Agenda (public) 0120 final

Trust Board
There will be a meeting of the Trust Board on Thursday 16 January 2020 at 10:00 in Alexandra Hospital Board Room, Redditch.

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

Sir David Nicholson
Chairman

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| Agenda | | | Enclosure |
|---|---|---|---|
| 1 | **Welcome and apologies for absence** | | |
| 2 | **Patient Story** | | |
| 3 | **Items of Any Other Business**<br>*To declare any business to be taken under this agenda item.* | | |
| 4 | **Declarations of Interest**<br>*To note any additional declarations of interest and to note that the declaration of interests is on the website.* | | |
| 5 | **Minutes of the previous meeting**<br>*To approve the Minutes of the meeting held on **12 December 2019** as a true and accurate record of discussions.* | *For approval* | **Enc A** |
| 6 | **Action Log** | *For noting* | **Enc B** |
| 7 | **Chairman's Report** | | **Verbal** |
| 8 | **Chief Executive's Report**<br>Chief Executive | *For noting* | **Enc C** |
| 9 | **Integrated Performance Report** | | **Enc D** |
| 9.1 | **Executive Summary**<br>Chief Executive | *For assurance* | |
| 9.2.1 | **Section 1 – Operational Performance Report**<br>Chief Operating Officer | | |
| 9.2.2 | **Finance and Performance Committee Assurance Report**<br>Finance and Performance Committee Vice Chairman | | |
| 9.3.1 | **Section 2 – Quality Performance Report**<br>Chief Nurse/Chief Medical Officer | | |
| 9.3.2 | **Quality Governance Committee Assurance report**<br>Quality Governance Committee Chairman | | |

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| **9.4.1** | **Section 3 – People and Culture Performance Report**<br>Director of People and Culture | | |
| **9.4.2** | **People and Culture Committee Assurance Report**<br>People and Culture Committee Chairman | | |
| **9.5.1** | **Section 4 – Financial Performance Report**<br>Chief Finance Officer | | |
| **10** | **Strategy** | | |
| **10.1** | **Risk Management Strategy**<br>Chief Nurse | *For approval* | **Enc E1** |
| **10.2** | **Communications and Engagement Strategy**<br>Director of Communications and Engagement | *For approval* | **Enc E2** |
| **11** | **Governance** | | |
| **11.1** | **Report on nursing and midwifery staffing levels**<br>Chief Nurse | *For assurance* | **Enc F1** |
| **11.3** | **Undertakings**<br>Chief Executive | *For assurance* | **Enc F2** |
| **11.2** | **Trust Management Executive Report**<br>Chief Executive | *For assurance* | **Enc F3** |
| **13** | **Assurance Reports** | | |
| **13.1** | **Audit and Assurance Committee Report**<br>Audit and Assurance Committee Chairman | *For assurance* | **Enc G1** |
| **13.2** | **Remuneration Committee Report**<br>Chairman | *For assurance* | **Enc G2** |
| **14** | **Trust Board – as corporate trustee of Worcestershire Acute Hospitals Charity** | | |
| **14.1** | **Charitable Funds Strategy**<br>Director of Communications and Engagement | *For ratification* | **Enc H1** |
| **14.2** | **Charitable Funds Report**<br>Charitable Funds Committee Chairman | *For assurance* | **Enc H2** |
| | **Any Other Business** *as previously notified* | | |
| | Date of Next Meeting<br>*The next public Trust Board meeting will be held on 13 February 2020 in rooms 1&2, Education Centre, Kidderminster Hospital and Treatment Centre.* | | |
| | **Public Q&A session** | | |

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

**Enc A**

Worcestershire Acute Hospitals NHS Trust

**MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 12 DECEMBER 2019 AT 10:00 hours**
**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 |
| | Mike Hallissey | Chief Medical Officer |
| | Matthew Hopkins | Chief Executive |
| | Dame Julie Moore | Non-Executive Director |
| | Vicky Morris | Chief Nursing Officer |
| | Robert Toole | Chief Finance Officer |
| | Bill Tunnicliffe | Non-Executive Director |
| | Stephen Williams | Non-Executive Director |
| | Mark Yates | Non-Executive Director |
| **Board members: (non-voting)** | Richard Haynes | Director of Communications & Engagement |
| | Colin Horwath | Associate Non-Executive Director |
| | Richard Oosterom | Associate Non-Executive Director |
| | Tina Ricketts | Director of People and Culture |
| | Kimara Sharpe | Company Secretary |
| | Sarah Smith | Director of Strategy and Planning |
| **In attendance** | Fleur Blakeman | NHS I Improvement Director |
| **Public Gallery:** | Press | 0 |
| | Public | 4 (including 3 staff members) |

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125/19 **WELCOME**

Sir David welcomed all to the meeting and wished seasonal greetings to those present. He stated that Mr Williams would be late due to traffic problems, Mr Brennan was taking an urgent call and Mr Hopkins would leave at 11am to take a system wide call.

126/19 **Patient story**

Mrs Edwards presented the patient story. She confirmed that she has the consent of the complainant to read the story. She stated that the story showed team work and how to support a family in difficult circumstances.

The complainant wrote to the Trust following death of her husband at Worcestershire Royal Hospital. He had received exemplary care in the ED and compassion was shown in the bereavement office. She was very disappointed to have had a poor experience within the mortuary department.

*Mr Brennan joined the meeting.*

She described the staff at the mortuary as brusque and she felt that she and her family

were an inconvenience. There was a lack of sensitivity in respect of viewing her husband and there was significant noise disturbance. The overall experience left her shocked and traumatised. She made the complaint to ensure that the standards within the mortuary department were reviewed and she wanted to ensure that other families had an improved experience.

The Trust gave unreserved apology. A number of actions have been completed including:

1. Signage – improved so relatives can find the mortuary more easily
2. Noise disturbance – this was due to the funeral directors. Work has been undertaken with funeral directors so they are aware of the noise that carries
3. Chapel of rest – work has been undertaken with the mortuary team to ensure that they are aware how to prepare relatives
4. Training package – this has been implemented for the mortuary and the bereavement team.

The training consists of a series of workshops run by external providers such as CRUISE. The training is continuing. The workshops also gave an opportunity for staff to talk about their experiences. This is the first time that the mortuary staff have had specific training for their unique role.

Sir David thanked Mrs Edwards for the story. He invited questions from the Board members.

Mr Yates wondered whether there had been other similar complaints. Mrs Edwards confirmed that most complaints have an element of communication problems within them but the area of the mortuary rarely has complaints against it.

Mr Horwath stated that there were a number of positives that had come out the complaints such as the support for staff. He wondered whether there was support in place for staff when there had been a sudden death within the wards or the ED. Mrs Edwards confirmed that there was and she described the immediate support available through the staff on the wards and occupational health.

Sir David reflected that the mortuary staff were relatively isolated and he asked whether there were other groups of staff in similar circumstances. Mrs Edwards stated that the complaint had acted as a trigger and the staff were shocked. The Specialised Clinical Services Division had been supporting the staff and she was pleased that the learning from the complaint will enable other isolated areas to be identified.

*Mr Williams joined the meeting.*

Ms Smith asked whether the signage had been improved. Mrs Edwards said that some initial improvements had been made but there was more to do. She was pleased that the Patient and Public Involvement (PPI) forum was supporting this work. Mr Yates reported that the survey had been undertaken for Access Able and this would identify signage problems.

Sir David thanked Mrs Edwards again for the patient story.

127/19 **ANY OTHER BUSINESS**

There were no items of any other business.

128/19 **DECLARATIONS OF INTERESTS**

Sir David declared that he has been appointed a governor of Nottingham Trent

University. There were no additional declarations of interest.

129/19 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 14 NOVEMBER 2019**

**RESOLVED THAT the minutes of the meeting held on 14 November 2019 be confirmed as a correct record and signed by the Chair.**

130/19 **MATTERS ARISING/ACTION SCHEDULE**

Mrs Sharpe confirmed that all matters arising were either not yet due or completed.

131/19 **Chairman's report**

Sir David asked the board to note the vice chairman's action which had been to extend the contract for laundry services. He expressed disappointment that this had to be undertaken as a Chairman's action when it should have been within the planned programme of contract renewal. Mr Yates confirmed that this had already been taken forward within the line management.

