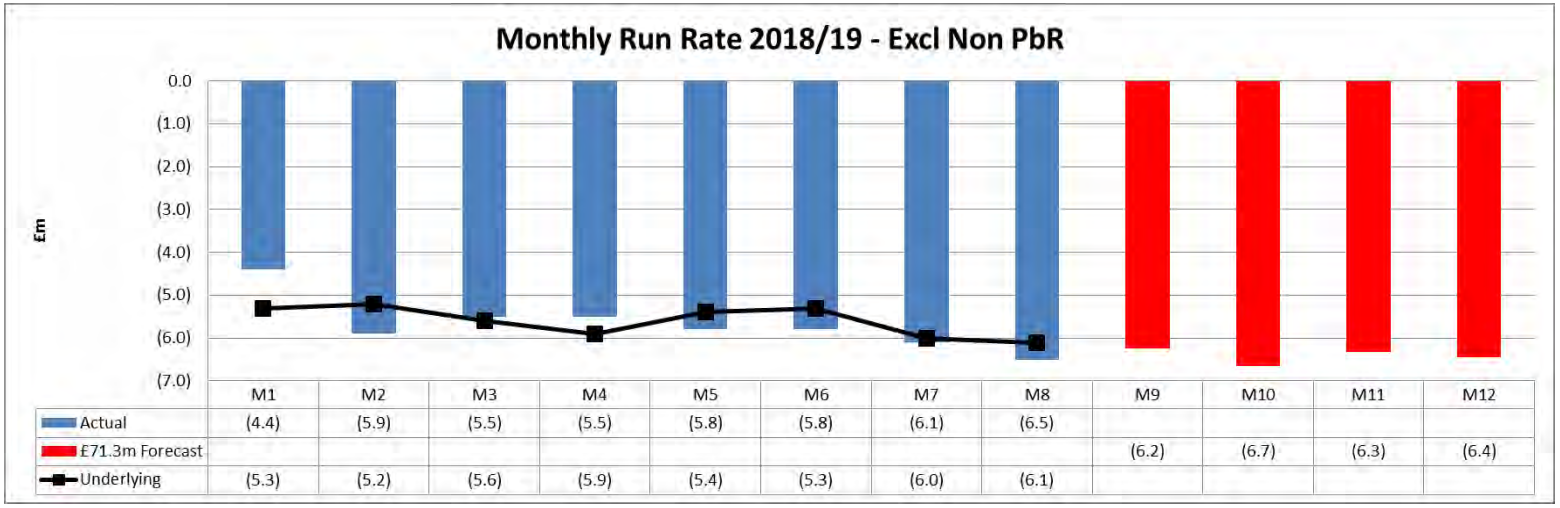
- The base case forecast includes the actual run rate for M1-M8. An assessment of the underlying run rate has been undertaken and rolled forward in order to determine a baseline forecast for the remaining months of the year – see page 8.
- This approach incorporates a roll forward of recurrent CIPs based on recent months levels of delivery. In addition, Divisional forecasts have been adjusted to include Divisional specific schemes such as Malvern lease extension (AMIT Division). Productivity schemes such as Theatres and Outpatients have been rolled forward to the end of the year based on current performance, and then adjusted to reflect intended changes in capacity, such as the commencement of the third and final surgical locum that the Trust had agreed as part of the Theatre plan.
- The patient care income forecast has been updated as described above, to reflect actual performance and rolled forward delivery of productivity schemes. The projection for months 9 through 12 recognises the improvement in months 6 and 7 following the actions taken to improve activity levels, and adjusts to include activity for the third surgical locum not yet appointed. No further step change is assumed in income / activity as a result of the theatres/ outpatients productivity programme, recognising the actions already in place and the risk to availability of capacity through winter. The forecast for patient care income assumes the Trust achieves the contract cap with Worcestershire CCGs.
- The cost of winter has been applied to the base case forecast consistent with the allocation agreed by the Board - £4.2m.
- Further risks to the base case forecast exist and are documented on page 6.

Full Year Forecast 2018/19

The baseline forecast at month 8, indicates a year end deficit of **£71.3m**. The following table and chart summarises the monthly profile of the forecast deficit for the remaining months of the year.

Type		ACTUAL M1	M2	M3	M4	M5	M6	M7	M8	FORECAST M9	M10	M11	M12	Total
Pay	Pay	(22,562)	(22,675)	(22,388)	(22,944)	(24,288)	(23,044)	(23,549)	(23,619)	(23,963)	(23,733)	(23,709)	(23,776)	**(280,249)**
Pay Total		**(22,562)**	**(22,675)**	**(22,388)**	**(22,944)**	**(24,288)**	**(23,044)**	**(23,549)**	**(23,619)**	**(23,963)**	**(23,733)**	**(23,709)**	**(23,776)**	**(280,249)**
Non Pay	Non Pay	(10,227)	(10,494)	(10,498)	(10,614)	(11,053)	(11,508)	(11,093)	(11,332)	(10,883)	(10,824)	(10,737)	(10,165)	**(129,427)**
	Non Pay Non PbR Drugs	(3,122)	(3,010)	(2,875)	(3,193)	(3,114)	(2,907)	(3,562)	(2,842)	(3,116)	(3,116)	(3,116)	(3,390)	**(37,364)**
	Non Pay Non PbR Devices	(324)	(341)	(308)	(334)	(405)	(338)	(321)	(276)	(319)	(319)	(319)	(363)	**(3,967)**
	Depreciation & Amortisation	(822)	(822)	(822)	(844)	(844)	(844)	(844)	(844)	(812)	(812)	(812)	(779)	**(9,898)**
	Interest Payable	(1,250)	(1,250)	(1,250)	(1,250)	(1,250)	(1,250)	(1,291)	(1,326)	(1,370)	(1,404)	(1,404)	(1,448)	**(15,744)**
	Interest Receivable	0	0	0	0	0	0	0	0	(31)	(31)	(31)	(62)	**(154)**
Non Pay Total		**(15,746)**	**(15,917)**	**(15,753)**	**(16,235)**	**(16,666)**	**(16,847)**	**(17,111)**	**(16,619)**	**(16,531)**	**(16,505)**	**(16,418)**	**(16,207)**	**(196,555)**
Income	Interest Receivable	0	0	0	0	0	0	11	64	0	0	0	(64)	**11**
	Other Operating Income	2,196	2,389	2,442	2,604	3,635	2,768	2,599	2,662	3,208	2,622	2,622	2,698	**32,445**
Income Total		**2,196**	**2,389**	**2,442**	**2,604**	**3,635**	**2,768**	**2,610**	**2,726**	**3,208**	**2,622**	**2,622**	**2,634**	**32,455**
Healthcare Incom	Patient Care Revenue	27,742	27,653	27,012	27,453	28,015	28,080	28,062	27,851	27,615	27,520	27,753	27,150	**331,907**
	Patient Care Revenue Non PbR Drugs	3,126	3,006	2,875	3,193	3,106	2,916	3,562	2,842	3,112	3,112	3,112	3,382	**37,344**
	Patient Care Revenue Non PbR Devices	332	342	327	315	359	316	223	199	316	316	316	433	**3,791**
	Patient Care Revenue PSF 18/19	623	(623)	0	0	0	0	0	0	0	0	0	0	**0**
Healthcare Income Total		**31,823**	**30,377**	**30,214**	**30,960**	**31,480**	**31,312**	**31,848**	**30,892**	**31,043**	**30,948**	**31,181**	**30,965**	**373,042**
Grand Total		**(4,288)**	**(5,826)**	**(5,486)**	**(5,615)**	**(5,840)**	**(5,811)**	**(6,203)**	**(6,620)**	**(6,243)**	**(6,668)**	**(6,324)**	**(6,383)**	**(71,307)**

Pay, non pay and directorate income aligns to underlying position documented on page 8.



M8 Reduction in patient care revenue as a result of normalisation of material one off items in prior months and phasing.

Key Drivers of the Variance to Plan

Forecast	£71.2m
Budget Deficit	**(41.5)**
Approved additional expenditure to plan:	
Bed Capacity	(1.2)
Reserves	1.5
Total approved additional expenditure (after reserves applied)	**0.3**
Key Operational Variances:	
CIP shortfall	(13.7)
Under performance on original HC Income Plan - includes variable cost of increased activity	(12.0)
Radiology additional capacity	(1.4)
Workforce - increased premium/job plans/ED net of vacancies	(2.7)
Balance sheet - PFI unwinding / Other	(1.4)
Business Case Underspend	2.1
AMIT - KTC Energy/CVI's/VAT adj	(1.0)
Total Operational Variances	**(30.1)**
Adverse Variance to plan	(29.8)
Deficit	**(71.3)**

Risk/Opportunities

Worcestershire Acute Hospitals NHS Trust - Risk/Opportunities 2018/19 Forecast

Item	Mitigation	Range		
		Down	Up	Recommended
Forecast Deficit as at month 7		**(71.3)**	**(71.3)**	**(71.3)**
RISKS				
That winter expenditure exceeds the forecast	Robustly project manage monitoring commitments	(2.0)	0.0	(1.2)
That winter funding is lower than expected	CFO to CFO negotiation with escalation to CEO and NHSI if required	(2.3)	0.0	
Contract Management - application of penalties and commissioner challenges - inc Evesham block contract challenge	Engagement with CCG to agree robust policies and processes to minimise reconciliation challenges	(0.7)	0.0	
	Robustly respond to any challenges			
	CFO to CFO negotiation with escalation to CEO and NHSI if required			
Forecast deficit adjusted for risk items		**(76.3)**	**(71.3)**	**(72.5)**

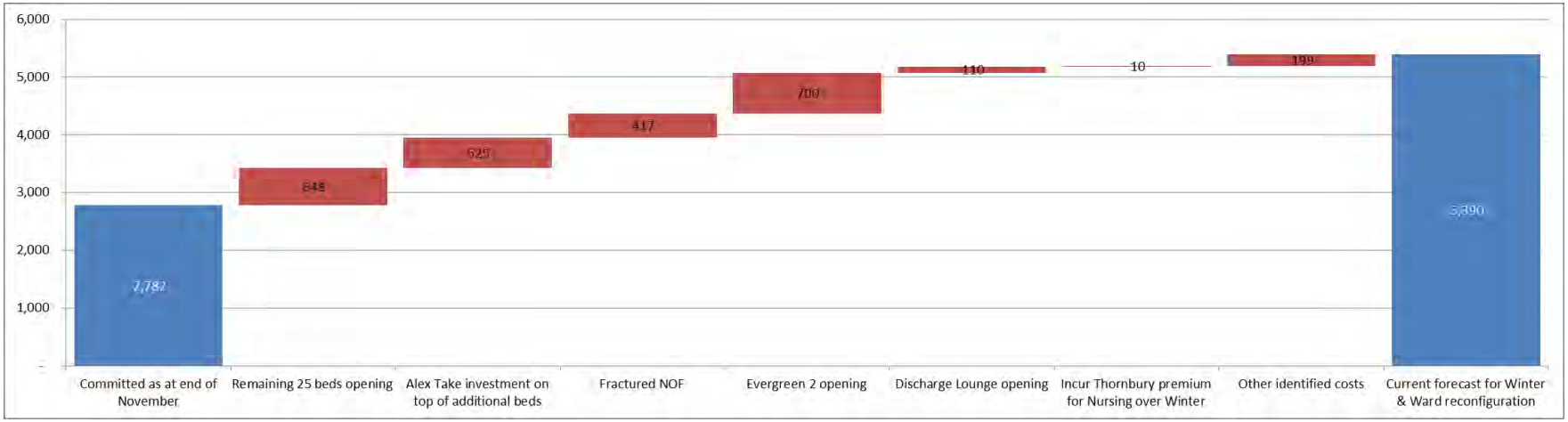
Costs of Ward Reconfiguration and Winter

Worcestershire Acute Hospitals NHS Trust

Summary of total spend

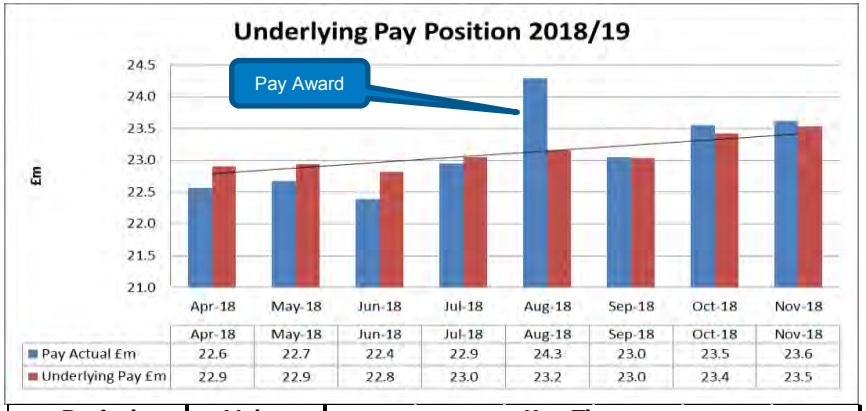
	FY £k	Start date	Status
			16 beds already committed, remainder to be open
41 extra beds baseline - (based on 46 beds model agency premium including Thornbury)	833	Dec-18	by end of January
Alex Take investment on top of additional beds	525	Dec-18	
ID Medicial premium investment (130 Nurses)	792	Dec-18	Committed - on site December
			16 beds already committed, remainder to be open
Corporate/AMIT incremental overheads from additional beds	230	Dec-18	by end of January
			Evesham beds used in December but Surgery
Fractured NOF	417	Jan-19	activity moved to AGH site from 2nd January
Historic winter spend up to end of Nov			Committed - already incurred or can't exit until
Plus existing surge costs until cessation (includes stopping Endoscopy)	1,575	Apr-18	remainder of site move completed
			Due to cooincide with opening of link bridge on
Evergreen 2 opening	700	Jan-19	16th January
Other identified costs	318		
Total	**5,390**		