Mr Toole explained that the process of putting in more controls in respect of procurement had revealed that the contract had not had the required approval when it was initially signed. The correct governance was now being put into place.

**RESOLVED THAT the report be noted.**

132/19 **INTEGRATED PERFORMANCE REPORT (IPR)**

132/19/1 **Executive summary**

Sir David invited Mr Hopkins to introduce this report. Mr Hopkins highlighted the key areas.

He was pleased to report that there had been improvements with the indicators within the people agenda. The exception to this was sickness levels.

Operationally there were still significant challenges in relation to two week and 62 day cancer standards. However, diagnostics was one of the best performers in the region.

Mr Hopkins then turned to urgent and emergency care. Considerable resources were being invested in this area and nationally, the emergency access standard performance is 5% worse than last year with the performance in the Midlands 6.7% down. Attendances are up by 5% against the national position of 4%. There had been flu cases in the hospital and paediatric attendances were up across the region. The Trust was the 4th worse performing organisation in November in the region. There had been a 1.4% deterioration compared to last year within the region.

He was pleased that the Home First Programme has made some progress but the actions to improve the 4 hour access target had to yet to be made. There had been a system wide workshop at the end of November which focussed on improving the position across the county. The workshop had been positive with partners making commitments to support the Trust. The next step was to realise the commitments to improve patient flow and therefore patient experience, which was essential. He confirmed that the issue in respect of urgent care was a whole hospital issue not just the ED.

Sir David invited Mr Brennan to expand on Home First Worcestershire. Mr Brennan explained that the work stream concentrating on red to green had seen improved performance. There had been an improvement in the number of patients waiting for a

pathway had decreased from an average of 77 to 56 over a three week period. The target was 30. This performance was as a result of the social care and community trust staff being co-located within the hospital.

There was still little progress on criteria led discharge which led to a backlog of discharges over the weekend. There was a clear capacity issue within the 'take' and actions were being taken with additional consultants.

Other work that was ongoing included ensuring that the root cause of the admission was treated and not other problems that patients may have.

Whilst the initial impact of the surgical assessment unit is positive, more data is needed to show continuous improvement to the reduction of waiting time.

Ms Day asked about the trajectories in the Home First action plan. Mr Brennan confirmed that the trajectories were set at the beginning of the year and they would not be changed, He then stated that the areas that are focussed on are the one hour ambulance delays, the number of patients spending over six hours in the ED, length of stay for emergency patients and the decision to admit (DTA) target of four hours. Ms Day asked that the use of the trajectory is revised as she felt it was misleading.

**ACTION: revise the use of trajectories in the Home First action plan (Mr Brennan)**

Dr Tunnicliffe was encouraged to hear about the work streams. He was surprised that there had been little progress in criteria led discharge. He asked what the barriers were in this work. Mr Hallissey stated that it was cultural. It was difficult to change people's behaviour. Record keeping was not as good as it should be. There was, however, a commitment to improve with work ongoing with the consultant body. Mr Brennan stated that a significant issue was not dealing solely with the reason why a patient had been admitted. He confirmed that individuals are now attending each ward round to follow up the decisions made. This is making a difference. He also stated that the patient flow centre has a mismatch of patients needing pathway support and he was hopeful that by the end of January, the patient flow centre would be closed.

Mr Horwath wondered where the extra consultants would be found for the 'take'. Mr Brennan confirmed that he was working with Mr Hallissey to redeploy consultants and this would be undertaken prior to Christmas.

Mr Hopkins stated that there was a gap in the number of trainees and the frailty service needed to be enhanced. Mr Hallissey described the work that Dr Trevelyan has undertaken on frailty and the proposal to significantly increase the number of care of the elderly consultants who would then facilitate the movement of patients through the system and link to the community and nursing homes to prevent admissions. The approach would save money and liberate space for elective cases.

Mr Hallissey also explained the work he has undertaken on the lack of medical manpower. He is putting together a short life task and finish group to review and develop different models for the workforce.

Mr Oosterom welcomed the approach to frailty but wondered where the additional consultants would come from. Mr Hallissey explained that he was exploring different ideas and was positive that a momentum could be achieved. Ms Smith added that considerable investment had already been undertaken in this area.

Ms Blakeman queried the overall level of assurance. She felt it should be level 2 not 3

and she asked who the overall executive lead was as it was not clear within the document. Mr Brennan confirmed that he was the executive lead.

Sir David reflected that all hospitals were facing pressures which needed system wide solutions. He stated that the solutions needed to be specific for Worcestershire. Patient safety was critical. He also requested that work was undertaken with primary care and the Health and Care Trust to ensure that there was no duplication. Mr Hallissey agreed.

132/19/3 **Financial and Operational Performance/Finance and Performance Committee Assurance Report**

Mr Williams (who chaired the finance and performance committee meeting) expressed frustration that it was not possible to give a level of assurance in respect of the Home First plan as progress was difficult to monitor. Verbal assurance is given, but there is a lack of written assurance.

In respect of finance, the October performance was in line with expectation. The cost improvement programme would probably achieve £11m to achieve the £83.8m forecast. It was unlikely there would be a better outturn. He urged progress to be made to ensure that programmes were ready to commence on 1 April 2020 for the year 2020/21.

*Mr Hopkins left the meeting*

Mr Oosterom was pleased that the governance work which was ongoing would improve the situation. Mrs Morris explained that the levels of assurance were currently being tested and further discussion would take place in the committees. Mr Williams stated that there needs to be clarity on what is not being achieved.

Dr Tunnicliffe stated that the testing has improved the efficiency of the committee and has enabled the real issues to have been grasped. He supported Mrs Morris in her work that was currently being undertaken.

Ms Day also stated that progress had been made and she was reassured with the current progress being made with the development of the annual plan. However she was not assured with any progress being made to transform the work so that the finances improved.

Ms Smith agreed. She stated that the annual plan process has been built by the divisions and directorates so that by the end of December, cost improvement programmes will have been identified and be able to be put into budgets. She also confirmed that transformational programmes were beginning to be identified such as the medical workforce work as described by Mr Hallissey earlier in the meeting.

Dame Julie stated that staff did not believe in transformation and she wondered how much divisions were really engaged. Ms Ricketts described the work being undertaken by the human resource business partners on reviewing the staff profile, agency and bank spend at granular level. She stated that this would take time to embed. Mr Hallissey outlined the transformational work being undertaken with the right site right surgery work stream. He stated that currently progress was slow but momentum would gather.

Sir David was disappointed that only half the cost improvement programme had been delivered. He was pleased to hear of Mr Oosterom's optimism for the commencement of 2020/21 with respect to the CIP. Mr Oosterom stated that key elements needed to be identified, in particular the work that the Trust can influence.

Sir David asked for clarification on the contract that was being asked for approval. Mr Toole explained that across the STP, a single supplier was being used and by aligning the five contracts, significant savings could be made. Contract management would be robust by each organisation.

**RESOLVED THAT the report be received for assurance**. **Approval was given to the Finance and Accounting and Employment services award.**

132/19/2 **Quality Performance/Quality Governance Committee Assurance Report**

Mrs Morris updated members with the infection prevention and control report. There had been seven cases of *c diff* during October and the actions as identified before were being embedded. Work was still needed with the Chief Pharmacist on antimicrobial prescribing. She confirmed that Mr Hallissey would be chairing the medicines safety committee from January and this would have a renewed focus on prescribing with improved outcomes by March. She was pleased that the recent NHS I visit had resulted in the Trust being de-escalated to green from red.

Mr Hallissey added that there continued to be a problem with the completion of the sepsis bundle in terms of urine output and intravenous fluid. A new process was in place to track patients and was picked up through EZnotes. The clinical lead was undertaking an audit on barriers on why the paperwork was not completed.

In respect of learning from deaths, the percentage mortality was in line with peers. There was a difference between the two sites for HSMR and SHMI. He was pleased that there were now enough medical examiners in post to ensure real time mortality reviews.

Mr Williams asked about progress with the flu vaccination programme for staff. Mrs Morris explained that currently 67% front line staff had been vaccinated. Last year's outturn was 76% and the aim was 80%. She described the initiatives underway through occupational health.

Dr Tunnicliffe gave the report on the QGC meeting. He emphasised the work on assurance levels. The meeting had considered a report on long waits in the ED. The seven day service report had been approved for submission. This report triangulated with the report on medical manpower as described earlier in the meeting.

**RESOLVED THAT the report be received for assurance.**

132/19/4 **People and Culture Performance**

Ms Ricketts described the progress made in all areas. There had been a significant reduction in vacancy rates due to overseas recruitment. However, sickness was higher than previous years, both long term and short term. The deep dive which would be considered by the People and Culture Committee highlighted that staff were not indicating the reason for sickness. The implementation of the sickness policy also needed to be improved and the business partners would support this within the divisions.

Mr Yates confirmed that all indicators apart from sickness were moving in the right direction. He gave credit to Ms Ricketts and her team.

**RESOLVED THAT the report be received for assurance.**

**DATE OF NEXT MEETING**

The next Public Trust Board meeting will be held on Thursday 16 January 2020 at 10:00

in the Alexandra Hospital Board room, Redditch.

The meeting closed at 11.29 hours.

**Signed _____ Date**
**Sir David Nicholson, Chairman**

**Enc B**

**WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST**

**PUBLIC TRUST BOARD ACTION SCHEDULE – JANUARY 2020**

**RAG Rating Key:**

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

| Meeting Date | Agenda Item | Minute Number (Ref) | Action Point | Owner | Agreed Due Date | Revised Due Date | Comments/Update | RAG rating |
|---|---|---|---|---|---|---|---|---|
| 12-12-19 | IPR | 132/19/1 | Revise the use of trajectories in the Home First action plan | PB | Jan 2020 | | Trajectories revised. Overseen by F&P Committee. Action closed. | |
| 12-9-19 | Patient Story | 63/19 | Arrange dementia training for Trust Board members. | CNO (VM) | Oct 2019 | | To be programmed into a Board seminar. | |

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

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|---|---|
| Meeting | Trust Board |
| Date of meeting | 16 January 2020 |
| Paper number | C |

# Chief Executive's Report

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Matthew Hopkins<br>CEO | | |
| **Presented by** | Matthew Hopkins<br>CEO | **Author /s** | Kimara Sharpe<br>Company Secretary |

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

| **Report previously reviewed by** | | |
|---|---|---|
| Committee/Group | Date | Outcome |
| | | |

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

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

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| Meeting | Trust Board |
| Date of meeting | 16 January 2020 |
| Paper number | C |

## Introduction/Background

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

## Issues and options

I should like to thank all our staff for their hard work over the exceptionally busy Christmas and New Year period.

**Operational performance:** We continue to have a significant mismatch across the health and care system between the growth in the number of attendances at our emergency departments, and our capacity to safely and efficiently manage them. I would urge everyone to consider whether attendance at our EDs is truly necessary or whether other health care options could be utilised for example our network of minor injury units, pharmacists or NHS 111.

As progress in alleviating pressures in our emergency departments has remained slow, I have agreed with the executive team the following changes to the our key Home First Programme:

- I am now chairing the programme board. The Chief Operating Officer remains SRO.
- I have revised the terms of reference for the programme board to tighten the membership and confirm lines of accountability
- We have secured additional resource to deliver the programme, with the help of NHSE/I
- We have increased our clinical leadership to each work stream
- We have implemented dynamic risk assessments and we are revising our escalation policy.

We will continue to monitor progress daily and formally at the Trust Management Executive. We will also report to the Finance and Performance Committee. I have attached to this report, a formal update on the Home First programme.

**CQC unannounced visit**: We received an unannounced inspection of our emergency departments by the CQC in December. We are awaiting the draft report.

**Freedom to Speak up Guardian**: Melanie Hurdman, Matron in midwifery, has been appointed to succeed Bryan McGinity as Freedom to Speak Up Guardian. She will combine this role with a reduced clinical role.

**Local wellbeing events launching for patients, families and carers affected by cancer:** Patients, families and carers affected by cancer can benefit from a new monthly programme of health and wellbeing events across Worcestershire launching in the new year, aimed at encouraging a positive approach to moving forward after diagnosis. The events, developed by the Cancer Services Team at the Trust, will be held at venues across the county, and will be a ‘one stop shop’, providing advice and information across a range of topics.

**Worcestershire Midwives shortlisted for national award:** I am delighted that midwives from Worcestershire have been shortlisted for a national award from the Royal College of Midwives (RCM). Team Ruby and Team Sapphire (the new Continuity of Carer midwives from the Trust) have been nominated for Team of the Year. The roll out of the continuity of carer model (which aims to ensure that more mums-to-be see their named midwife, or a

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midwife from a small team, right through their pregnancy journey including birth) started earlier this year, with the aim that most pregnant women across the two counties will receive their care this way by 2021.

**Chair of the Herefordshire and Worcestershire CCG**: Dr Ian Tait has been appointed as the new CCG chair with effect from 1 April 2020.

**Queen's speech:** The new government has set out its legislative agenda through a Queen's speech. They will introduce an NHS funding bill to enshrine in law the multi-year funding settlement for the NHS, legislation to deliver the long term plan, the reintroduction of the Health Service Safety Investigations Bill and reform of the Mental Health Act. We await further details on the implementation.

**NHS Leaders Meeting**: On 17th December I attended a national event hosted by Sir Simon Stevens which outlined the priorities for 2020 and beyond, mirroring the statements made in the Queen's speech. Key messages included the expectation of a new NHS Bill which would signal the merger of NHS England and NHS Improvement. There was also a major focus on the NHS People Plan and the role of national regulators in promoting workforce growth and retention.

## Recommendations

The Trust Board is requested to

- Note this report

## Appendices - none

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|---|---|
| Meeting | Trust Board |
| Date of meeting | 16 January 2020 |
| Paper number | C (attachment) |

# Home First Worcestershire Programme - Update

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Paul Brennan<br>Chief Operating Officer | | |
| **Presented by** | Matthew Hopkins<br>Chief Executive | **Author /s** | Marsha Jones, PMO |

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

| **Report previously reviewed by** | | |
|---|---|---|
| Committee/Group | Date | Outcome |
| | | |

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|---|---|
| **Recommendations** | The Trust board are requested to receive this report for assurance |

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

| **Risk** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Key Risks** | *BAF 4* | | | | | | | |
| **Assurance** | *Through the Programme board and TME. F&P oversight.* | | | | | | | |
| **Assurance level** | **Significant** | | **Moderate** | | **Limited** | | **None** | |
| **Financial Risk** | *As identified* | | | | | | | |

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|---|---|
| Meeting | Trust Board |
| Date of meeting | 16 January 2020 |
| Paper number | C (attachment) |

## Introduction/Background

The Home First Worcestershire (HFW) Programme has been created to improve the safety, efficiency and performance of the urgent and emergency care pathways at the Trust, focusing primarily on the elements of the pathway that are within our control.

The primary objective is to have empty adult inpatient beds each morning on both the Alex Hospital (AH) and the Worcestershire Royal Hospital (WRH) sites (see SPC 1.).

The consequence for patients of achieving this objective would be a significant reduction in ambulance handover delays (see SPC 2), a significant reduction in aggregated long waiting times in our emergency departments (see SPC 3), and reduced exposure to avoidable harm. The consequence for staff would be a significant improvement in their working conditions and job satisfaction.

The HFW Programme Board drives the implementation of the six work streams and the headline measures of improvement:

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

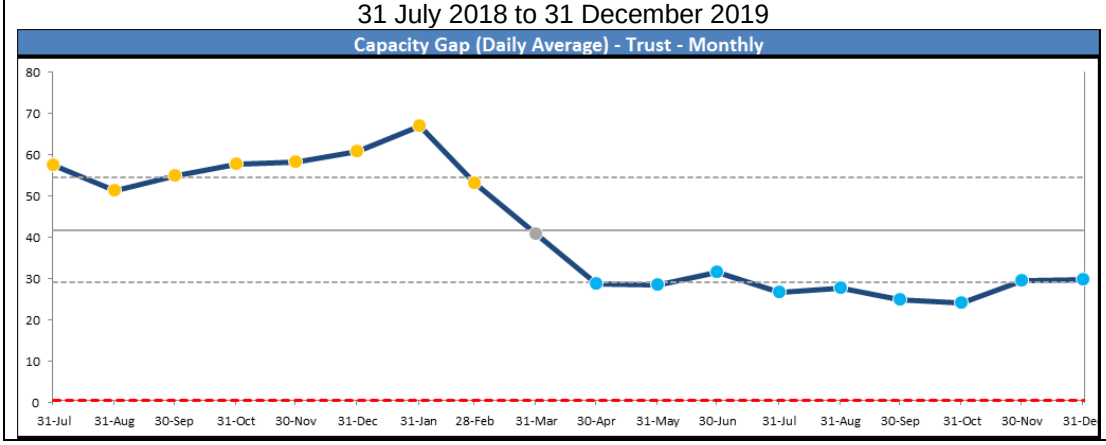
The Chief Executive now chairs the Programme Board and the membership has been enhanced to ensure more targeted action (see appendix 1). Additional project management resource has been secured and an improvement method is used to identify and test solutions and measure impact to identify changes for adoption or adjustment.