Current committed expenditure and steps to full forecast

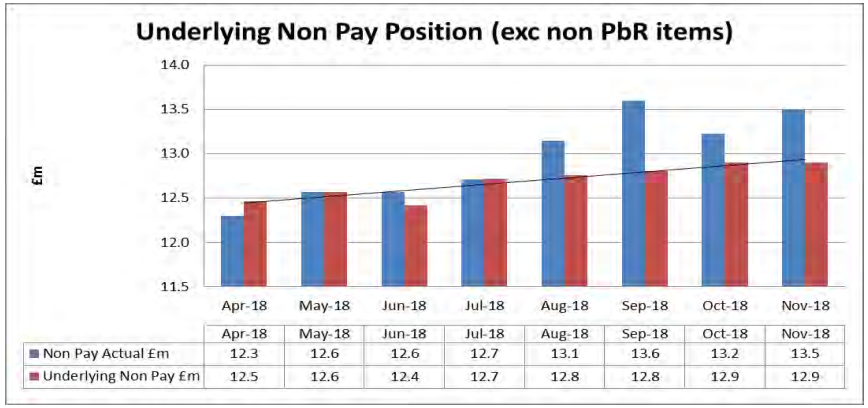


Appendices

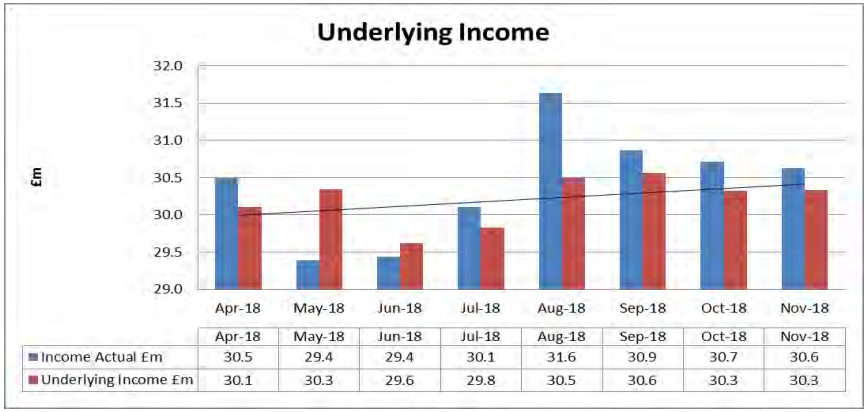
Underlying Position

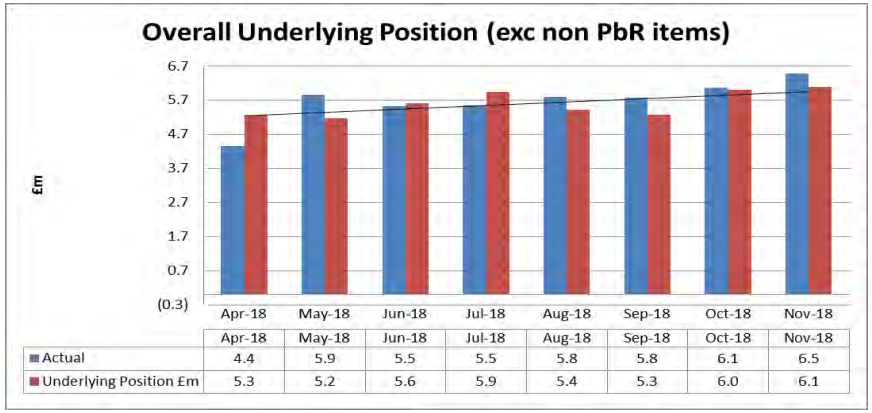


Period	Value	Key Themes
June-July	(£0.2m)	Nursing recruitment/fill rate ST&T increased fill
July-August	(£0.1m)	Medics Recruitment Increased WLI ST&T Recruitment
August-September	£0.10	Non Clinical increased vacancies Medics premium reduction on-call Nursing reduction in fill
September-October	(£0.4m)	Medics Recruitment and Maternity Cover Medics increase capacity - SCSD Nursing New Starters / increased fill



Increased Non Pay costs driven by activity levels. Primarily T&O Loan Kit, Radiology Outsourcing and Theatre Productivity





Differential due to device cost in excess of income

Underlying position has been calculated by removing any material non recurrent items and normalising for any prior month adjustments – e.g. Pay award.

Divisional Control Totals

Worcestershire Acute Hospitals NHS Trust

£000's	AMIT	Corporate	Specialty Medicine	Urgent Care	Surgery	SCSD	W&C	Trustwide	Total
Base Forecast	**(62,856)**	**(29,963)**	**(70,606)**	**(34,180)**	**(54,508)**	**(148,054)**	**(33,764)**	**(12,121)**	**(446,051)**
Divisional CIP not in base	269		160						**429**
1. Procurement		13	254		36	86			**389**
2. NHSP Nursing			22	17	14	14	4		**71**
3. WTD								50	**50**
4. 2.5% Bank Rates			20	14	16	13	5		**68**
5. A/L - nursing			44	29	48	35	25		**181**
Other A/L - admin								40	**40**
6. Non Clinical agency		170							**170**
7. Discretionary	98	41	12	8	7	25	9		**200**
8. Temp Medics			32	20	21	25	7		**105**
Total Adjustments	367	224	544	88	142	198	50	90	**1,703**
Control Total	**(62,489)**	**(29,739)**	**(70,062)**	**(34,092)**	**(54,366)**	**(147,856)**	**(33,714)**	**(12,031)**	**(444,348)**
Patient care Income	208		55,111	70,470	92,554	103,264	49,706	1,729	373,042
Total Forecast	**(62,281)**	**(29,739)**	**(14,951)**	**36,378**	**38,188**	**(44,592)**	**15,992**	**(10,302)**	**(71,307)**

Divisional Control Totals

Worcestershire Acute Hospitals NHS Trust

Division	Type	Actuals								Forecast				
		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
AMIT	Pay	(644)	(626)	(626)	(682)	(768)	(667)	(666)	(672)	(694)	(694)	(694)	(688)	(8,119)
	Non Pay	(5,062)	(5,068)	(5,041)	(4,962)	(5,199)	(5,268)	(5,483)	(5,194)	(5,123)	(5,087)	(5,073)	(4,724)	(61,285)
	Directorate income	556	526	552	549	445	637	468	554	1,106	520	520	481	6,915
		(5,149)	**(5,168)**	**(5,114)**	**(5,096)**	**(5,523)**	**(5,299)**	**(5,681)**	**(5,312)**	**(4,711)**	**(5,261)**	**(5,246)**	**(4,931)**	**(62,489)**
Corporate	Pay	(1,837)	(1,894)	(1,859)	(1,860)	(1,166)	(1,713)	(1,813)	(1,808)	(1,694)	(1,675)	(1,677)	(1,627)	(20,622)
	Non Pay	(1,671)	(1,652)	(1,750)	(1,827)	(2,018)	(2,178)	(1,858)	(2,057)	(1,863)	(1,756)	(1,750)	(1,695)	(22,075)
	Directorate income	1,032	1,119	1,175	1,002	1,111	1,066	1,068	1,094	1,077	1,077	1,077	1,060	12,958
		(2,476)	**(2,427)**	**(2,434)**	**(2,685)**	**(2,073)**	**(2,824)**	**(2,603)**	**(2,771)**	**(2,481)**	**(2,354)**	**(2,350)**	**(2,261)**	**(29,739)**
Specialty Medicine	Pay	(4,202)	(4,243)	(4,469)	(4,230)	(4,438)	(4,569)	(4,431)	(4,435)	(4,514)	(4,382)	(4,364)	(4,525)	(52,803)
	Non Pay	(1,409)	(1,410)	(1,414)	(1,416)	(2,402)	(1,510)	(1,672)	(1,573)	(1,572)	(1,567)	(1,568)	(1,513)	(19,028)
	Directorate income	183	195	145	180	98	128	162	126	136	136	136	145	1,768
		(5,429)	**(5,458)**	**(5,739)**	**(5,466)**	**(6,743)**	**(5,950)**	**(5,942)**	**(5,882)**	**(5,951)**	**(5,813)**	**(5,796)**	**(5,893)**	**(70,062)**
Urgent Care	Pay	(2,301)	(2,464)	(2,039)	(2,350)	(3,453)	(2,352)	(2,587)	(2,521)	(2,639)	(2,587)	(2,570)	(2,555)	(30,417)
	Non Pay	(549)	(559)	(508)	(473)	373	(348)	(315)	(368)	(345)	(342)	(342)	(319)	(4,096)
	Directorate income	0	10	9	2	183	43	29	40	29	29	29	18	422
		(2,849)	**(3,014)**	**(2,539)**	**(2,822)**	**(2,898)**	**(2,657)**	**(2,873)**	**(2,849)**	**(2,955)**	**(2,900)**	**(2,882)**	**(2,856)**	**(34,092)**
Surgery	Pay	(3,665)	(3,628)	(3,481)	(3,666)	(3,951)	(3,699)	(3,663)	(3,778)	(3,833)	(3,763)	(3,764)	(3,771)	(44,661)
	Non Pay	(852)	(898)	(851)	(869)	(883)	(851)	(1,072)	(945)	(913)	(911)	(910)	(973)	(10,928)
	Directorate income	42	119	102	112	146	94	106	89	100	100	100	112	1,223
		(4,476)	**(4,406)**	**(4,230)**	**(4,424)**	**(4,688)**	**(4,456)**	**(4,628)**	**(4,634)**	**(4,646)**	**(4,573)**	**(4,573)**	**(4,631)**	**(54,366)**
SCSD	Pay	(7,121)	(7,172)	(6,933)	(7,263)	(7,676)	(7,339)	(7,556)	(7,521)	(7,472)	(7,486)	(7,479)	(7,468)	(88,487)
	Non Pay	(4,988)	(5,158)	(4,978)	(5,372)	(5,276)	(5,259)	(5,756)	(5,317)	(5,249)	(5,311)	(5,267)	(5,255)	(63,186)
	Directorate income	333	300	343	345	310	335	302	305	308	308	308	318	3,817
		(11,776)	**(12,031)**	**(11,567)**	**(12,289)**	**(12,642)**	**(12,264)**	**(13,011)**	**(12,533)**	**(12,413)**	**(12,489)**	**(12,437)**	**(12,405)**	**(147,856)**
Women & Children	Pay	(2,522)	(2,550)	(2,487)	(2,536)	(2,652)	(2,530)	(2,584)	(2,598)	(2,548)	(2,544)	(2,540)	(2,471)	(30,562)
	Non Pay	(274)	(314)	(306)	(287)	(269)	(261)	(278)	(285)	(327)	(350)	(328)	(340)	(3,617)
	Directorate income	(26)	44	39	19	(6)	70	43	62	57	57	57	51	465
		(2,822)	**(2,819)**	**(2,754)**	**(2,804)**	**(2,926)**	**(2,721)**	**(2,820)**	**(2,820)**	**(2,819)**	**(2,838)**	**(2,811)**	**(2,760)**	**(33,714)**
Trustwide	Pay	(270)	(98)	(494)	(356)	(183)	(176)	(250)	(287)	(567)	(602)	(622)	(671)	(4,577)
	Non Pay	(941)	(858)	(905)	(1,028)	(991)	(1,170)	(675)	(881)	(1,139)	(1,181)	(1,181)	(1,389)	(12,340)
	Directorate income	76	76	76	394	1,348	394	432	456	394	394	394	448	4,886
		(1,135)	**(879)**	**(1,322)**	**(990)**	**174**	**(951)**	**(493)**	**(712)**	**(1,312)**	**(1,389)**	**(1,409)**	**(1,612)**	**(12,031)**
Total	**Pay**	**(22,562)**	**(22,675)**	**(22,388)**	**(22,944)**	**(24,288)**	**(23,044)**	**(23,549)**	**(23,619)**	**(23,963)**	**(23,733)**	**(23,709)**	**(23,776)**	**(280,249)**
	Non Pay	**(15,746)**	**(15,917)**	**(15,753)**	**(16,235)**	**(16,666)**	**(16,847)**	**(17,111)**	**(16,619)**	**(16,531)**	**(16,505)**	**(16,418)**	**(16,207)**	**(196,555)**
	Directorate income	**2,196**	**2,389**	**2,442**	**2,604**	**3,635**	**2,768**	**2,610**	**2,726**	**3,208**	**2,622**	**2,622**	**2,634**	**32,455**
Grand Total		**(36,111)**	**(36,203)**	**(35,700)**	**(36,575)**	**(37,319)**	**(37,123)**	**(38,050)**	**(37,512)**	**(37,286)**	**(37,616)**	**(37,505)**	**(37,348)**	**(444,348)**

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	F2

National Quality Board Mortality Metrics

For approval:		For assurance:	x	To note:	

Accountable Director	Dr Suneil Kapadia, Chief Medical Officer		
Presented by	Dr Suneil Kapadia, Chief Medical Officer	**Author /s**	Dr Steve Graystone, AMD Patient Safety John Reading, Information Manager

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

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

Recommendations	The Trust Board is asked to note the contents of the report.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	F2

Executive Summary

- In the first 6 months of the financial year 2018/19 a total of 948 adult deaths (in patients without a registered learning disability) occurred in the Trust
- Of these the care provided has been reviewed in 722 cases (76.2%) vs 83% for 2017/18
- On the balance of probability (>50%), the death of one patient was felt to be avoidable
- During the same time period three deaths have occurred in patients with a registered learning disability
- On review, none of these deaths was deemed avoidable
- Evidence of learning and improvement from mortality reviews, by clinicians, needs to be strengthened.

I expect this paper to be considered at QGC in future prior to Trust Board.

Background

The NHS National Quality Board has set an expectation that certain metrics with respect to mortality reviews are discussed at Trust Boards. The metrics in question are:

- Total number of adult deaths (excluding maternal deaths)
- Total number of deaths reviewed
- Number of deaths were the likelihood of avoidability is greater than 50%
- Total number of deaths in adults with a registered learning disability
- Total number of deaths in this group reviewed
- Number of avoidable deaths (>50% probability) in adult patients with a learning disability
- Learning and improvement resulting from the Trust Mortality review programme

This paper provides information with respect to these mandated metrics.

Issues

Deaths are reviewed by Medical Examiners using the Structured Judgement Review methodology or by speciality teams using a template that asks specific questions about phases of care.

The values for the current financial year are shown below.

The methodology used to decide avoidability is that if a reviewer identifies significant issues with the care provided an incident is logged in Datix tagged as having been identified through a mortality review. These incidents are then managed through the Divisional governance investigation process to identify if it should be managed as a serious incident.

In all serious incidents where the patients outcome is death, on completion of the investigation, the serious incident review and learning group membership makes a judgement as to whether the death was related to the issue under investigation and if so if the death was more likely than not avoidable.

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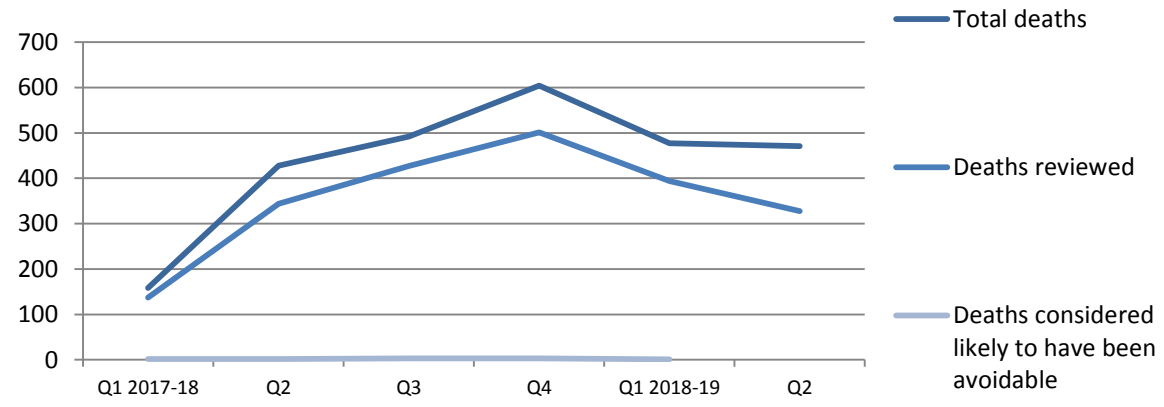
Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable	
Q2 2018/19	Q1 2018/19	Q2 2018/19	Q1 2018/19	Q2 2018/19	Q1 2018/19
471	477	328	394	0	1
Qs1 & 2 2018/19	Last year 2017/18	Qs1 & 2 2018/19	Last year 2017/18	Qs1 & 2 2018/19	Last year 2017/18
948	1682	722	1409	1	10

Trend over time

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable

(Note: Changes in recording or review practice may make comparison over time invalid)



For adult patients with a registered learning disability the metrics are:

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	F2

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in Scope		Total Deaths Reviewed using the SJR process		Total Number of deaths considered to have been potentially avoidable	
Q2 2018/19	Q1 2018/19	Q2 2018/19	Q1 2018/19	Q2 2018/19	Q1 2018/19
2	1	2	1	0	0
Qs1 & 2 2018/19	Last year 2017/18	Qs1 & 2 2018/19	Last year 2017/18	Qs1 & 2 2018/19	Last year 2017/18
3	11	3	5	0	0

Learning from deaths

Each speciality is expected to hold regular mortality and morbidity meetings, usually monthly. At these meetings the issues identifed through the mortality review process are reviewed. Where the issues are local to that speciality actions to improve the quality of care are devised at the meeting. These are reported to the divisional management teams monthly. Where issues are beyond the scope of the individual speciality team to improve these are escalated to the divisional management team in the same report. The divisional management teams report to the Monthly mortality review group with respect to quality improvements made at speciality and divisional level. Where it is felt that an organisational approach to a quality improvement issue is required this is raised at the CGG through the monthly report from the MRG.

Currently, the mortality review process is being reviewed and strengthened to ensure learning from deaths is improved to deliver better patient care.

Examples of improvements in the quality of care resulting from the mortality review process are contained in Appendix 1 and the Shared Learning pathway in Appendix 2

Recommendations

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

Appendices

Appendix 1: Examples of quality improvement from mortality reviews
Appendix 2: Shared Learning pathway

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	F2

Appendix 1
Lessons and change in practice as a result of mortality reviews 2018/19

April

- Modification in PCI criteria for patients with cardiogenic shock and poor pre-event status.
- Incorporation of NEWS 2 into high care observation charts
- End of day ward round to review pm admissions on respiratory ward
- Improved process of discharge of patients on long term oxygen therapy from general medical wards
- Change in admission pathway to ensure all decompensated cirrhotic patients are admitted to the gastroenterology ward
- Changes in the way cardiotogographs are viewed and interpreted to reduce the risk of error.

May

- Introduction of pre-optimisation process for higher risk surgical patients
- Improvements in the #NOF pathway to facilitate blood product availability pre-operatively
- Development of consistent pathway between T&O and A&E for VTE prophylaxis for patients with lower limb fractures

June

- Improvement in pathway for patients not on a respiratory ward but with interstitial lung disease to get a Respiratory Consultant review within 24 hours of referral
- DNACPR considered on admission and as part of ward round reviews: pilot in gastroenterology
- Wider choice of modes of CPAP delivery to reduce ICU delirium

July

- Change in T&O rota's to facilitate earlier THR for patients with a fractured neck of femur
- Improved pathway for responding to a mental health crisis in hospital inpatients
- Improved recording of MDT outcomes in the patient record
- Improved access to interpreter services

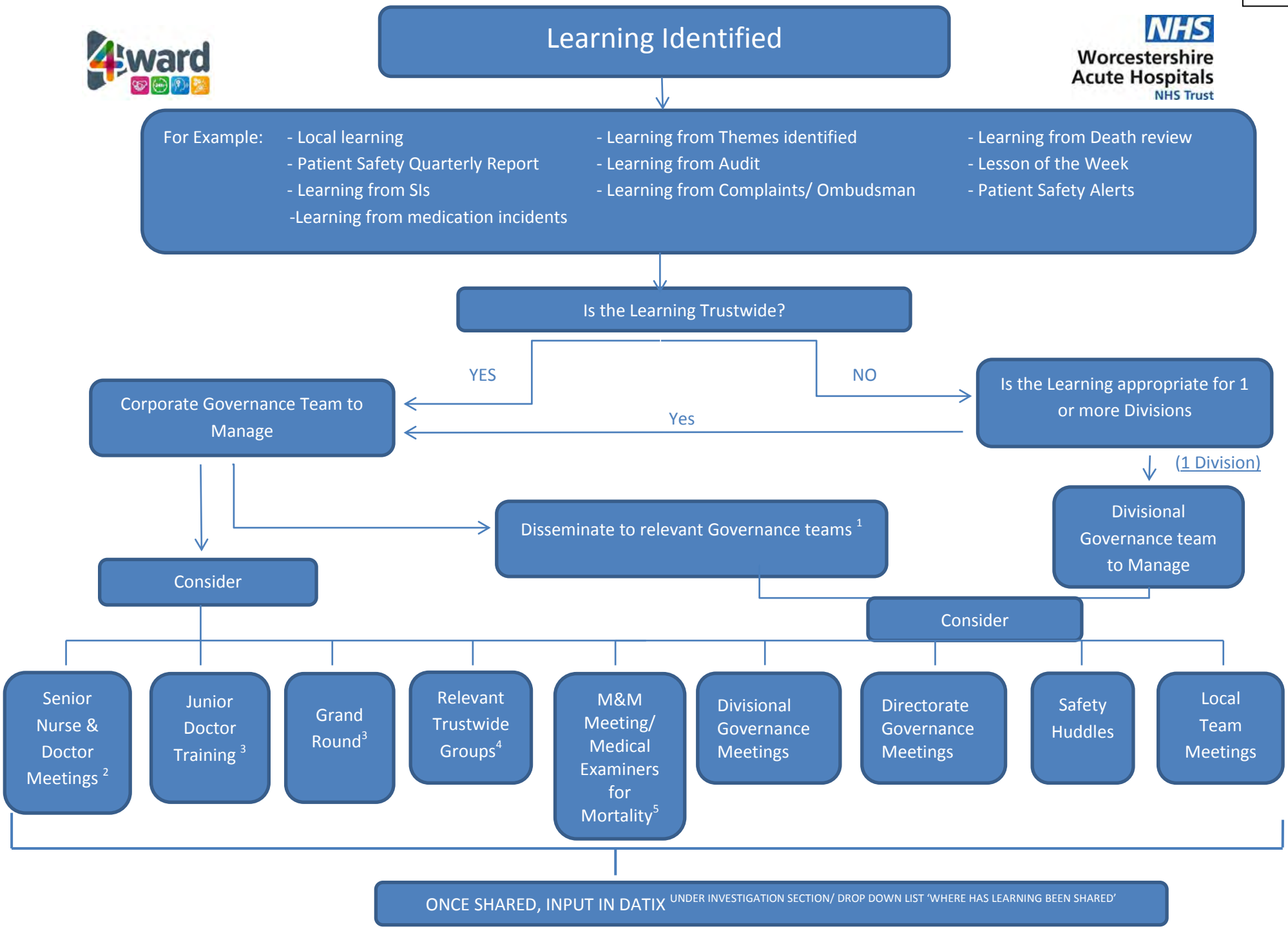
August

- Change in infection prophylaxis regime in some oncology patients to ensure specific infections are covered

September

- Change in care pathway for patients with ascites to limit beta blocker use

APPENDIX 2


Learning Identified
For Example:
- Local learning
- Patient Safety Quarterly Report
- Learning from SIs
-Learning from medication incidents
- Learning from Themes identified
- Learning from Audit
- Learning from Complaints/ Ombudsman
- Learning from Death review
- Lesson of the Week
- Patient Safety Alerts
Is the Learning Trustwide?
YES
NO
Corporate Governance Team to Manage
Is the Learning appropriate for 1 or more Divisions
Yes
(1 Division)
Divisional Governance team to Manage
Disseminate to relevant Governance teams [1]
Consider
Consider
Senior Nurse & Doctor Meetings [2]
Junior Doctor Training [3]
Grand Round[3]
Relevant Trustwide Groups[4]
M&M Meeting/ Medical Examiners for Mortality[5]
Divisional Governance Meetings
Directorate Governance Meetings
Safety Huddles
Local Team Meetings
ONCE SHARED, INPUT IN DATIX UNDER INVESTIGATION SECTION/ DROP DOWN LIST 'WHERE HAS LEARNING BEEN SHARED'

1. Divisional Governance Teams:

- Surgery
- SCSD (SCSDGovernanceTeam@nhs.net)
- Women and Children's
- Urgent Care wah-tr.medicinegovernance@nhs.net
- Speciality Medicine wah-tr.medicinegovernance@nhs.net

2. Senior Nurse Meeting

- Send to PA to CNO

Senior Doctor Meeting

- Send to …….

3. Junior Doctors Training/ Grand Round

Send to:

- Director of Education
- Education Team
- College Tutor

4. Relevant Trustwide Groups

- Mortality Review Group
- Resus and Deteriorating Patient Group
- Patient and Care Working Group
- Research and Development Working Group
- Safety Harm Working Group – Including: Tissue Viability, Falls, Nutrition and Hydration, VTE
- Infection Prevention Control
- Safeguarding Forum
- Medicines Safety Committee
- Serious Incident Review and Learning Group
- Caring Safely Task and Finish Group

5. Medical Examiner for Mortality

Send to Mortality Lead for dissemination.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	F3

Report on Nursing and Midwifery Staffing Levels – October 2018

For approval:		For assurance:		To note:	x

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome
People and Culture Committee	18th December 2018	Received for assurance

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

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

Recommendations	The Board is requested to note this report.

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	F3

Executive Summary

This paper provides an overview to the People & Culture Committee of the nursing and midwifery staffing levels for the planned and the actual staffing levels for October 2018.

The paper provides an overview of the Trust's position regarding the mandatory submission for nursing fill rates, required by the Department of Health via UNIFY, highlighting key areas of risk and the mitigation taken at Divisional/ Directorate level.

The paper also includes an overview by Division of their staffing position for registered and non – registered staff and the turnover rate is included, which indicates the ability of the organisation to retain staff against the regional and national benchmarks.

Risks and incidents which have been attributed to staffing levels are also provided in order to review the impact and outcomes on patients.

Safe staffing levels are in place across the Trust and the mitigation is detailed in Appendix 1.

Background

The Trust is required to submit monthly data to Unify. This information provides the detail per ward of the nursing and midwifery staffing fill rates and bed days. This information is displayed on the Trust's website.

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

The staffing levels fill rates are RAG rated as Green above 90%, Amber 80-89% and Red below 79%. Areas showing as more than 100% will have used additional staff to their ward establishment. Reasons for this include, increased capacity i.e additional beds being open, and one to one nurse to patient ratio to provide enhanced observations for specific patient needs (specialling).

Issues

Staffing levels/Vacancies

The data below in Table 1 highlights the funded and in post rates within the nursing workforce for October 2018.

Overall the nursing and midwifery vacancies have decreased by 23 whole time equivalent (wte) for Health Care Assistants (HCAs). This decrease is as a result of the targeted recruitment campaign from September 2018 for HCA vacancies within the Trust in support of winter pressures. The RN vacancy rate is stable.

Table 1

Vacancy (Trust wide)	October 2018
Qualified	233.75
Unqualified	25.88
Total	259.63

Over the next two months there are a further 40 HCAs due to commence employment within the Trust. These staff have been recruited to support winter pressures and the additional Wards at the Alexandra Hospital site (Ward 4 and Ward 1) and the winter ward on the Worcester Royal Hospital site. Table 2 provides a summary of the vacancy rates across the Divisions.

Table 2

Division	**RN vacancy wte**	**HCA vacancy wte**	**Concerns**
Speciality Medicine*	81.75	17.12	Wards with vacancies greater than 25% of their establishment are Avon 3 and Acute Stroke, ward 11, Evergreen, ward 12.
Urgent Care	48.91	0	The ward with a vacancy factor of greater than 25% is Medical Assessment Unit at the Alexandra Hospital site.
Surgery	47.26	6.71	Wards with a vacancy factor greater than 25% of their establishment is Trauma and Orthopaedics and ward 17.
SCSD	45.19	1.15	No areas above 25%
Women & Children	10.64	0	No areas above 25%

*These figures exclude the additional winter wards

Actions to support proactive recruitment.

- Increased profiling of medicine and surgery in both recruitment events and adverts, This includes targeted recruitment for specialty wards/ units rather than generic recruitment adverts. This includes the use of social media which was very successful for HCAs.
- Wards with vacancies greater than 25% - prioritise block booking of bank and agency to ensure safe cover.
- A specialised managed agency project – “project nightingale” will be in place from December 2018 to support safe staffing of the winter wards. This will be provided through an external company supporting the Trust to fill substantive vacancies with the same agency staff from December until the end of March.

- A weekly staffing meeting involving DDNs and Workforce Leads/ Deputy CNO is in place to provide oversight of planned staffing and actual staffing numbers and actions in place for escalation.
- Wards with >25% vacancies will have a monthly workforce review meeting.

Fill rates of staffing shifts
Fill rates are calculated from the expected level of staffing on a shift by shift basis against what was actually provided. This data is produced from the safer staffing app and submitted to Unify in response to Lord Carter's recommendations. The full data set is provided in the unified data - Appendix 1.

Overall Trust position
Table 3 demonstrates the average fill rates across the Trust. It is a concern that the fill rate for trained and untrained staff on the day shift is under 90%. This is a driver for Project Nightingale where temporary staff are being brought in to cover lines of off duty in wards/departments to enhance safer staffing levels. The Trust is working with 2 companies to support the wards having temporary staff working lines of off duty. The total number of staff which they are expected to provide is up to 150 wte.

Table 3 Trust wide RN/HCA fill rates for days and nights

RN day	RN night	HCA day	HCA night
88.9%	**93.6%**	**89.1%**	**105%**

For October 2018 wards that have triggered red on the Unify data in Appendix 1 have the explanation and mitigation detailed within the Appendix.

Staffing is reviewed by the Matrons and Divisional Directors of Nursing three times a day and by the matrons on call overnight. Mitigation processes are activated in real time when temporary staffing measures are not achieved. These included reviews of the acuity and dependency of patients on wards to ensure needs are being met with reduced staffing numbers. Decisions taken included: cancelling training, use of non-ward based nursing staff, ward managers included in provision of patient care, not opening extra capacity beds and accepting acutely dependant patients.