This summary update for the Trust Board focuses on recent progress in implementing HFW and the next steps.

**SPC1 Capacity Gap per month (Trust wide)**

Number of patients at midnight either in ED with a DTA or boarding on a ward

31 July 2018 to 31 December 2019



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|---|---|
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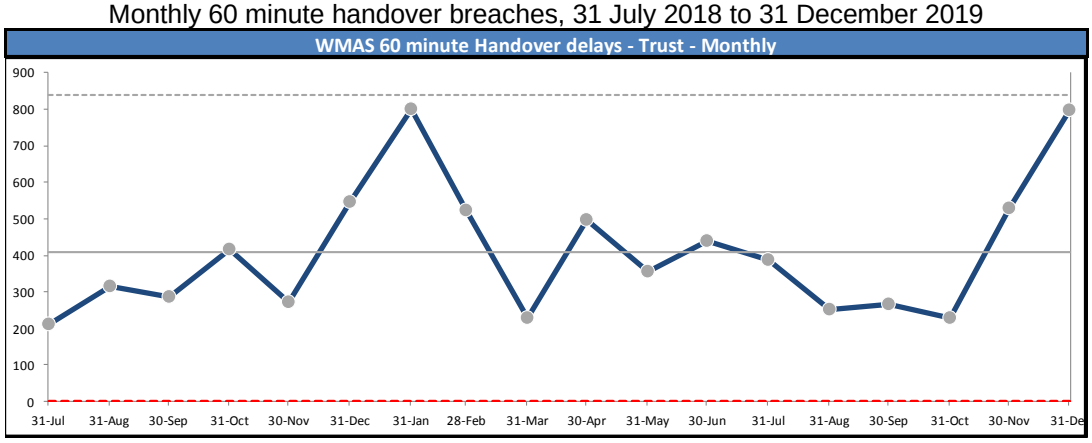
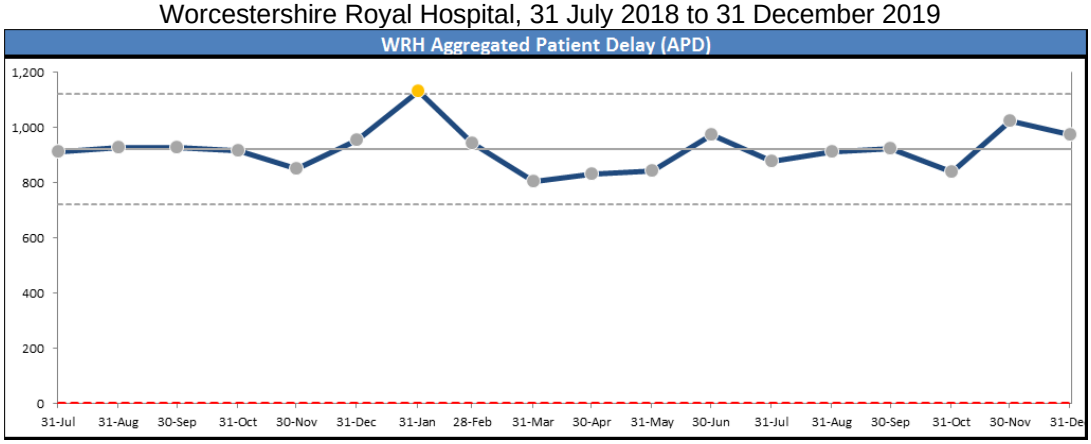
**SPC2 Ambulance Handover Breaches**

Monthly 60 minute handover breaches, 31 July 2018 to 31 December 2019

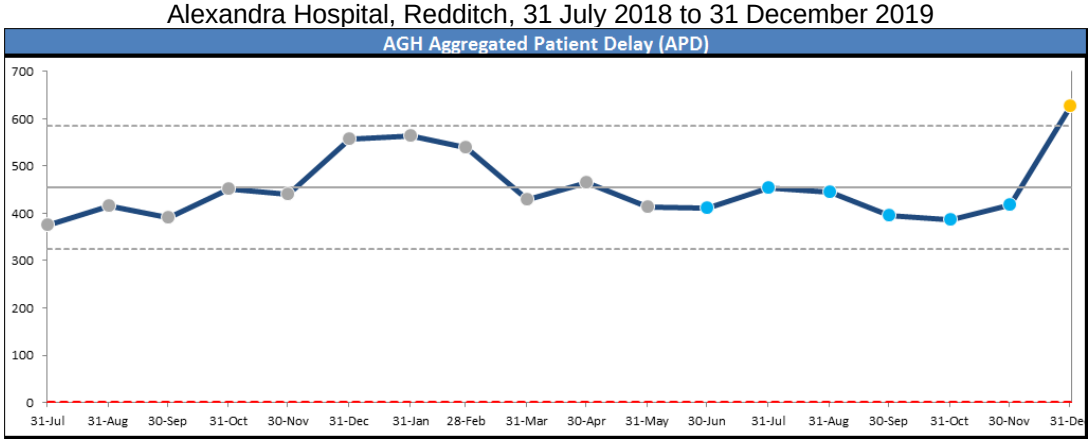



**SPC 3 Aggregated Patient Delay**

The average wait from breaching 4 hours to departure from the emergency department Worcestershire Royal Hospital, 31 July 2018 to 31 December 2019




Alexandra Hospital, Redditch, 31 July 2018 to 31 December 2019

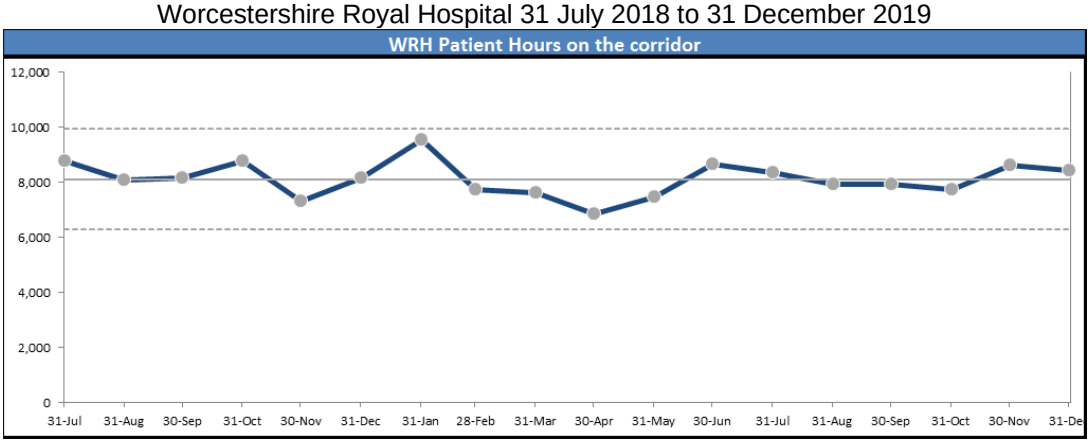


| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 16 January 2020 |
| Paper number | C (attachment) |

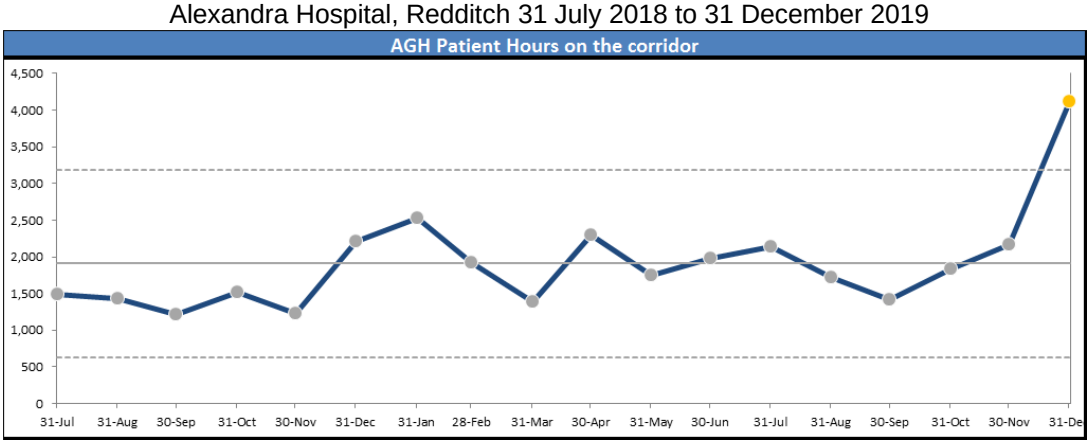
**SPC 4 Patient Hours on the Corridor**

Monthly number of hours patients spend on the corridor.

Worcestershire Royal Hospital 31 July 2018 to 31 December 2019




Alexandra Hospital, Redditch 31 July 2018 to 31 December 2019




## Issues and options

### 1. Demand & Capacity Mismatch

As part of a focus on December 2019 performance, system predicted data was submitted as part of the Winter Pulse Check to NHSE/I (submitted in October), which has been compared to what was actually realised in December. Predictions were based on previous trends, plus growth and improvements based on the Capacity (Intervention) Plan. This includes Same Day Emergency Care (SDEC) % and acute discharge %.

The overview analysis highlights in December:

- Ambulance arrivals were +5.8% above prediction at WRH and -5.12% below prediction at AH.
- A&E attendances were +3.35% above prediction at WRH and -1.10% below prediction at AH.
- Emergency Admissions were +7.9% above prediction at WRH and -2.99% below

prediction at AH

- All Admissions were +7.91% above prediction at WRH and -0.20% below prediction at AH.
- Discharges were +10.8% above prediction at WRH and +0.42% above prediction at AH.
- The benefits of improvement work in SDEC areas on the WRH site have been realised a +18.81% difference: evidenced in November of the planned impact and actual Impact.

Even more recent demand data shows significant increases in demand over the last two weeks of December and the first week of January, as shown below.

**Worcestershire Royal - 16th Dec to 6th Jan**

| | Year | | | Growth 2018 to 2019 | | |
|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | % | act | per day |
| A&E Attendances | 4,254 | 4,288 | 4,463 | +4.08% | +175 | +8 |
| Ambulance Arrivals | 2,066 | 1,919 | 2,069 | +7.82% | +150 | +7 |
| Emergency Admissions | 2,003 | 2,061 | 2,233 | +8.35% | +172 | +8 |

**The Alex - 16th Dec to 6th Jan**

| | Year | | | Growth 2018 to 2019 | | |
|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | % | act | per day |
| A&E Attendances | 3,242 | 3,261 | 3,398 | +4.20% | +137 | +6 |
| Ambulance Arrivals | 1,184 | 1,340 | 1,524 | +13.73% | +184 | +8 |
| Emergency Admissions | 1,130 | 1,158 | 1,222 | +5.53% | +64 | +3 |

However, the deterioration in performance on the AH site has led to a review of staffing and clinical leadership as well as planned introduction of a senior manager on the site to operationally manage the day to day operational flow.

**2. Workstream Updates**

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 16 January 2020 |
| Paper number | C (attachment) |

**2.1 SDEC Workstream**

Since the last update to the Trust Board, the Surgical Case Day Unit (SCDU) Improvement Project has made good progress in improving performance on the time measured from referral to specialist teams to departure from the Emergency Department for surgical patients. The new process is aligned with and enables compliance with our Internal Professional Standards (see SPC 5). After a successful pilot period additional funding has been secured. A business case is being developed to maintain the service substantively within the hours of 8am to 10pm (WRH) and 8am to 8pm (AH site).

**SPC 5: Internal Professional Standards: referral to ED departure**


In December 2019 27.57% of emergency admissions to Worcestershire Royal and 34.18% of emergency admissions to the Alexandra site receive their care through the SDEC service (measured by referrals to AEC, FAU, GAU, PAU, SAU). To ensure that we achieve the national standard of 30% of attendances streamed to SDEC services, further focus is planned to increase the number of clinical pathways streamed. The focus is on ensuring that patients with a medical need are streamed to the appropriate SDEC location either straight from ambulances or upon arrival at ED, in full alignment with the AEC directory.

A critical factor in supporting streaming is the further development of destinations to stream to. AEC, PAU and surgical assessment unit are progressing well with job plans reorganised to enable a timely response. Further work is however required to release the acute assessment area from currently operating as a bedded area. With the 33 additional acute beds coming online during February, this presents an opportunity which the weekly delivery group is working towards. Additional operational resource will be on stream from w/c 13 January to assist with implementation of clinical protocols to increase SDEC uptake.

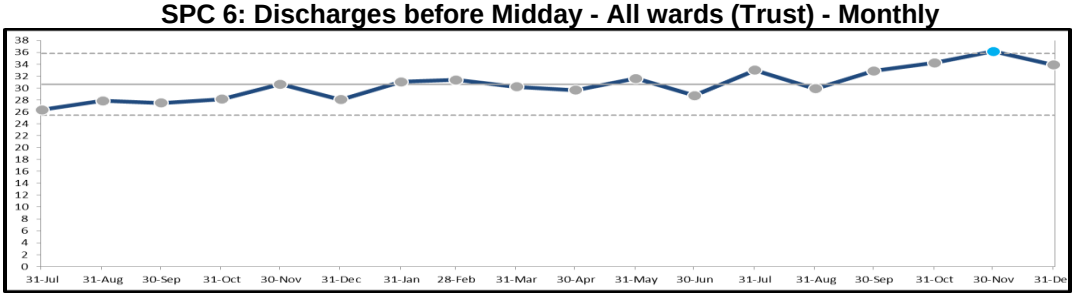
Similarly in November, there was a system agreement of schemes to be delivered by partners to impact on a reduction in the Bed Day Gap (see waterfall chart 1). Our schemes showed some impact collectively especially through improved SDEC to achieve 154 bed days - actual were 299. But we are aware of the lack of progress in delivery of front door streaming. This will be addressed with through support by all system partners and dedicated project and performance management personnel.

Dr Ben Owens (ECIST) supported a wider review into front door streaming. The GP in ED supports patients with primary care suitable conditions in hours. This service is supported in the out of hours service by the out of hours GP service. The hours of operation are currently 2pm until 10pm but extension to midday is under consideration. Throughput is however c1.5 patients per hour. The streaming review identified that it is possible to raise this to 3 per hour.

**2.2 SAFER and Red2Green**

These principles are being delivered through an accelerated implementation plan. The development of 'How we are doing dashboards' provides weekly updates to the ward teams and shows a steady month on month improvement in the number of discharges before midday (see SPC 6). A recognition and reward system has been established to promote positive reinforcement and create a competitive environment amongst wards.

**SPC 6: Discharges before Midday - All wards (Trust) - Monthly**




A number of actions now need to be delivered to progress to consistently achieve national best practice of 33% of discharges before midday across 7 days. The analysis of the information identifies improvements over the 5 working days only. To achieve this we must introduce Criteria Led Discharge (CLD), but to ensure a safe and sustained approach to CLD, a programme of education and training is being written, applying NHSE/I documentation and best practice. This will be designed and implemented through January and February to ensure a shift in improvement of weekend before midday discharges.

A second consultant physician input into the acute take (12 hours) should increase the discharge rate at 0, 1 and 2 day lengths of stay which should be in excess of 60%. We aimed to have sourced an additional SHO from 2pm until 10pm and additional consultant support 5 to 9pm but there are still rota gaps. In order to fill the gap additional GIM consultant capacity has been sourced externally to give 7 day cover through to the end of March. With a solution to rota fill identified, monitoring of the impact will begin, with the aim of achieving 60% of admissions with a 0, 1` or 2 day LOS.