Work is progressing for the implementation of the Allocate safe staffing module that will provide a greater accuracy in reporting staffing in real time going forward. A pilot of 4 wards commenced this month. The full implementation of the NHSP interface and the safer care module from Allocate will have all inpatient wards live on the system from the end of April 2018.

Incident reports and red flags
In October 2018 there were 74 Incidents reported with the specific category of nurse/midwifery staffing. The number of reported incidents that fall within the red flag criteria has reduced from the previous report in August and September which was 159.

The red flag shifts were indicative of events where staffing could be a causative factor; these incidents were triangulated with red triggered fill rates on the Unify data. These incidences

were all recorded on Datix where staff select the appropriate outcome of short staffing. Table 4 provides a breakdown of red flag shifts reported.

Table 4 Incident reported with category nurse/midwifery staffing

	No Harm	Minor Harm	Moderate Harm
October 2018	64	9	1

Staffing incidents of harm
There was 1 moderate harm incident reported which describes the use of theatre recovery as an escalation area. The harm was a generic harm as this could have impacted on patients receiving their surgery in a timely fashion.

There were 9 incidents that reported minor harm. All nine were related to situations where there has been decreased staffing on shift. In all incidents, mitigations have been put into place through the use of either bank or agency, moving staff from neighbouring wards to ensure patients' needs were met.

Winter planning
In meeting the increased needs of patients during winter, increased numbers of nursing staff are required. This totals 61.76 WTE RN's and 91.21 HCA's. There is a recruitment drive in place for recruitment of health care assistants.

Proactive Recruitment in place

- Social media continues to be actively used to raise the trust's profile regarding nurse vacancies and opportunities being offered through targeted advertising.
- Fortnightly staffing meeting will now become weekly during winter months to discuss health rosters (e-rostering), vacancies and bank usage ensuring that posts are being actioned appropriately. This is overseen by Chief Nursing Officer and areas where deep dives are needed are being explored through Divisional Directors of Nursing.
- Fortnightly meetings with strategic partners is in place to ensure agency partners and HR, are addressing the agency staff being used appropriately.
- Recruitment of a nurse to have a specific focus on raising the profile of the Trust regarding employment and career opportunities which are available is being explored (a 'recruitment nurse').
- The Lead for Professional Development is working with the University regarding the pre-registration employment process and opportunities and the 'Golden ticket' approach to support Worcester University student nurses to be guaranteed a post on qualifying.
- The Lead for Nursing Workforce will work with HR in raising profile of nursing in local schools for Worcestershire.
- The Professional Development Team are supporting recruitment events planned for 2019.

Recommendations	The Board is requested to note this report.

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	F3

Appendices

Appendix 1 – Unify Data – October 2018

APPENDIX 1

RAG RATED DATA - OCTOBER 2018 ACUITY Day And Night						
Ward	Specialty	Average fill rate - registered nurses/ midwives (%)DAY	Average fill rate - care staff (%) DAY	Average fill rate - registered nurses/ midwives (%)Night	Average fill rate - care staff (%) Night	Mitigation
Acute Stroke Unit	328 - STROKE MEDICINE	82.5%	97.7%	91.6%	96.8%	
Avon 2	301 - GASTROENTEROLOGY	89.2%	95.2%	76.3%	108.1%	Robust governance around rosters 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and chief nurses. If shifts do not fill and on completion of ward risk assessment, swift escalation to all tiers of agency including Mayday and Thornbury. Datix unsafe shift(s) and completion of the acuity tool to capture acuity and dependency of patients. If night qualified numbers remain below 90% the ward will not board patients from 6am (approx. time) Difficult to support sister ward (A3) as same shifts difficult to cover

Avon 3	350 - INFECTIOUS DISEASES	91.4%	94.4%	78.5%	100.0%	Robust governance around rosters 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and chief nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Datix unsafe shift(s) and completion of the acuity tool to capture acuity and dependency of patients. If night qualified numbers remain below 90% the ward will not board patients from 6am (approx. time) Difficult to support sister ward (A2) as same shifts difficult to cover Operation nightingale to be considered to support this ward
Avon 4	430 - GERIATRIC MEDICINE	93.5%	126.8%	100.0%	116.9%	
Beech A	100 - GENERAL SURGERY	99.5%	94.1%	66.7%	98.4%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Established for 3 RNs on night duty. Can safely run with 2 RNs at times when patient acuity allows.
Beech B	100 - GENERAL SURGERY	71.8%	137.1%	87.1%	87.1%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Ward safely covered with RNs as co located ward support if RN levels reduced on Beech B.
Beech C	100 - GENERAL SURGERY	83.3%	75.8%	100.0%	100.0%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Able to safely cover with an HCA less on nights as dictated by patient acuity.
Coronary Care	320 - CARDIOLOGY	98.4%	-	100.0%	-	

Critical Care	192 - CRITICAL CARE MEDICINE	72.8%	61.3%	78.5%	-	The unit is managed as a county wide unit. Safe staffing is in place for both units and reflects the numbers of patients who are being nursed.
Critical Care	192 - CRITICAL CARE MEDICINE	96.9%	62.9%	97.7%	-	The unit is managed as a county wide unit. Safe staffing is in place for both units and reflects the numbers of patients who are being nursed.
EGAU/ANW Gynaecology	502 - GYNAECOLOGY	96.8%	77.4%	91.9%	77.4%	Unit safely staffed for patient acuity and activity.
Evergreen	430 - GERIATRIC MEDICINE	76.2%	119.4%	66.7%	160.2%	Qualified staff for Evergreen remains a concern on days and nights. In view of this when unable to fill shifts, extra HCA are booked to support the team. Robust governance around rosters 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Datix unsafe shift(s) and completion of the acuity tool to capture acuity and dependency of patients. Support from Avon 4 if able – When Evergreen staff depleted Avon 4 puts out shifts to support the ward. Operation Nightingale supporting this ward
Head and Neck	145 - ORAL & MAXILLO FACIAL SURGERY	102.4%	84.7%	101.6%	50.0%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Unit safely staffed on nights as can managed at times with 1 HCA down if not able to be covered.
Laurel 1	320 - CARDIOLOGY	100.0%	96.8%	111.3%	119.4%	
Laurel 2	340 - RESPIRATORY MEDICINE	102.4%	95.2%	100.0%	98.4%	
Laurel 3	303 - CLINICAL HAEMATOLOGY	81.0%	73.7%	91.9%	138.7%	HCA on days has decreased fill rate. As of 4/12 and post discussion with Deputy and Chief Nursing Officer, if HCA shifts do not fill and the ward is deemed unsafe/high risk, authorisation to go to agency has been granted. Robust governance needed and strict monitoring of these requests.

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Laurel CCU	320 - CARDIOLOGY	98.4%	-	98.4%	-	
Lavender Suites	501 - OBSTETRICS	89.4%	84.1%	97.2%	94.0%	
MAU	300 - GENERAL MEDICINE	87.1%	83.9%	95.7%	90.9%	
Medical Assessment Unit	300 - GENERAL MEDICINE	83.2%	104.3%	81.9%	93.5%	
Medical Short Stay	300 - GENERAL MEDICINE	91.0%	73.7%	93.5%	107.5%	Ward Manager worked within the numbers to ensure patient safety
Neonatal TCU	422 - NEONATOLOGY	83.9%	95.2%	87.1%	96.8%	
Neonatal Unit	422 - NEONATOLOGY	89.4%	56.5%	95.5%	48.4%	Safe staffing in place for the numbers of babies being cared for. Clear escalation in place for safer staffing.
Riverbank	420 - PAEDIATRICS	91.4%	56.5%	101.1%	109.7%	Safe staffing in place for the numbers of children being cared for. Clear escalation in place for safer staffing.
SCDU	100 - GENERAL SURGERY	93.5%	94.4%	100.0%	203.2%	
Silver Assessment Unit	800 - CLINICAL ONCOLOGY	104.3%	75.0%	95.7%	94.6%	Safe staffing in place. The establishment is being reviewed in the light of the acuity study to confirm the number of staff required.
Surgical High Care Unit	100 - GENERAL SURGERY	93.0%	80.6%	97.8%	109.7%	
Trauma and Orthopaedic A	110 - TRAUMA & ORTHOPAEDICS	67.2%	136.3%	95.2%	98.4%	The orthopaedic unit is being managed as a whole 36 bedded unit. Safer staffing in place across the unit. This will be reported as one unit in the next report.
Trauma and Orthopaedic B	110 - TRAUMA & ORTHOPAEDICS	106.5%	72.6%	104.8%	77.4%	The orthopaedic unit is being managed as a whole 36 bedded unit. Safer staffing in place across the unit. This will be reported as one unit in the next report.
Vascular Unit	100 - GENERAL SURGERY	83.2%	66.1%	99.2%	51.6%	Unit safely staffed for the patient numbers and their acuity.
Ward 1	100 - GENERAL	104.0%	100.0%	100.0%	-	

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	SURGERY					
Ward 10	101 - UROLOGY	108.6%	94.6%	100.0%	106.5%	
Ward 11	100 - GENERAL SURGERY	69.7%	89.1%	143.5%	153.2%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Datix unsafe shift(s) and completion of the acuity tool to capture acuity and dependency of patients. In view of this when unable to fill shifts, extra HCA are booked to support the team. Operation Nightingale to be considered to support this ward. This ward is high risk in regards to falls risk. Day shifts are more difficult to cover. Ward Manager counted in the qualified numbers on daily
Ward 12	430 - GERIATRIC MEDICINE	72.6%	93.5%	93.5%	103.2%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Datix unsafe shift(s) and completion of the acuity tool to capture acuity and dependency of patients. Operation Nightingale to be considered to support this ward. This ward is high risk in regards to falls risk. Day shifts are more difficult to cover. Ward 11 not able to support Ward managers in the numbers.
Ward 14	430 - GERIATRIC MEDICINE	82.8%	95.2%	98.4%	98.4%	
Ward 16	110 - TRAUMA & ORTHOPAEDICS	94.8%	73.4%	75.3%	95.2%	Staffing flexed to meet the patient acuity, safe staffing in place.
Ward 17	110 - TRAUMA & ORTHOPAEDICS	95.2%	101.2%	97.8%	97.6%	

Ward 18	100 - GENERAL SURGERY	79.7%	70.7%	100.0%	103.7%	Safer staffing levels confirmed.
Ward 2	302 - ENDOCRINOLOGY	89.8%	100.0%	68.8%	180.6%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Datix unsafe shift(s) and completion of the acuity tool to capture acuity and dependency of patients. If night qualified numbers remain below 90% the ward will not board patients from 6am (approx. time).
Ward 5	340 - RESPIRATORY MEDICINE	73.9%	95.2%	77.4%	111.3%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Datix unsafe shift(s) and completion of the acuity tool to capture acuity and dependency of patients. If night qualified numbers remain below 90% the ward will not board patients from 6am (approx. time) Operation Nightingale to be considered to support this ward This ward is high risk in regards to falls risk. Day shifts are more difficult to cover.
Ward 6	320 - CARDIOLOGY	75.8%	89.8%	101.6%	104.8%	Robust governance around rotas 6 weeks in advance. All shifts are out to NHSP 6 weeks in advance. Ward Manager proactive with shift swaps to cover outstanding shifts, if unsuccessful clear escalation to Matron/DDDN/DDN and Chief Nurses. If shifts do not fill and on risk assessment escalation to all tiers of agency including Mayday and Thornbury. Datix unsafe shift(s) and completion of the acuity tool to capture acuity and dependency of patients. If night qualified numbers remain below 90% the ward will not board patients from 6am (approx. time) Operation Nightingale to be considered to support this ward This ward is high risk in regards to falls risk. Day shifts are more difficult to cover.

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Service Reconfiguration Plan

For approval:		For assurance:	x	To note:	

Accountable Director	Paul Brennan Acting Chief Executive		
Presented by	Paul Brennan Acting Chief Executive	**Author /s**	Paul Brennan Acting Chief Executive

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	4, 5, 6, 7,9 and 12

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

Recommendations	The Trust Board is invited to note that maintaining patient safety across the urgent care pathway is the primary aim and within this context we have set key objectives to underpin the delivery of safe and effective care by the end of January 2019 and the implementation of the required changes to enable the MAU and MSSU to operate as assessment and short stay units respectively by April 2019. The Trust Board is recommended to approve the increase in the financial allocation from £4.2m to £5.4m to fund the proposed service reconfiguration and bed capacity increases across the Trust.

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Executive Summary

The Trust Board is invited to note the key objectives to underpin the delivery of safe and effective care.

Background

1. Bed Capacity

he Trust provides inpatient care across three sites, although provision at Kidderminster is limited to a single day ward with overnight stay provision, from a total of 828 inpatient beds in 46 wards. The General and Acute bed stock is 663 with 379 beds at Worcester Royal Hospital and 284 at the Alexandra Hospital. The remaining 165 beds are predominately located at Worcester Royal Hospital for intensive and high care, Obstetric, Paediatric and Neonatal services.

On regular occasions the Trust opens a range of clinical areas such as Endoscopy, Theatre Recovery, AEC and the Frailty Unit to accommodate patients overnight due to capacity limitations to cope with the prevailing demand. In addition the Medical Assessment Unit (MAU) and Medical Short Stay Unit at Worcester Royal Hospital are actually operating as a short stay ward and acute medical ward respectively thereby limiting flow and the potential to avoid admission. The average length of stay in MAU is 1.2 days against an expected maximum stay of 12 hours and the corresponding position for MSSU is 3.8 days against an expected maximum stay of 48 hours. The Trust also has a significant number of patients with an average length of stay in excess of 14 days. A MDT (multidisciplinary team) review of patients waiting over 14 days on the 10th October 2018 identified 133 such patients of which 62 no longer required acute hospital care; the major reasons were waiting for a community hospital bed (12 patients), waiting a nursing home placement (10 patients), discharge delay but ready to return home (10 patients), waiting social care provision (5 patients) and identified for discharge tomorrow but fit for discharge today (5 patients).

The CCG commissioned Carnall Farrar to undertake a demand and capacity review to provide an independent assessment of the System Winter Plan to determine whether sufficient capacity existed to manage the forecast demand. The outcome of the Carnall Farrar assessment was:

- Without any intervention to operate at 92% occupancy there is a shortfall of 109 general and acute beds in the Acute Trust, including ED corridor demand, at the peak point of demand in February 2019 reducing to a shortfall of 88 in August 2019.
- Split by site the analysis indicates a shortfall of 119 at Worcester Royal and an overcapacity of 10 at the Alexandra Hospital in February 2019. The corresponding bed numbers for August 2019 are forecast to be a shortfall of 102 beds at Worcester and an overcapacity of 14 beds at the Alexandra Hospital.
- The impact of the proposed System Winter Plan, excluding the proposal to open additional capacity in Aconbury, indicated that if all demand, capacity and community change levers had the desired impact this could reduce the bed shortfall to 29. Under this scenario the position at Worcester Royal Hospital is a bed shortfall of 69 offset by a surplus of 40 beds at the Alexandra Hospital.