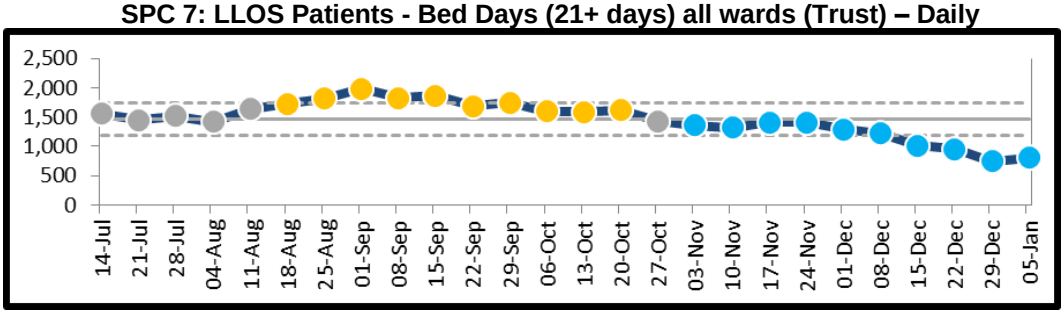
Some of the improvement so far has been achieved through better utilisation of the discharge lounges. To ensure the demand and capacity of those environments is matched an audit is currently underway which is due to report back to the HFW Board on 14th January.

Additional project management resource is coming on stream over the next two weeks to help the next phase of roll out, and medical clinical leads are being identified on each site to ensure medical engagement in the new ways of working.

**2.3 Long Length of Stay** (LLOS)
This workstream is progressing well. In March 2019 the number of patients staying over 21 days was on average 114. NHSI mandated a 40% reduction against that baseline by March 2020. This target was achieved in December 2019, with the number reduced to 62 patients (see SPC 7). While over the latter two weeks of 2019 the number has increased again, there is high confidence that the March 2020 target will be met.

The key to success here has been the strong leadership from the Executive Sponsor and Workstream Lead, the attention to detail and the challenge and escalation to unblock patient delays.

**SPC 7: LLOS Patients - Bed Days (21+ days) all wards (Trust) – Daily**




External support to drive improvements in our patients' length of stay has been achieved through an improvement project, jointly led by Worcestershire Health and Care Trust and the County Council, testing an integrated care team approach to support patients to return home sooner. Known as the Onward Care Team (OCT) this will require community nurses and social workers to work differently.

The development of the OCT is a priority to support improved flow and increase the rate of discharge to patients' normal place of residence. The staff consultation process is supporting over 20 colleagues through the process of moving job roles, location and banding. The process is on track to deliver the full OCT model for 1st February. Whilst the consultation process is ongoing, the core functions of the OCT model continue to be delivered on the Alexandra site drawing on colleagues who have volunteered whilst formal consultation processes are continuing. From Monday 6th January the Worcestershire Royal site has been supported by a team of nurses from the community who will be delivering dynamic case finding to identify patients to fill community capacity. This is being covered by moving nurses from other teams and will be the main point of contact for family liaison, professional agreement and filling community capacity.

**2.4 Frailty/HAFD workstream**
A pilot of the front door Geriatric Elderly Medicine Team took place during the weekend of 18th to 22nd December 2019. This is now being evaluated. Adjustments have been made for a second test this month to inform a new model of care that with HR business support could be accelerated. Dr Ian Sturgess is assisting the design of the model and the implementation.

One outcome may be that we need to combine the capacity across the frailty teams and current community and social care resources in ED / AEC, giving greater capacity and

delivery. There is a compelling relationship between this work and the formation of the 2-hour response development being led by the Health and Care Trust. These 2 work programmes will have a close working relationship as they already have this opportunity highlighted. The Health and Care Trust have recruited more community nurses who will be coming into service over the next 3 months which will give increased capacity to support admission avoidance both in ED and supporting people to remain safe and well in their own homes.

Table 1 sets out the next steps for this workstream.

**Table 1: Frailty/HAFD Milestones**

| |
|---|
| 1. Development of HAFD Internal Communication Plan including video |
| 2. Identify Frailty Champions |
| 3. Development of FrailSafe Bundle and test on HAFD pilot wards |
| 4. Identify measures from FrailSafe for Matron Quality Audit |
| 5. Agree and test front door CFS decision making model - triage or at DTA? |
| 6. Development of CGA Light |

A key action to support the reduction in Hospital Acquired Functional Decline is the augmentation of Pathway 1. This is an area where there has been direct system investment with the new provider coming on stream in February. However there is currently workforce capacity not filled with a request for partners to consider how the OCT can support with a pull model for patients to return to their own address sooner.

Progress has been made for the weekend capacity to be enhanced, and in addition the council have commissioned block booking of 5 residential home beds. The commission for additional home care capacity will start to come online from the beginning of February 2020 and increase capacity from 70 discharges per week to 110 per week for patients needing care packages. This capacity will be used to support further step down from acute, community hospitals and admission avoidance. In the interim, additional capacity will be recruited for AHPs and assessors in the promoting independence service, and for additional social worker capacity. Implementation and mobilisation will be monitored through weekly COOs meeting and via the AEDB dashboard. In order to ensure we are best using the current and future capacity the following actions are in place:

- Wards being instructed to identify patients for next day discharge
- Funding to support expansion of the capacity management team, providing operational drive on both sites
- Recruitment of additional senior operational resource on a temporary basis (from 7th January) to support embedding best practice and bringing discharges forward
- Implementation of temporary OCT solution until full rollout of OCT on February 1st
- Operation of command and control processes in the acute to drive discharge
- COO escalation of community hospital delayed transfers to free capacity.

**2.5 Clinical Site Management**

The recently appointed Director of Capacity has identified a capacity and capability gap in the site management function, particularly in the provision of out of hours clinical site management. Their role is crucial to the smooth operational running of the hospitals and the management of critical incidents and business continuity.

A new model is under development with increased capacity funded by the NHSI/E regional team, but the implementation has been slow due to the day to day operational demands on the Director of Capacity. Additional project management and HR support is now in place to progress the design and consultation on the new model.

Aligned to this a consultation process for the strengthening of the Matron shift arrangements on each site and the General Manager on call rota in underway. This will lead to increased senior operational and nursing input, to improve the out of hours arrangements.

The next step will then be to strengthen the overall 24/7 hospital clinical and management arrangements.

**2.6 Internal Professional Standards**

Internal professional standards are a clear, unambiguous description of the values and behaviours expected in an organisation. They are most powerful when they are centred on patient care, are written and agreed by the clinical leaders and openly supported by the executive team.

These have now been developed in consultation with the divisional directors and launched. The first edition focuses on enabling emergency medicine consultants to be able to onward refer to specialties following their own clinical assessment and if there is a delay in response from any specialty team, to transfer the patient to the specialty assessment area for them to be assessed there. This will improve flow and reduce exit block in the EDs.

The second edition relates to the clinical responsibility for patients referred to medical specialty teams within the EDs, where there is a delay in their onward movement to an inpatient bed. The standards make it clear that the responsibility lies with the medical specialty teams and they are responsible for the clinical safety and review of the patient.

The third edition is in the form of a policy which details obligatory Internal Professional Standard's (IPS) that have to be achieved in order to ensure:

1. **Safe management of patients attending the Emergency Department.**

a. To comply with quality indicators in emergency and urgent care.
b. To standardize the referral process from the Emergency Department to specialties, including the escalation process.
c. To define standards for investigation requests and results in the Emergency Department.

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

The Chief Medical Officer (CMO) has charged the divisional medical leads to oversee implementation. An audit process is being developed to monitor compliance which will be reported through to the HFW Programme Board, with improvements delivered and monitored through divisional performance review meetings and specialty level reviews.

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 16 January 2020 |
| Paper number | C (attachment) |

Additional project management and operational support has been secured to help drive the implementation and monitoring of this workstream.

## Conclusion

Home First Worcestershire is the top quality improvement priority. There are further changes and new initiatives coming on stream in January and February to improve the quality and operational performance. The additional new beds opening in February will enable the patients to be cared for in the right bed first time. Reducing the number of internal moves is evidenced to provide a better patient experience, but also reduces a patient's length of stay. Focussing collectively on taking a Frailty sensitive approach to the older person with delivery of agreed new ways of working to ensure patients to return to their own address and to prevent HAFD is a primary driver of all partners.