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2. Emergency Access Indicators

Emergency Department activity and 4 hour performance indicators for 2017/18 and April to September 2018 are shown in the table below.

	2017/18		April to September 2018	
Indicator	Activity	Performance	Activity	Performance
ED Attendances	130,305		67,796	
Breaches	39,263	69.87%	22,465	66.86%
Admitted Attd's	39,091		19,322	
Admitted Breaches	22,378	42.75%	11,895	38.44%
Non Admitted Attd's	91,214		48,474	
Non Admitted Breaches	16,885	81.49%	10,570	78.2%

Activity and performance for the period the 1st April to the 31st December 2018 is shown in the table below.

Indicator	WAHT
ED Attendances	94,941
Breaches	34,767
Performance	63.38%
Admitted Attd's	27,898
Conversion Rate	29.38%

In addition to the above activity 53,139 patients have been treated in the Minor Injuries Units at Kidderminster, Bromsgrove, Tenbury, Evesham and Malvern during the period 1st April 2018 to 31st December 2018. This activity is included in the Trust's Emergency Access Standard national returns, in line with NHSI/E guidance, which means the reported performance for the year to date is 76.46%. For the purpose of this report the focus is on improving flow through the Trust's type 1 Emergency Departments at the Worcester Royal and Alexandra Hospitals as year to date only 63% of patients have been treated and discharged within four hours.

3. Focus for January 2019 to March 2019

Maintaining patient safety across the urgent care pathway is the primary aim and within this context we have set a number of key objectives to underpin the delivery of safe and effective care. These key objectives are:

- No patient requiring overnight care is to be placed outside a designated inpatient ward
- No patient is to experience 12 hour plus waits in our Emergency Departments
- No patient is to wait more than 30 minutes from arrival by ambulance to handover to our Emergency Departments
- A maximum length of stay in the Medical Assessment Unit (MAU) of 12 hours and 48 hours in the Medical Short Stay Unit (MSSU).

The Trust is committed to achieve the first three objectives by the end of January and to implement the required changes to enable the MAU and MSSU to operate as assessment

and short stay units respectively by April 2019. In order to deliver these key objectives the following actions are being implemented:

- The Alexandra Hospital will be designated as the centre for fractured neck of femur. Approximately 450 patients present to Worcester Royal Hospital per annum utilising the equivalent of 15 inpatient beds. Average length of stay for this procedure is 11.5 days at Worcester and 15 days at the Alexandra. To accommodate the additional activity at the Alexandra Hospital William Ashley Ward at Evesham Community Hospital opened in December 2018 as a 16 bed fractured neck of femur step down and rehabilitation ward with patients transferring four days post operatively. This has been implemented for patients currently undergoing their procedure at the Alexandra Hospital and the transfer of the service from Worcester Royal Hospital is to be implemented on the 3rd January 2019 releasing 15 beds at Worcester by the 15th January 2019.
- There are currently three wards on the Alexandra site that are used to varying degrees for ambulatory, outpatient and day care services. These are Ward 9/Garden Suite is a 24 bed ward currently part used as a chemotherapy day unit, Ward 4 is a 22 bed ward on the ground floor currently part used as a Frailty Unit and Ward 1 is a 19 bed ward currently part used as a Children's Outpatient and assessment unit. The Frailty Unit has been relocated to the unoccupied bays on Ward 9 alongside the chemotherapy unit and the Paediatric service has been relocated to outpatient facilities on the site. This has released 41 beds at the Alexandra Hospital for alternative use.
- Ward 1 will become the medically fit for discharge unit (currently located on Ward 11), Ward 11 will be designated the Frailty Inpatient Unit (currently located on Ward 12) and Ward 12 will used as a Frailty Decision Unit (6 beds) and Frailty Short Stay Unit (22 beds) integrated with the Frailty Assessment Unit. This will be implemented on the 28th January 2019.
- Ward 4 will open as a 22 bed Medical Short Stay Unit on the 28th January 2019, but in the interim will operate as a 16 bed acute medical ward.
- The Trust will reinforce with the West Midlands Ambulance Service the previously agreed post code changes (WR 10 – Evesham, WR11 – Pershore and DY10/11) to convey general medical patients to the Alexandra Hospital
- implement a further post code change (Droitwich and Kidderminster) for general medical patients to be directed to the Alexandra Hospital

The transfer of Frailty and fractured neck of femur services to the Alexandra Hospital, alongside the post code changes (equating to an additional 23 ED attendances and 11 admissions) will release the equivalent of 56 beds at the Worcester Royal Hospital between the 3rd and 28th January 2019. In addition the Trust will open an additional 28 bed acute medical ward in the Aconbury Building following the commissioning of the link bridge on the 16th January 2019 providing an overall increase in capacity of 84 beds at Worcester Royal Hospital

4. **Final Implications**

The Winter Plan originally approved by the Trust Board was based on a financial allocation of £4.2m. The proposals outlined in section 3, whilst negating cost elements of the original plan, for example closing surge areas such as Endoscopy Recovery, will have an overall financial cost of £5.4m. The additional £1.2m cost associated with the proposed changes has been included in the Trust Forecast Outturn assessment being presented to the Trust

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Board on the 10th January 2019. A breakdown of the costs is shown in the table below.

	FY £k	Start date	Status
41 extra beds baseline - (based on 46 beds model agency premium including Thornbury)	833	Dec-18	16 beds already committed, remainder to be open by end of January
Alex Take investment on top of additional beds	525	Dec-18	
ID Medicial premium investment (130 Nurses)	792	Dec-18	Committed - on site December
Corporate/AMIT incremental overheads from additional beds	230	Dec-18	16 beds already committed, remainder to be open by end of January
Fractured NOF	417	Jan-19	Evesham beds used in December but Surgery activity moved to AGH site from 2nd January
Historic winter spend up to end of Nov Plus existing surge costs until cessation (includes stopping Endoscopy)	1,575	Apr-18	Committed - already incurred or can't exit until remainder of site move completed
Evergreen 2 opening	700	Jan-19	Due to cooincide with opening of link bridge on 16th January
Other identified costs	318		
Total	**5,390**		

Issues and options

The Quality Impact Assessment will be considered by the A&E Delivery Board Operations Group on the 15th January 2019, the A&E Delivery Board on the 22nd January 2019 and the Trust Quality Governance Committee on the 24th January 2019.

Recommendations

The Trust Board is invited to note that maintaining patient safety across the urgent care pathway is the primary aim and within this context we have set key objectives to underpin the delivery of safe and effective care by the end of January 2019 and the implementation of the required changes to enable the MAU and MSSU to operate as assessment and short stay units respectively by April 2019. The Trust Board is recommended to approve the increase in the financial allocation from £4.2m to £5.4m to fund the proposed service reconfiguration and bed capacity increases across the Trust.

Appendices - none

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Audit and Assurance Committee Assurance Report

For approval:		For assurance:	x	To note:	

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

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

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

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Executive Summary

The Committee met on November 20 and discussed the following items:

- **IT systems audit**: The Trust Board has requested that the Committee have regular updates on the progress of the actions associated with this audit, undertaken in 2017/18. Whilst it was obvious progress has been made, it was evident that the new management arrangements in respect of IT were being embedded. We have asked for a further progress report at the next meeting. It was agreed that there were no significant concerns with the progress being made.
- **Evaluation of the Finance and Performance Committee**: the Chairman of the F&P Committee attended and spoke about the work of the Committee. There was a commitment to review the current lengthy agenda at an away day to be held in January 2019. One area that the Chairman felt could be usefully included within the work plan was the monitoring of the PFI contract. He was pursuing this with the Chief Financial Officer.
- **Internal Audit**: There was good progress reported on the Audit Plan. The number of high level actions was reducing and after the meeting several would be able to be closed as they related to items on the agenda.
    - **Patient monies audit**: Moderate assurance was provided for this audit. Considerable progress has been made since the audit was undertaken with the policy being developed and new procedures being put in place. As this is an area where controls have not been as robust as they could be, internal Audit will undertake a follow-up audit in early 2019/20.
    - **Complaints follow-up**: Internal audit was complimentary about the progress of managing complaints. There continue to be challenges with the use of Datix but the new Complaints Manager had a clear grip on the issues. The report was considered by the Quality Governance Committee at its meeting on 22 November.
    - **Data Security and Protection Toolkit**: this review was a stocktake of the new Toolkit. Progress was as to be expected. This is being overseen by the Information Governance Steering Group and the Committee will receive a report in relation to the compliance prior to the submission on 31 March 2019.
    - **Delayed Discharges and Stranded Patients – follow up**: This follow up audit showed that limited action had been taken in respect of the recommendations in the audit undertaken 12 months' previously. The Internal Audit Manager was liaising with the new Chief Operating Officer who was reviewing all the systems and processes. A further audit will be carried out early in 2019/20.
- **Losses and Special Payments**: The regular six monthly report showed that of the £214k losses reported, the majority was expired pharmacy stock, but the amount was less than 1% of the value of the total drug stock. The Head of Pharmacy will be attending our next meeting to explain the mechanisms in place to minimise the losses.
- **Midyear Annual Governance Statement**: The significant issues as presented were agreed. These were relating to finance, operational performance, infection control and quality special measures.

Other items that were considered were:

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- Tender waivers
- Counter fraud annual report
- Counter fraud progress report
- Invoice fraud checklist
- Employment agency invoicing
- Work plan

Background

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

Issues and options

Recommendations

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

Appendices

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Meeting	Trust Board
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Paper number	G2

Charitable Funds – Report to Trust Board, the Corporate Trustee

For approval:	x	For assurance:		To note:	

Accountable Director	Mark Yates Charitable Funds Committee Chairman		
Presented by	Mark Yates Charitable Funds Committee Chairman	**Author /s**	Kimara Sharpe Company Secretary

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

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

Recommendations	The Board, as the Corporate Trustee, is requested to: • Note the report • Approve the revised terms of reference

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Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	G2

Executive Summary

The Charitable Funds Committee met on 4 December and discussed the following items:

- **CCLA quarterly report, market report and benchmarking information**: This showed a growth of funds for the full year. Investment managers will be attending our next meeting to discuss whether the investment portfolio needs to be revised.
- **Terms of Reference**: The Committee has extensively reviewed the terms of reference and present them attached to this report for approval.
- **Annual Report, Final Accounts and Audit Opinion (attached)**: Grant Thornton, the external auditors appointed by the Trust to carry out the audit, presented their report. This was the first time a full audit has been undertaken for a several years. This is because the donations received were in excess of the threshold for an audit vs an examination of the accounts. There were no adjustments to the financial statements, no recommendations for management as a result of the audit work and there are no follow up recommendations from the previous year's audit. A unqualified audit opinion is expected, following receipt of CCLA controls report. The Trust Board, as Corporate Trustee, is requested to note these documents and the audit opinion. The Committee has requested a full audit every three years.
- **Charitable Funds handbook**: This is an excellent publication which explains in simple terms how the Charitable Funds operate and how staff can access them.
- **Reserves Policy**: This was agreed.
- **Staff to support Fundraising**: The Committee acknowledged that more work could be undertaken in this area and have agreed to a six month extension to the current Fundraising Officer's contract and a year's fixed term contract for a Head of Community Development. One function of the latter's role will be to develop a strategy and work plan.
- **Retirement Gifts**: Following the last Board meeting, the Committee were asked to recommend to the Director of People and Culture to develop a policy which ceases the provision of retirement gifts from either charitable funds or the general Trust budget and to reinstate long service awards and a staff awards scheme.

The Committee also received information relating to the fund balances and were pleased that the Trust is working with an expert in this area to determine how the funds can be managed more rigorously.

Background

The Charitable Funds Committee meets twice a year to ensure that the funds donated are being managed and spent in an optimal way. Members of the Charitable Funds Committee are there to ensure that the Trust fulfils its duties as a charity Trustee when it manages the charitable funds.

Issues and options

Recommendations

The Trust Board is requested to

- note this report
- approve the terms of reference

Appendices

- Terms of Reference, Annual Accounts, Annual Report

NHS
Worcestershire
Acute Hospitals
NHS Trust

Terms of Reference

Charitable Funds Committee

Version: 3.1

Terms of Reference approved by: Charitable Funds Committee/Trust Board

Date approved: September 2017/December 2018/January 2019

Author: **Company Secretary**

Responsible directorate: Chief Executive

Review date: by March 2020

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1 Authority

1.1 The Charitable Funds Committee (the committee) is constituted as a standing committee of the Trust Board as the corporate trustee. Its constitution and terms of reference shall be as set out below, subject to amendment at future board meetings.

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

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

1.4 The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 The Committee must act in accordance with any statutory/legal requirements or best practice required by the Charity Commission.

2 Purpose

2.1 The Charitable Funds Committee has been established to manage funds held in trust either as charitable funds or non-charitable funds. The Committee reports to the Trust Board as Corporate Trustee.

3 Terms of Reference

The Trustee is responsible for the overall management of the Charitable Funds. It is required:-

- To ensure that best practice is followed in terms of guidance from the Charity Commission, National Audit Office, Department of Health and other relevant organisations.
- To ensure that the appropriate policies and procedures are in place to support the Charitable Funds Investment Strategy.
- To advise Fund Managers on income and expenditure and that this is reviewed at regular intervals.
- To ensure all income and expenditure is as per the Fund managers' manual
- To review and support the Fundraising Strategy ensuring adherence to the strategic direction of the charitable funds.
- To monitor all significant transactions within charitable funds.
- To monitor the charitable funds of the Trust to ensure that any specific conditions are met.
- To adhere to the Trust Standing Financial Instructions and Scheme of Delegation for charitable funds.
- On an annual basis, to review and approve summary level income and expenditure plans from Fund Managers, ensuring that they complement the strategy.
- To approve expenditure in alignment with the Scheme of delegation

- To review the number of funds on an annual basis and undertake a programme of rationalisation, where appropriate.
- To approve any request to set up new funds and cost centres including research monies ensuring that they meet the criteria for charitable status as specified by the Charity Commission.
- To decide the bases of apportionment for investment income and administration costs, respectively.
- To receive and approve an annual risk assessment.
- To approve the annual financial accounts and annual report, prior to their submission to the Charities Commission.
- To ensure gifted income is used in accordance with Standing Financial Instructions and the purpose stated by the donor.
- To review the internal control arrangements within the Trust, in relation to donated funds held, in conjunction with Internal Audit, External Audit and individual staff.

4 Membership

All Board Directors are Trustees of the Trust's Charitable Funds. The Committee shall be appointed by the Board from amongst the Board and shall consist of three Non-Executive Directors and three Executive Directors.

One of the non-executives shall be the Chair of the Committee.