This summary report is not exhaustive in the description of new developments and new models being trialled, but captures the main areas of progress with the programme. There is an urgent need to accelerate implementation and the improved governance and strengthened resource picture will increase pace.

## Recommendations

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

## Appendices

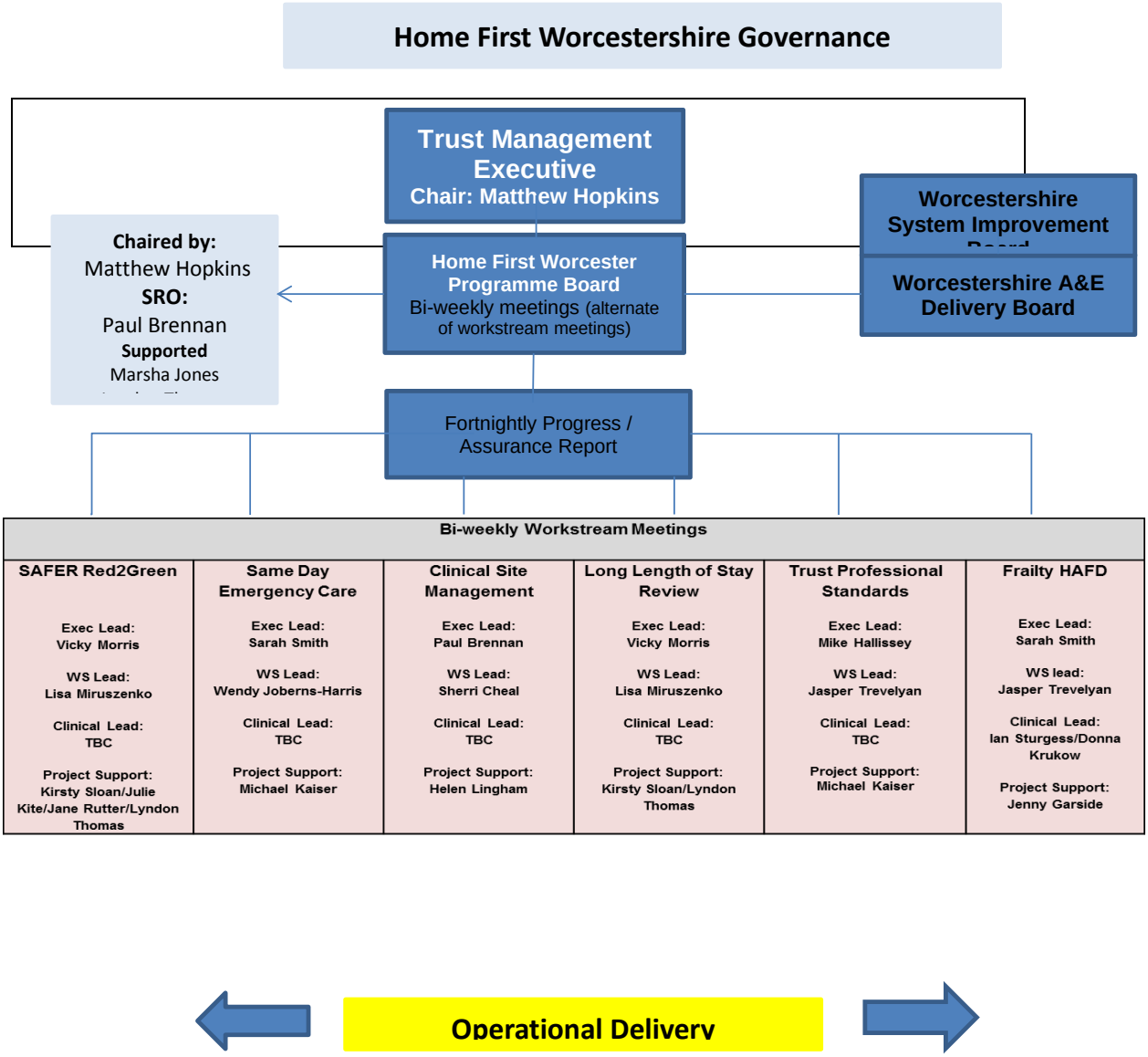
1 – HFW – Governance
2 - Glossary

NHS
Worcestershire Acute Hospitals
NHS Trust

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 16 January 2020 |
| Paper number | C (attachment) |

Appendix 1

Reporting Governance HFW Programme



Glossary

ED – Emergency Department

DTA – decision to admit

SPC – statistical Process Chart

SDEC – Sam Day Emergency Care

LLOS – long length of stay

HAFD – hospital Acquired functional decline

SCDU – Surgical Case Day unit

AEC – ambulatory emergency care

PAU – paediatric assessment unit

GAU – gynaecology assessment unit

SAU- surgical assessment unit

AEDB – A&E Delivery Board

NHS
Worcestershire Acute Hospitals NHS Trust

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 16th January 2020 |
| Paper number | D |

# Trust Board - Integrated Performance Report – Month 8 2019/20

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Matthew Hopkins<br>Chief Executive | | |
| **Presented by** | Paul Brennan – Deputy Chief Executive & Chief Operating Officer | **Author /s** | Nicola O'Brien – Head of Information and BI Analytics<br>Steven Price – Senior BI Analytics Manager |

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

| **Report previously reviewed by** | | |
|---|---|---|
| **Committee/Group** | **Date** | **Outcome** |
| Trust Management Executive | 11th December 2019 | Approved |
| People and Culture Committee | 17th December 2019 | Moderate |
| Finance and Performance Committee | 18th December 2019 | Limited |
| Quality Governance Committee | 19th December 2019 | Limited |

| | |
|---|---|
| **Recommendations** | The Board is asked to:<br>1. Review the key messages from the Integrated Performance Reports provided in Month 8 2019-20<br>2. Note areas of improved, sustained and under-performance.<br>3. Seek assurance as to whether the risks of under-performance in each area have been suitably mitigated, with robust plans for stabilisation and recovery.<br>4. Note that the finance report is part of a separate paper. |
| **Key points to note** | This paper continues in its revised format, designed to aid discussion and challenge regarding how effective our action/recovery plans are to mitigate current declining performance and drive forward improvements.<br><br>**The key points from this paper are as follows:**<br>• An Accelerated Design Event was held with Worcestershire providers and led to the commitment from all to support Home First and patient flow.<br>• An increase in the attendances of children (0-18yrs) has increased the demand on both the Emergency Department and |

Worcestershire Acute Hospitals NHS Trust

| | |
|---|---|
| Meeting | Trust Board |
| Date of meeting | 16th January 2020 |
| Paper number | D |

| | |
|---|---|
| | River Bank Ward at the Worcestershire Royal Hospital.<br>• The number of 12 hour breaches was significantly higher compared to previous months.<br>• No statistically significant change to Cancer 2WW, Breast symptomatic and RTT performance; and the number of cancer patients waiting both 62+ and 104+ days is significantly high.<br>• Diagnostics remains on track to meet the year-end target.<br>• Sepsis six bundle performance remains significantly below target, although the provision of antibiotics within one hour is above trajectory.<br>• E-Coli, MRSA, MSSA and CDif metrics have not met the expected year to date targets.<br>• An audit of ReSPECT training and barriers to completion has been undertaken and a series of actions have been agreed to address the poor performance.<br>• Workforce metrics continue to improve with the exception of sickness absence and non-medical appraisal rates. Mandatory training saw a slight dip which is mainly due to the change in eligibility for Prevent (WRAP) training as required by the CCG. |
| BAF risk numbers are: 1,2,3,4,5,6, 7,8,10,11 and 12. | |

Enc

# Trust Board

# Integrated Performance Report

# Improvement Statements

## November 2019
Month 8

16th January 2020

# PERFORMANCE IMPROVEMENT STATEMENTS

## 1. Patient Flow as supported by the Home First Programme

Strategic Objective: Best services for local people

| Metrics | Current performance (November) | December Trajectory | January Trajectory | February trajectory | 19/20 Year-end target |
|---|---|---|---|---|---|
| % of patients waiting less than 4 hours from arrival to admission, transfer or discharge (EAS) | 74.47% | 86.00% | 86.00% | 86.00% | 86.00% |
| Number of ambulance handovers (60 minutes) | 528 | 329 | 330 | 107 | 0 |
| Number of patients spending 12+ hours from decision to admit to admission | 137 | 0 | 0 | 0 | 0 |