Members

Three non-executive directors
Chief Financial Officer
Chief Nurse **or** Chief Medical Officer
Director of Communications & Engagement

In attendance: Company Secretary or deputy

The Assistant Director of Finance, Payables and Charitable Funds Manager and the Head of Financial Planning and Financial Services shall normally be expected to attend meetings and report to the Committee on the use of and accounting for funds held on trust. The Committee will request the attendance of others as necessary.

The Trust's Investment Advisors will be required to attend at least one meeting per annum.

Substitutes/Deputies - Any Non-Executive Director of the Trust may act as nominated substitute / deputy in the absence of any Non-Executive Director and this attendance will count towards the quorum. Any Executive Director may act as nominated substitute / deputy in the absence of any Executive Director and this attendance will count towards the quorum.

5 Quorum

A quorum shall consist of three members, of which one shall be the Chair or Vice-Chair of the Charitable Funds Committee.

6 Frequency

Meetings shall be held at a minimum of twice a year. Members are expected to attend at least 50% of the meetings.

7 Record of Business

Minutes of the Committee meetings shall be produced and circulated to the members of the Committee no later than 5 working days following each meeting. The Minutes of Committee meetings shall be formally recorded and a report of each meeting submitted to the Board. The Chairman of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

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

9 Committee Secretary

The Company Secretary is responsible for ensuring the Committee's business is recorded appropriately.

10 Review Period

The Committee membership and Terms of Reference are to be reviewed annually by 31st March.

December 2018

WORCESTERSHIRE ACUTE HOSPITALS CHARITY

TRUSTEES' REPORT

TRUSTEES' ANNUAL REPORT AND FINANCIAL STATEMENTS

YEAR ENDED 31st MARCH 2018

4ward is our Trustwide culture change programme which is helping us build a more positive, supportive workplace for the benefit of our patients and colleagues. At its heart are our four Signature Behaviours.

WORCESTERSHIRE ACUTE HOSPITALS CHARITY

TRUSTEES' REPORT

The Trustees present the Charitable Fund's Annual Report with the Audited Financial Statements for the year ended 31st March 2018.

LEGAL AND ADMINISTRATIVE ARRANGEMENTS

The Charitable Fund is registered with the Charity Commission, registered number 1054612, in the name of "Worcestershire Acute Hospitals Charity."

The maintenance of the accounting records and day-to-day administration of the fund are carried out at Worcestershire Royal Hospital, Finance Department, 2nd Floor, 3 Kings Court, Worcester, WR5 1WS.

Bankers

Lloyds TSB Bank Plc.
4, The Cross
Worcester
WR1 3PY

NatWest Bank Plc.
1, The Cross
Worcester
WR1 3PR

Investment Managers

CCLA Investment Management Ltd
Senator House
85 Queen Victoria Street
London
EC4V 4ET

Auditors

Grant Thornton UK LLP
The Colmore Building
20 Colmore Circus
Birmingham
B4 6AT

CORPORATE TRUSTEE

Worcestershire Acute Hospitals NHS Trust, as Corporate Trustee, is responsible for the proper management and administration of the Worcestershire Acute Hospitals Charity and its subsidiaries. In practise, this means that the Board members of Worcestershire Acute Hospitals NHS Trust act as Trustees on behalf of the Trust in the management and administration of its Charitable Fund.

The Charitable Funds Committee, being a recognised sub-committee of the Trust Board, has delegated authority on behalf of the Trustees in the execution of all responsibilities relating to the Trustees.

The voting members of Trust Board during 2017/18 were as follows:

Caragh Merrick, Chairman
Michelle McKay, Chief Executive
John Burbeck, Non-Executive Director until June 2017
Philip Mayhew, Non-Executive Director
Bill Tunnicliffe, Non-Executive Director
Chris Swan, Non-Executive Director
Mark Yates, Non-Executive Director from August 2017
Steve Williams, Non-Executive Director from January 2018
Bryan McGinity, Non-Executive Director until December 2017
Inese Robotham, Interim Chief Operating Officer from October 2017
Suneil Kapadia, Chief Medical Officer from May 2017
Stewart Messer, Chief Operating Officer until February 2018
Vicky Morris, Chief Nursing Officer
Jim O'Connell, Interim Chief Operating Officer until October 2017
Jill Robinson, Chief Finance Officer
Andrew Short, Interim Chief Medical Officer until May 2017

Non-voting members of Trust Board
Denise Harnin, Director of Human Resources and Organisational Development until September 2017
Kay Darby, Interim Director of Governance Sept 2017 to March 2018
Tina Ricketts, Director of People and Culture from January 2018
Kimara Sharpe, Company Secretary
Sarah Smith, Director of Planning and Development
Lisa Thomson, Director of Communications until April 2017
Richard Haynes, Director of Communications and Engagement from September 2017
Haq Khan, Acting Director of Performance until November 2017
Kiran Patel, Medical Advisor until May 2017
Steve Williams, Associate Non-Executive Director from November to December 2017
Mark Yates, Associate Non-Executive Director from May 2017to July 2017
Richard Oosterom, Associate Non-Executive Director from June 2017

TRUSTEES' RESPONSIBILITIES

The Trustees exercise their responsibility for the proper management and control of the Charitable Fund via a system of delegated authorities and formal internal control procedures, as documented within the Trust's Standing Orders and Standing Financial Instructions. These require officials to report to every meeting of the Charitable Funds Committee (CFC) on all issues which require their attention, and on the current financial standing of the Charitable Fund. The CFC in turn report back to the Trust Board all items that need to be brought to its attention, or which are otherwise important or significant. The Assistant Director of Finance has also used the Internal Audit function to carry out regular reviews of Charitable Fund activities and obtains professional advice on other matters where necessary. It is believed that the Trustees have carried out their responsibilities conscientiously and have acted in accordance with the law and the charity's governing documents throughout.

The Trustees acknowledge and accept their responsibility for the major risks to which the Charity is exposed. A schedule of these risks has been produced on behalf of the Trustees, and plans to mitigate the degree of risk have been developed. The risks are subject to regular review, and updates as to the progress of the implementation of action plans. In addition, robust systems of internal control have been implemented which are subject to review by both internal and external auditors on a regular basis. The Trustees adhere to the Trust's Induction and Training Policies.

ORGANISATIONAL STRUCTURE

Following the merger of the former Alexandra Healthcare NHS Trust, Kidderminster Healthcare NHS Trust and Worcester Royal Infirmary NHS Trust, the associated charities of these Trusts were amalgamated under the umbrella of Worcestershire Acute Hospitals NHS Trust Charitable Fund, with effect from 1st April 2000.

The governing document, which originally related to Worcester Royal Infirmary NHS Trust, is dated 15 March 1997. Following the merger, this document was amended on 9 August 2001 to govern the newly amalgamated charity.

The charity has an umbrella registration, with a special purpose charity beneath it:

Umbrella – Worcestershire Acute Hospitals NHS Trust Charitable Fund

Special Purpose – Kidderminster Hospital General Fund

CHARITY OBJECTIVES

The objectives of the charities, as stated in their governing document, are:

Worcestershire Acute Hospitals Charity

The Trustees shall hold the Fund upon trust to apply the income and at their discretion, so far as may be permissible the capital, for any charitable purpose or purposes relating to the NHS, wholly or mainly for the services provided by Worcestershire Acute Hospitals NHS Trust.

Kidderminster Hospital General Fund

The Trustees shall hold the Fund upon trust to apply the income and at their discretion, so far as may be permissible the capital, for any charitable purpose or purposes relating to the NHS, wholly or mainly for the services provided by Kidderminster General Hospital.

MANAGEMENT

The Charitable Fund vested in the NHS Trust is operated through the umbrella charity and special purpose charity named above, with subsidiary designated funds that reflect the wishes of donors. These are for the benefit of both patients and staff, and for research activities, as far as is reasonably practicable. The Charity Trustees have complied with their duty to have due regard to the guidance on public benefit published by the Commission in exercising their powers or duties.

AIMS AND OBJECTIVES

The Trustees aim, through the Charitable Fund, to supplement NHS services, support innovation, encourage professional development and enhance the patient experience.

The principle objective of the Trustees is to ensure that charitable funds are spent on the purpose(s) for which the funds have been established, and are utilised in a timely and appropriate manner. This latter statement is reinforced by the assertion that the Charity aims to spend what it receives in a year. This is achieved by the exercise of control procedures to ensure that expenditure is in line with the stated aims and objectives, and by the monitoring of all individual balances held at each Charitable Funds Committee meeting to ensure adherence to the Reserves Policy as set out on pages 17 & 18 below. The Charitable Funds Committee also requires fund managers to provide to the Committee written expenditure plans for the forthcoming 3 years where the fund balances exceed £7,500.00.

In addition, donors are encouraged to give in a tax efficient manner, in order to maximise income.

SIGNIFICANT ACTIVITIES DURING THE YEAR 2017/2018

Members of the Charitable Funds Committee (CFC) have continued actively to consider appropriate uses for larger funds, consulting with fund managers and operational managers, and proactively pursuing expenditure plans to ensure that the philosophy of "spend it, don't save it" is adhered to. At each Charitable Funds Committee reports are provided on expenditure plans received, plans which are outstanding, and funds of a lower value where there has been little or no expenditure during the last 12 months. An update is also provided as to significant legacies or donations planned or advised, to both ensure that the proceeds are received, and to consider whether investment opportunities may exist.

ACHIEVEMENTS AND PERFORMANCE DURING THE YEAR 2017/2018

As may be seen from the Reserves Policy below, the Trustees' intention is that expenditure in each year will at least equal income, in order to avoid an over-accumulation of funds. This objective is held in balance with the need, at times, to allow a designated fund to build up for a specific purpose. Funds should also be used prudently and not simply to match expenditure to income.

In the year 2017/2018, incoming resources totalled £1,099k, and resources expended totalled £550k, a net gain of £549k. Gains on revaluation of investment assets were £29k, giving a net increase in total funds of £578k. The Charitable Funds Committee has actively reviewed a number of funds where large balances are held, and are pursuing with fund managers their plans for timely use of the amounts in hand.

The Internal Audit Review of the Charitable Fund's accounting system and processes resulted in the Trustees receiving significant assurance that the operation of the system's internal controls can be relied upon to prevent risks from impacting on the achievement of the Charity's objectives.

PLANS FOR FUTURE PERIODS

The Charity Trustees wish to work in concert with the NHS Trust, with a view to using charitable funds in line with the NHS Trust's plans, in order to optimise the benefits received by patients and staff from a coherent strategy and best use of available resources. See also "Expenditure Strategy" on page 9 below.

As stated in the Reserves Policy (see pages 17 & 18), the Trustees will vigorously pursue the preparation of expenditure plans for those funds where balances exceed £7,500.

Performance of Investments will be kept under review to consider whether more modest gains from no-risk investment would be preferable to the potential risk of losses associated with fluctuating market values.

Please see below some of our current Fundraising Appeals.

We need to raise £1 million for the future of prostate cancer surgery in Worcestershire - Rory the Robot!

http://www.rorytherobot.com

Worcestershire is a major urology cancer centre, performing around 125 - 150 radical prostate cancer surgeries a year.

With Rory's assistance, patients will benefit from less pain, minimal blood loss, quicker recovery and reduced complications.

Worcestershire Acute Hospitals Charity launched the £1million Rory the Robot fundraising appeal in March 2014. Since then around £415,000 has been raised towards the cost of a state of the art da Vinci robotic surgical system.

The system itself will primarily be used to treat patients with prostate cancer but has the potential to be utilised by other surgical teams in the future.

In Worcestershire alone there are between 125 to 150 radical prostate cancer operations carried out each year.

Approximately 2,500 men in the region are surviving prostate cancer at any one time.

Prostate cancer unfortunately claims the life of one man every 45 minutes and will be the most common cancer by 2030.

EXPENDITURE STRATEGY – REPLACEMENT OF WORN-OUT EQUIPMENT

Introduction

As a general principal, charitable funds are not used for purposes more properly the responsibility of the NHS. Therefore, replacement of worn-out equipment is not regarded as an appropriate use of the funds.

However, it is understood that in times of financial stringency within the NHS Trust, the interests of patients may best be served by the provision from charitable funds of new equipment to replace outdated or worn out items.

The following expenditure strategy is based upon guidance from the Healthcare Financial Management Association that "charitable funds can be used for NHS statutory purposes as part of a strategy, as opposed to a 'year-end bail out." This guidance is based upon the Charity Commission's Policy Statement of June 2005 on the subject of "Charities and Public Service Delivery." This states that the law does not prevent charities from using their own funds to provide services on behalf of public authorities, even if an authority has a legal duty to provide a service.

Strategy Statement

In light of the above, the Trustees have agreed to broaden the scope of what will be considered as appropriate types of expenditure, to include the replacement of outdated or worn-out items. Proposals for such expenditure will be carefully monitored, to ensure that purchases still meet other criteria, such as compatibility with other equipment in use and with the Trust's overall strategy for the development and delivery of services in the county.

Therefore, applications will be considered from managers of designated funds, and from others wishing to access general-purpose funds, for equipment for which, formerly, the use of charitable funds would have been denied.

However, the Trustees' intention is that the majority of charitable funds should continue to be used for purposes "over and above that which the NHS should provide." Traditionally this includes items which are additional to, or better than those already in use. These either enhance the patient experience or assist the staff in the performance of their work, or both. In addition, staff benefit from the use of funds towards the costs of additional training or attendance at conferences.

On this basis, during the financial year ending 31 March 2018, the Trustees will limit total expenditure on the replacement of worn-out equipment to a sum not exceeding £100,000.

REVIEW OF FINANCIAL POSITION AND ACTIVITY IN THE YEAR

During the year net assets increased by £578k, this is a result of a significant increase in Donations (mainly due to Rory the Robot on-going Fundraising and a large donation from the County Air Ambulance), Legacies and the revaluation of the Investments. Income from donations and legacies increased by 26% compared to the previous year; expenditure increased by 59% and Investments increased by £29k.

The Trustees are pleased with the outcome of the year's activity, and are continuing to monitor the turnover of funds in line with the requirements of the Charity's Reserves Policy. The Reserves Policy is detailed in full on pages 17 & 18.

The funds supported a wide range of expenditure, benefiting both patients and staff. Expenditure included purchases of equipment, training courses and other amenities for patients and staff.

The Trust will reiterate to Fund Managers the need to make the best use of these assets in financial year 2018/2019, with the Trustees being proactive in supporting and encouraging higher levels of expenditure. Regular reviews of compliance with submitted expenditure plans for the year will support this.

Money spent: what we spent the money on

Total Expenditure for 2017/2018 was £536k.

Type of Grant (Expenditure)	2017/2018 £'000	2016/2017 £'000	2015/2016 £'000
Patient Welfare and Amenities	9	8	*57
Staff Welfare and Amenities (Inc. Staff Yearly Functions)	9	9	18
Research	174	173	184
Medical & Surgical Equipment	96	104	90
Furniture & Fittings	16	35	47
Salaries	40	21	52
Course fees	34	45	62
Computer Hardware & Software	11	3	5
Alternative Therapy Sessions	34	36	21
Printing & Stationery (Inc. Books & journals)	4	4	1
Building Work	78	2	12
Hire of Rooms	9	6	6
Audit Fees	1	**-4	2
Other/Miscellaneous	21	14	8
TOTAL	**536**	**456**	**565**

The Format of the above table had been amended in 2016/2017 to reflect the Final Accounts

*Includes purchase of Ward-Henry Patient information Boards
** See note 5.2 of the Final Accounts 2016/2017

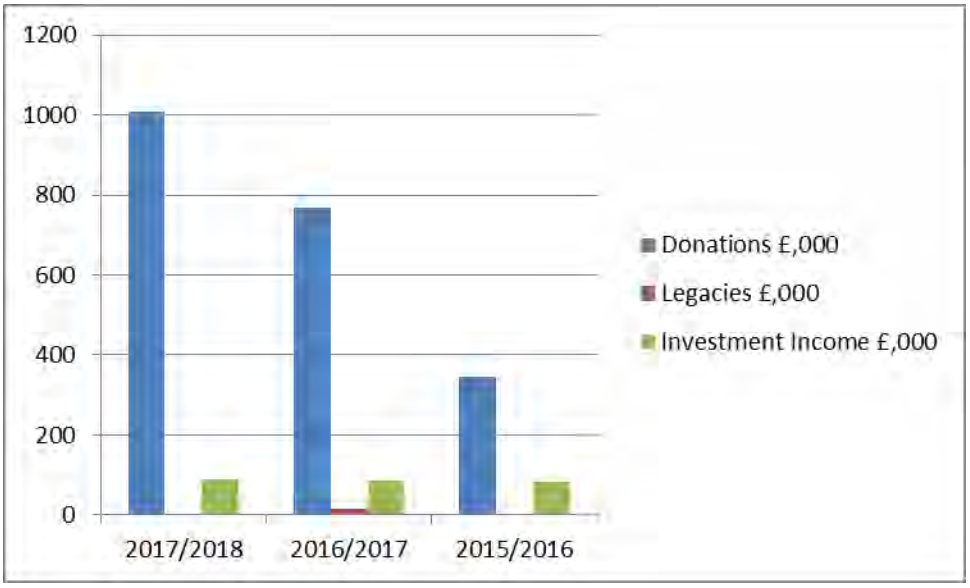
Examples of some of the larger items of expenditure are:

	£'000
a) Recliners for Parents on the SCBU	6
b) Learning and Education equipment for Patients and staff in Diabetes	7
c) Echo Probe for Cardiology Department	20
d) New Acute Oncology Bay building works	57

Investment Management and Governance Costs	36

How the work is funded, our achievements and performance

Money received 2017/2018 - £1,099k. Sources of income and comparison to previous years are shown below:



Sources of Income	2017/2018 £'000	2016/2015 £'000	2014/2015 £'000
Donations	1,009	768	344
Legacies	2	17	3
Investment Income	88	87	84
TOTAL	**1,099**	**872**	**431**

The following funds received the larger donations:

Fund	Amount £'000
a) Eveson Charitable Trust	20
b) Strictly Worcestershire	20
c) Daisychain Benevolent Fund	24
d) County Air Ambulance	625

a) Donation from the Eveson Charitable Trust for the Islet Research Lab.
b) Donation from Strictly Worcestershire for Rory the Robot.
c) Donation from Daisychain Benevolent Fund for the Paediatrics Department.
d) Donation from the County Air Ambulance for a New Helipad at Worcester.

On behalf of the patients and staff who have benefited from improved services due to donations and legacies, the Trustees would like to thank all patients, relatives and others who have made charitable donations. Please see below an example of one of the kind donations we have received this year.

Maternity Bereavement Suite

A fundraising appeal to raise £60,000 for a new Bereavement Suite in the maternity unit at Worcestershire Royal Hospital has been hugely successful.

The suite will provide a private space for parents who have experienced the tragedy of a stillbirth or the loss of their baby post-birth, where they can begin to grieve the loss of their baby.

It will be an addition to the existing bereavement facility – the Fay Turner Suite – which will also benefit from a refurbishment.

Trudy Berlet, Bereavement Support Midwife at Worcestershire Acute Hospitals NHS Trust, said: "We know from the conversations we have with parents how important these facilities are – a space for mothers, partners and family to go, away from the noise and bustle of the nearby maternity ward.

Fundraising Practices

The fundraising approach taken by the charity, or by anyone acting on its behalf, and whether a professional fundraiser or commercial participator carried out any fundraising activities.

The principal focus for charitable fundraising activity in 2017/18 and 2018/19 has been the "Rory the Robot Appeal" which is raising money towards the cost of buying and running a surgical robotic system to improve prostate cancer treatment.
Fundraising activity is co-ordinated by a member of staff who has been seconded into the role of Fundraising Officer and is line managed by the Trust's Head of Communications and accountable to the Director of Communications and Engagement.
During 2017/18 and 2018/19 we have not engaged any professional fundraiser or commercial participator.

Details of any fundraising standards or scheme for fundraising regulation that the charity has voluntarily subscribed to.

We have not voluntarily subscribed to any fundraising standards or scheme for fundraising regulation.

Details of any fundraising standards or scheme for fundraising regulation that any person acting on behalf of the charity has voluntarily subscribed to.

None.

Details of any failure by the charity, or by any person acting on its behalf, to comply with fundraising standards or scheme for fundraising regulation that the charity or the person acting on its behalf has voluntarily subscribed to.

N/A (see above).

Whether the charity monitored the fundraising activities of any person acting on its behalf and, if so, how it did so.

Report to Charitable funds committee on activities of the Fundraising Officer as part of a case for need to support the continuation of the post.

The number of complaints received by the charity, or by a person acting on its behalf for the purposes of fundraising, about fundraising activity.

None received.

What the charity has done to protect vulnerable people and other members of the public from behaviour which:

- **is an unreasonable intrusion on a person's privacy**
- **is unreasonably persistent**
- **places undue pressure on a person to give money or other property**

No specific actions taken. However, ongoing activities of Fundraising Officer are monitored through annual performance review and objective setting with Head of Communications and weekly meetings with Director of Communications.

Working with our Partners

The Worcestershire Acute Hospitals NHS Trust also benefits from Working with our Partners! On behalf of the patients, relatives and staff who have benefited from improved services due to these donations the Trustees would like to thank all these Charities for their hard work and kind charitable donations.

The League of Friends of the Alexandra Hospital was established in 1986 when the Hospital opened. The aim is to provide equipment and services for the Patients and the Staff of the Alexandra Hospital. They have a very busy and friendly coffee shop and also around 300+ volunteers. Voluntary activities include helping in the coffee shop, flower arranging and Pastoral care. They also work with Age UK to provide 'Dignity Champions' on Wards.

The League of Friends of the Kidderminster Hospitals purpose is to relieve patients and former patients of the Kidderminster Hospitals and other invalids in the community who are sick, convalescent, disabled, handicapped, infirm or in need of financial assistance and generally to support the charitable work of the said Kidderminster Hospitals. They also have a busy and friendly coffee shop and shops.

The Friends of Worcestershire Royal Hospital provide funds for the purchase of equipment and comforts for the benefit of patients and staff at Worcestershire Royal Hospital and other hospitals in the Trust. Apart from Donations and Legacies the Friends have coffee mornings, cake & plant sales, collections outside local shops and Subscriptions to raise money – this is all done by Volunteers.

INVESTMENT POLICY

Objectives

The overall objectives of the Trustees' Investment Policy are to create sufficient income and capital growth to enable the charity to carry out its purposes consistently year by year with due and proper consideration for future needs and the maintenance of, and if possible, enhancement of the value of invested funds while they are retained. To this end, funds will be concentrated in low risk investments, as far as possible to minimise potential losses. Within this criterion, competitive rates will be sought.

Both capital and income may be used at any time for the furtherance of the charity's objectives as detailed on page 5.

Investment Manager

An Investment Manager will be retained, to provide quarterly reports regarding the performance of investments. The Trustees will review the reports and will ensure the most prudent and appropriate portfolio mix. At the present time the Trust's specific ethical exclusions are armaments, tobacco and gambling. In addition to this there are additional "Responsible Investment" constraints laid down by the Investment Manager's Board which would be required to be adhered to.

The Investment Manager will be remunerated in accordance with the agreed published scale, and will attend meetings of the Charitable Funds Committee at least `once a year.

Dividends and Interest

The Trustees may reinvest all the surplus income.

Authorised Parties

The following parties are authorised by the Trustees to issue instructions to the Investment Manager:

Michael White – Assistant Director of Finance

Review

This Policy will be reviewed annually by the Charitable Funds Committee.

Investments

Income received is paid into a bank account held with Lloyds TSB. The remainder of the Fund is held in Common Investment Funds (COIF), managed by CCLA Investment Management Ltd. Investments are carried out in accordance with the provisions of the Trustee Act 2000 and the general powers contained in the charity's governing documents.

The split of Investments at 31st March 2018 was as follows:

CCLA Investment Management Ltd	
	£'000
CCLA COIF Charities Investment Fund	1,271
CCLA COIF Charities Fixed Interest Fund	267
CCLA COIF Charities Property Fund	404
Total	1,942

As at 31st March 2018, the Investment Managers reported the current income yield on investments as follows:

	%
COIF Charities Investment Fund	3.54
COIF Charities Fixed Interest Fund	3.25
CCLA COIF Charities Property Fund	5.47

VALUE OF INVESTMENTS

Due to the fair global financial market conditions, unrealised gains included in the fund balances as at 31 March 2018 amounted to £29k. The performance and placement of investments will be kept under review, as far as possible to minimise losses and maximise gains.

RESERVES POLICY

INTRODUCTION

The Trustees of Worcestershire Acute Hospitals NHS Trust are committed to utilising its Charitable Fund within the objects of the Charity, and not to accumulate funds unless this is necessary to meet the cost of purchase of a particular item or service.

The policy of the Trustees is that charitable funds should be spent rather than conserved. The Trustees would normally expect that, in the course of any financial year, charitable funds expenditure should at least equal the value of income received in the form of donations, grants and legacies.

It is important, however, that funds are spent prudently and not expended simply to reduce the level of reserves held.

LEVEL OF RESERVES REQUIRED

The Trust was formed in April 2000, combining the former Worcester Royal Infirmary NHS Trust, the Kidderminster Health Care NHS Trust and the Alexandra Health Care NHS Trust. The new Worcestershire Royal Hospital in Worcester was opened in April 2002 and a new Treatment Centre in Kidderminster opened in January 2004. These events have been a catalyst for many changes in the provision of patient services across the county.

In these circumstances it has been considered prudent not to try to reduce the existing level of reserves unless expenditure complies with proposals for these service changes. However, in the year 2017/2018 the Charitable Funds Committee has been actively seeking to identify appropriate and beneficial uses for accumulated funds. It is intended that reserves will be monitored on an on-going basis to ensure that existing and new funds are used within a reasonable timescale.

RESERVES POLICY (continued)

MAINTAINING, MONITORING AND REVIEWING THE POLICY.

Day to day management of designated funds has been delegated to specific fund managers throughout the Trust, thus ensuring that funds remain under the control of those staff best able to decide on how the funds should be spent in line with donors' wishes.

Fund managers are encouraged wherever possible to combine existing funds, and funds with balances below £500 will be reviewed every 2 years in consultation with fund managers, with the aim of amalgamating these with similar funds, or closing funds where the balance is insufficient for meaningful use, and where further income is not anticipated. In the case of closure, balances will be transferred to General Purpose's charitable funds.

Requests to set up new funds are submitted to the Charitable Funds Accountant and referred to the Charitable Funds Committee (CFC) for approval.

Income and Expenditure is monitored by the Finance Department and reported to the CFC. The intention of the monitoring is to ensure compliance with Standing Orders and Standing Financial Instructions, to ensure value for money, and to check that advantage is taken of all available concessions, e.g. the ability to obtain exemption from VAT on qualifying equipment.

Fund Managers will be reminded that they are not permitted to accumulate funds unless they are saving for a particular item, and managers with funds which meet the following criteria are required to complete a three-year expenditure plan which aims to use the current balance available within that period:

1 Funds with a balance in excess of £7500, where a previously submitted expenditure plan has expired, or has not been implemented within a margin of 20% year on year. Particular attention will be given to funds where income has exceeded expenditure for 2 consecutive years.
2 Funds with a balance in excess of £2000 where there has been no expenditure within the previous 12 months.

Expenditure plans are monitored by the Finance Department and reported to the CFC. Action will be taken to ensure that managers utilise their funds in an appropriate and timely manner. The Committee reserves the right to:

a) identify appropriate uses for any funds not being utilised
b) appoint alternative fund managers
c) Approve expenditure on behalf of the fund manager.

REVIEW OF THE RESERVES POLICY

This policy will be reviewed annually by the Charitable Funds Committee.

ACCOUNTS APPROVED BY CHARITABLE FUNDS COMMITTEE:

Date

Chairman

TRUSTEES' ANNUAL REPORT APPROVED BY CHARITABLE FUNDS COMMITTEE:

Date

Chairman

WORCESTERSHIRE ACUTE HOSPITALS CHARITY

Charity Registration Number 1054612

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

The following data will be used throughout the Financial Statements:

This year: 2017/2018

Last year: 2016/2017

WORCESTERSHIRE ACUTE HOSPITALS CHARITY 1054612
Worcestershire Acute Hospitals NHS Trust
Kings Court Business Park
Charles Hastings Way
Worcester, WR5 1WS

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

FOREWORD

The Trust Board, as Corporate Trustee of the Charitable Fund, act as Trustees on behalf of the Trust in the management and administration of the Charity. These accounts have been prepared by the Trustees under section 98(2) of the National Health Service Act 1977 (as amended) in the forms which the Secretary of State has, with the approval of Treasury, directed.

WORCESTERSHIRE ACUTE HOSPITALS CHARITY

Worcestershire Acute Hospitals Charity is registered with the Charity Commission and includes funds donated for the benefit of Worcestershire Acute Hospitals NHS Trust.

MAIN PURPOSE OF THE CHARITABLE FUND

The main purpose of the Charitable Fund is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by Worcestershire Acute Hospitals NHS Trust.

WORCESTERSHIRE ACUTE HOSPITALS CHARITY

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

Statement of trustees' responsibilities

The trustees are responsible for:

* keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the funds of the charity and to enable them to ensure that the accounts comply with the requirements in the Charities Act 2011 and those outlined in the directions issued by the Secretary of State;

* establishing and monitoring a system of internal control, and safeguarding assets

* establishing arrangements for the prevention and detection of fraud and corruption

The trustees are required under the Charities Act 2011 and the Statement of Recommended Practice 2015: Accounting and Reporting by Charities to prepare accounts for each financial year which show a true and fair view of the charity's incoming resources and application of resources during the year, and of its state of affairs at the end of the year. In preparing those accounts, the trustees are required to:

* apply on a consistent basis suitable accounting policies

* make judgements and estimates which are reasonable and prudent

* state that applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts

* prepare the financial statements on the going concern basis, unless it is inappropriate to do so

The trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts:

* as far as they are aware, there is no relevant audit information of which the charity's auditors are unaware

* they have taken all appropriate steps as required in order to make themselves aware of any relevant audit information, and to establish that the charity's auditors are aware of that information

The financial statements set out on pages 4 to 16 attached have been compiled from and are in accordance with the financial records maintained by the trustees.

By Order of the Trustees
Signed: (NB sign in any colour ink other than black)

Chairman*..... Date..... 2018

Trustee ..... Date..... 2018

*the Board may authorise another trustee to sign in place of the Chairman.

WORCESTERSHIRE ACUTE HOSPITALS CHARITY			Charity No	1054612
Annual accounts for the period				
Period start date	01-Apr-17	To	Period end date	31-Mar-18

Section A Statement of financial activities

Recommended categories by activity	Details of own analysis	Note	Unrestricted funds £,000	Restricted income funds £,000	Endowment funds £,000	Total this year £,000	Total last year £,000
Incoming resources							
Donations and Legacies		3	282	729	-	1,011	785
Investment income		3	88	-	-	88	87
Total Incoming Resources			370	729	-	1,099	872
Resources expended							
Charitable Activities		4	378	158	-	536	456
Other		4	14	-	-	14	13
(Gains) and losses on investment assets		8	- 29			- 29	- 142
Total resources expended			363	158	-	521	327
Net incoming/(outgoing) resources			7	571	0	578	545
Net movement in funds		14	7	571	0	578	545
Total funds brought forward			1,291	1,103	-	2,394	1,849
Total funds carried forward			1,298	1,674	-	2,972	2,394

Section B Balance sheet

	Note	Unrestricted funds £,000	Restricted income funds £,000	Endowment funds £,000	Total this year £,000	Total last year £,000
Fixed assets						
Investments	8	1,942	-	-	1,942	1,913
Total fixed assets		1,942	-	-	1,942	1,913
Current assets						
Debtors	9	18	-	-	18	19
Cash at bank and in hand	13	1,136	-	-	1,136	503
Total current assets		1,154	-	-	1,154	522
Creditors: amounts falling due within one year	10	124	-	-	124	41
Net current assets		1,030	-	-	1,030	481
Total assets less current liabilities		2,972	-	-	2,972	2,394
Net assets		2,972	-	-	2,972	2,394
Funds of the Charity						
Unrestricted funds		1,298	-	-	1,298	1,291
Restricted income funds	11	-	1,674	-	1,674	1,103
Total funds		1,298	1,674	-	2,972	2,394

	Signature	Print Name	Date of approval
Signed by one or two trustees on behalf of all the trustees			

Worcestershire Acute Hospitals Charity Cash Flow Statement 2017/2018			
	Note	Total Funds 17/18 £,000	Total Funds 16/17 £,000
See Note 13			
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	**13.1**	545	323
Cash flows from investing activities:			
Dividends, interest and rents from investments	**3.2**	88	87
Purchase of investments		0	201
Net cash provided by (used in) investing activities		**88**	**-114**
Change in cash and cash equivalents in the reporting period		**633**	209
Cash and cash equivalents at the beginning of the reporting period	**13.2**	**503**	294
Cash and cash equivalents at the end of the reporting period		**1136**	**503**

Section C Notes to the accounts

Note 1

1.1 Basis of Preparation

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the

The trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

1.2 Basis of accounting

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value, in accordance with:

- Accounting and Reporting by Charities – Statement of Recommended Practice (SORP 2015);

1.3 Changes to previous accounts

Due to re-categorisation of Restricted Funds to Unrestricted funds the SOFA and Balance Sheet have been amended for 2016/2017. **This does not affect the overall Fund Balance total.**

Note 2.1 Accounting policies

The following accounting policies have been applied by the charity.

INCOMING RESOURCES

Recognition of incoming resources	These are included in the Statement of Financial Activities (SoFA) when: • the charity becomes entitled to the resources; • the trustees are virtually certain they will receive the resources; and • the monetary value can be measured with sufficient reliability.
Incoming resources with related expenditure	Where incoming resources have related expenditure (as with fundraising or contract income) the incoming resources and related expenditure are reported gross in the SoFA.
Grants and donations	Grants and donations are only included in the SoFA when the charity has unconditional entitlement to the resources.
Legacies	These are accounted for as income resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.
Contractual income and performance related grants	This is only included in the SoFA once the related goods or services have been delivered.
Gifts in kind	Gifts in kind are accounted for at a reasonable estimate of their value to the charity or the amount actually realised. Gifts in kind for sale or distribution are included in the accounts as gifts only when sold or distributed by the charity. Gifts in kind for use by the charity are included in the SoFA as incoming resources when receivable.
Investment income	This is included in the accounts when receivable.
Investment gains and losses	This includes any gain or loss on the sale of investments and any gain or loss resulting from revaluing investments to market value at the end of the year.

Note 2.2 Accounting policies

The following accounting policies have been applied by the charity.

EXPENDITURE AND LIABILITIES

Liability recognition Liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to pay out resources.

Support Costs Are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs are shown in note 4.

Governance costs are classified as a support cost and have therefore been apportioned between fundraising activities and charitable activities.

Grants with performance conditions Where the charity gives a grant with conditions for its payment being a specific level of service or output to be provided, such grants are only recognised in the SoFA once the recipient of the grant has provided the specified service or output.

Grants payable without performance conditions These are only recognised in the accounts when a commitment has been made and there are no conditions to be met relating to the grant which remain in the control of the charity.

Pension Contributions There were no pensions contributions

STRUCTURE OF FUNDS

Restrictions Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are designated funds.

Pooling Scheme The charity does not have an operational pooling scheme.

ASSETS

Tangible fixed assets for use by charity There were no tangible fixed assets.

Investment Fixed Assets There were no property assets or quoted stocks and shares. Other investment fixed assets are shown at market value.

Note 3 Other Incoming Resources

3.1 Donations and Legacies

Analysis	This Year £,000	Last Year £,000
Donations from individuals or suppliers	984	756
Legacies	2	17
Donations via Just Giving	25	12
Total	**1,011**	785

3.2 Investment Income

CCLA quarter 1	21	18
CCLA quarter 2	18	17
CCLA quarter 3	18	18
CCLA quarter 4	18	19
Investment Fees reimbursed to income	14	13
Income not accounted for in 16/17	-1	1
Bank account interest	0	1
Total	**88**	87

Note 4 Resources expended

Analysis	This year £,000	Last year £,000
4.1 Other		
CCLA costs for managing our investments	14	13
Total	**14**	13
4.2 Charitable activities		
Patients welfare and amenities	9	8
Staff Welfare and amenities	9	9
Research - Salaries	174	173
Medical and Surgical Equipment	96	104
Furniture, Furnishing and Fittings	16	35
Course Fees and Expenditure	34	45
Alternative Therapy Sessions	34	36
Salaries	40	2
Building Work	78	2
Computer Hardware and Software	11	3
Audit Fees (see Note 5.2)	1	- 4
Printing, Stationary, Books and Journals	4	4
Hire of Rooms	9	6
Bought in services from NHS	20	19
Other	1	14
Total	**536**	456

4.3 Changes in Resources Available for Charity Use

Net Movement in Funds for the Year	Total 2018 £,000	Total 2017 £,000
Unrestricted funds	13	411
Restricted funds	565	134
Total	**578**	**545**

4.4 Analysis of Support Costs

Net Movement in Funds for the Year	Expenditure £,000	Governance Costs £,000	Total 2018 £,000	Total 2017 £,000
Expenditure prior to apportionment	500	21	521	327
Adjust for reapportionment of Support costs*	21	(21)	0	0
Expenditure as restated	**521**	**0**	**521**	**327**

*All support costs are apportioned against individual funds on a yearly basis

Note 5 Details of certain items of expenditure

5.1 Trustee expenses

Number of trustees who were paid expenses	-
No expenses paid during the year	-

5.2 Fees for examination or audit of the accounts

	This year £,000	Last year £,000
Independent examiner's or auditors' fees for reporting on the accounts	1	-4

The Audit Fee is a minus figure for 2016/17 due to £5k being reserved for 2015/2016 fees and the charges being only £1k.

Note 6 Paid employees

The charity has no direct paid employees; staffing is provided by way of bought-in services re-charged from Worcestershire Acute Hospitals NHS Trust. This arrangement enables flexibility in the use of staff time between the Trust and its charity.

Note 7 Grantmaking

7.1 Total value of grants

Purpose for which grants made	Grants to institutions Total £,000	Grants to individuals Total £,000
Charitable purposes relating to the National Health Service in Worcestershire	515	-
Total	**515**	**-**

7.2 Support Costs of Grantmaking

-

7.3 Grants made to institutions

WORCESTERSHIRE ACUTE HOSPITALS CHARITY	Purpose	Total amount of grants paid £,000
Worcestershire Acute Hospitals NHS Trust: grants £1000 or over	Charitable purposes relating to the National Health Service in Worcestershire	486
	Charitable purposes relating to the National Health Service in Worcestershire	29
	Total grants to institutions	**515**

Note 8 Investment assets

8.1 Fixed assets investments

	£,000
Carrying (market) value at beginning of year	1,913
Add: additions to investments at cost	-
Less: disposals at carrying value	-
Add/(deduct): net gain/(loss) on revaluation	29
Carrying (market) value at end of year	1,942

Analysis of investments

	8.2 Market value at year end £,000	8.3 Income from investments for the year £,000
Investments listed on a recognised stock exchange or held in common investment funds, open ended investment companies, unit trusts or other collective investment schemes	1,942	88
Total	1,942	88

Breakdown of holdings at 8.2 above:

	£,000
COIF Investment Fund	1,271
COIF Fixed Interest Fund	267
COIF Property Fund	404
TOTAL	**1,942**

Note 9 Debtors and prepayments

Analysis of debtors	Amounts falling due within one year		Amounts falling due after more than one year	
	This year £,000	Last year £,000	This year £,000	Last year £,000
Prepayments and accrued income	18	19	-	-
Total	18	19	-	-

Note 10 Creditors and accruals

10.1 Analysis of creditors

	Amounts falling due within one year		Amounts falling due after more than one year	
	This year £,000	Last year £,000	This year £,000	Last year £,000
Other creditors	124	41	-	-
Total	124	41	-	-

10.2 Commitments, Liabilities & Provisions

The Trustees recognise liabilities in the accounts once they have incurred either a legal or constructive obligation to expend funds.

Commitments amount to £59k, as detailed below; there are no liabilities and provisions

	£,000	£,000
Total as at 31 March 2017		187
Amounts charged to SoFA in year 2017/2018	187	
Amounts released due to change in value		(187)
Still outstanding as at 31 March 2018		0
Items arising during the year ended 31 March 2018		59
Commitment's as 31 March 2018		**59**

This total relates to sums reserved where, for example, a purchase order has been raised for which no invoice has yet been received. This ensures that funds are not over-committed. The actual costs may differ from the amounts set aside to cover any liability.
It is anticipated that the whole of the total shown will be either charged to the SoFA in the year ended 31 March 2019 or released due to changes in value.

10.3 Security over assets - None

Note 11 There were no Endowment Funds in 2017/2018 but there were Restricted Funds

Restricted Funds in Year 2017/2018	£,000
	1,674

Note 12 The only transactions with related parties are with the Worcestershire Acute Hospitals.
All expenditure paid for on behalf of the charity is reimbursed to the Trust on a monthly basis.

Note 13 Worcestershire Acute Hospitals Charity Cash Flow Statement 2017/2018

13.1 Reconciliation of Net Movement in Funds to net cash flow from Operating Activities	17/18	16/17
	£,000	£,000
Net Movement in Funds for reporting period (As per statement of Financial Activities)	549	403
Adjustments for:		
Dividends, interest and rents from Investments	-88	-87
(Increase)/Decrease in debtors	1	-2
Increase/(Decrease) in creditors	83	9
Net cash provided by (used in) operating activities	545	323

WORCESTERSHIRE ACUTE HOSPITALS CHARITY	17/18	16/17
	£,000	£,000
Cash in hand	1,136	503
Total Cash and cash equivalents	1,136	503

Note 14 Additional Disclosures

The following are significant matters which are not covered in other notes.

The Worcestershire Acute Hospitals Charity processed transfers between funds of £1k. This is due to Fund closures and mergers. These transfers do not effect the total funds carried forward figure.

Details of Material Funds

14.1 Unrestricted Funds

	Balance April 2017 £,000	Incoming Resources £,000	Resources Expended £,000	Balance March 2018 £,000
Medical	118	24	33	109
Surgical	75	17	25	67
Women & Children	134	94	36	192
Specialised Clinical Services	175	83	79	179
Corporate	178	48	154	72
Other	611	104	36	679
	1291	370	363	1298

14.2 Restricted Funds

	Balance April 2017 £,000	Incoming Resources £,000	Resources Expended £,000	Balance March 2018 £,000
Medical	756	1	135	622
Surgical	315	100	3	412
Women & Children	0	0	0	0
Specialised Clinical Services	32	3	5	30
Corporate	0	625	15	610
Other	0	0	0	0
	1103	729	158	1674

14.3 Details of Material Funds - Restricted

Name of Fund	Description of the nature and purpose of each fund
Eileen Dixon Legacy	Any charitable purpose relating to Oncology, Alexander Hospital.
Mrs Dorothy Hackney Legacy	To purchase Cardiac Equipment only.
Roger Bradley Legacy	Any charitable purpose relating to Laurel 3 and Haematology.
County Air Ambulance Trust	For the sole purpose relating to costs associated with the new Helipad at the Worcestershire Royal Infirmary.
Rory The Robot	To purchase a robotic surgical system.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	G3

Remuneration Committee Report

For approval:		For assurance:		To note:	x

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

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

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

Recommendations	Trust Board is requested to: • Note this report.

Meeting	Trust Board
Date of meeting	10 January 2019
Paper number	G3

Executive Summary

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

Background

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

Issues and options

Appointment of a Chief Executive: The Committee approved the appointment of Matthew Hopkins subject to the necessary pre-employment checks. The salary range (£204,500 to £210,000) and a relocation package (repayable if the post holder exits the Trust within 2 years of appointment) were approved.

Acting CEO: The Committee agreed to Mr Paul Brennan being appointed as Acting CEO and Accountable Officer from 15 December 2018 until the new CEO starts at the Trust.

Recommendations

The Trust Board is requested to:

- Note the report.

Appendices