**How have we been doing?**

- No statistically significant change with EAS performance at 74.46% or 60+ minute handover delays (despite the increase from 228 to 528).
- Our national ranking for 4 hour EAS improved with our performance being 0.5% worse than this time last year, but other Trusts in the Midlands region have declined by 5.38% even though there have been 148,000 fewer attendances.
- However 137 12+ hour breaches is a significant increase for the month.
- An Accelerated Design Event was held in November where all providers committed to supporting Home First and patient flow.
- A capacity / intervention plan for new initiatives to aid patient flow during winter was developed.
- We are starting to experience an unexpected increase in the attendances of children (an increase of 26% in the last three weeks).
- Immediate benefit were realised on ED due to the Internal Professional Standards workstream
- We were able to focus on the 14+ days cohort of stranded patients due to the positive impact on reducing 21+ days cohort
- Four tests of change agreed for Frailty / Hospital Acquired Functional Decline (HAFD)
- Home First Dashboards went live on WREN

**What actions are being taken to make the improvements?**

- Communication Plan has been agreed for the 6 workstreams including a Home First logo for branding. SAFER / R2G has been prioritised so that it is aligned to intensive rollout.
- Test cycle (week 3) of changes to the surgical day case unit started and evaluation of performance will be provided in the next report.
- Frailty / Hospital Acquired Functional Decline (HAFD) tests of change will be and are planned for the coming months.
    - Awareness raising of HAFD including incident reporting
    - Test the Front Door frailty model
    - Design and implement Frail Safe Bundle on pilot wards
    - Develop comprehensive geriatric assessment lite and test it at the front door
- Snapshot audit (with ECIST support) will be undertaken to inform primary care streaming.
- Specialty Medicine Team will work with Clinical Site Team to improve flow within their wards.

**Assurance level – LEVEL 3**

**SRO: Dependant on work stream**

# PERFORMANCE IMPROVEMENT STATEMENTS

Worcestershire Acute Hospitals NHS Trust

## 2. Two week wait cancer waiting times (Unvalidated)

Strategic Objective: Best services for local people

| Metrics | Current performance (November) | December Trajectory | January Trajectory | February Trajectory | 19/20 Year-end target |
|---|---|---|---|---|---|
| % patients seen within 14 days (2WW) (All Cancers) | 90.38% | 95.58% | 93.34% | 94.05% | 93.10% |
| % patients seen within 14 days (2WW) (Breast Symptomatic) | 72.22% | 93.00% | 93.00% | 93.00% | 93.00% |
| **Assurance level – LEVEL 3** | | | **SRO: Paul Brennan (COO)** | | |

## 3. 62 day cancer waiting times (Unvalidated)

Strategic Objective: Best services for local people

| Metrics | Current performance (November) | December Trajectory | January Trajectory | February trajectory | 19/20 Year-end target |
|---|---|---|---|---|---|
| % patients treated within 62 days | 66.01% | 86.04% | 86.04% | 86.04% | 86.04% |
| Number of patients waiting 62+ days | 241 | N/A | N/A | N/A | N/A |
| Number of patients waiting 104+ days | 68 | N/A | N/A | N/A | N/A |
| Assurance level – LEVEL 2 | | | **SRO: Paul Brennan (COO)** | | |

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

Strategic Objective: Best services for local people

| Metrics | Current performance (November) | December Trajectory | January Trajectory | February trajectory | 19/20 Year-end target |
|---|---|---|---|---|---|
| % Incomplete | 81.94% | 82.56% | 83.02% | 82.92% | 82.39% |
| 40+ Week Waiters – excludes the agreed exceptions | 147 | 0 | 0 | 0 | 0 |
| Assurance level – LEVEL 2 | | | **SRO: Paul Brennan (COO)** | | |

# PERFORMANCE IMPROVEMENT STATEMENTS

Worcestershire Acute Hospitals NHS Trust

## 5. Diagnostic test waiting times (Validated)

Strategic Objective: Best services for local people

| Metrics | Current performance (November) | December Trajectory | January Trajectory | February trajectory | 19/20 Year-end target |
|---|---|---|---|---|---|
| % patients waiting less than 6 weeks for a diagnostic test | 95.78%[1] | 89.77% | 94.99% | 96.71% | 99.03% |

**Assurance level – LEVEL 6** | **SRO: Paul Brennan (COO)**

# PERFORMANCE IMPROVEMENT STATEMENTS

## 6. Stroke (Validated)

Strategic Objective: Best services for local people

| Metric | Current performance (October) | November Trajectory | December Trajectory | January Trajectory | 19/20 Year-end target |
|---|---|---|---|---|---|
| % of patients spending 90% of time on a Stroke Ward | 72.1%[1] | 73% | 74% | 75% | 80.0% |
| % of patients who had Direct Admission (via A&E) to a Stroke Ward | 50.0%[2] | 52% | 53% | 55% | 90.0% |
| % patients seen in TIA clinic within 24 hours | 71.6%[3] | 65% | 70% | 72% | 70.0% |
| % of patients who had a CT within 60 minutes of arrival | 54.7%[4] | 55% | 56% | 57% | 80.0% |

| How have we been doing? | What actions are being taken to make the improvements? |
|---|---|
| • All four metrics show no significant change in performance<br>• Extended Stroke presence at weekdays and also introduced partial 7 day working. This reduces the reliance on the on-call medical SpR, which limits the delays in organising and allocating patients' to stroke if required.<br>• Stricter approach to bed management and protection of 2 HASU bed at all times.<br>• Enhancement to the performance report and comparison/reconciliation of data is helping to ensure that a range of measures can be improved on weekly/months basis.<br>• Appointment of SpR's to support TIA clinics and ensure consistent ward cover of middle grade doctors. | • Building work already progress for the ward to be moved to a smaller bed base and agreement also is in place for all Stroke beds to be ring-fenced at all times. This would allow the team to truly focus ensuring the key indicators are achieved for each individual patents. The ward move is planned for the 12th January.<br>• Discussion are on-going with regards to Stroke adopting Consultant of the Week model (CoW). This would ensure the stroke team is able to provide 24/7 on-call CNS/Consultant cover.<br>• These major changes should have positive impact on the trajectory.<br>• Advertising for Stroke Admin support role, once appointed should provide cover for data input and TIA clinics over the weekend.<br>• Adverting for fix term/permanent Stroke consultants. This will ensure sustainable 7 day service. |
| **Assurance level – LEVEL 3** | **SRO: Paul Brennan (COO)** |

# Finance & Performance Committee Assurance Report

| Accountable Non-Executive Director | Presented By | Author |
|---|---|---|
| Richard Oosterom<br>Associate Non-Executive Director | Steve Williams<br>Non-Executive Director | Kimara Sharpe<br>Company Secretary |

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

| Level of assurance and trend | | | |
|---|---|---|---|
| Significant assurance | Moderate assurance | Limited assurance | No assurance |
| | | X | |

## Executive Summary

The Finance & Performance Committee met on 18 December 2019.

**Divisional attendance – Surgery:** The divisional director of operations supported by the divisional finance lead and the deputy CMO, presented the current performance, challenges and risks. There is a regional review of the delivery of urology across the area in response the national challenges within this specialty. There has been a huge improvement in the patient experience within trauma and orthopaedics. There are few medical vacancies and the waiting list has decreased. This has been achieved through internal and external support to the directorate and sustained monitoring on a fortnightly basis. We were also informed of other services that need a system wide response such as maxillo-facial surgery and dermatology. Performance in RTT and patients waiting over 40 weeks have improved. We were also pleased to hear of early data showing the success of the recently introduced surgical assessment unit. It was also good to hear of the granular level data being considered such as income per consultant.

**Digital Care Record – Business Case** – this is covered in the private part of the Board due to commercial confidentiality.

**Financial performance - Month 8** – November performance was £1.2m below plan and £0.4m below forecast. This was largely due to the impact of non-elective activity impacting elective activity and non-delivery of the CIP. While the cumulative position remains within forecast levels and continues to be better than the external plan, with the expected CIP delivery (forecasted at £11m against targeted £22.5m) it will not be enough to meet the internal target £(73.7)m and we are losing buffers to cover unexpected risks to hit our external plan of £(82.8)m. Recovery plans had largely been predicated on reducing reliance on temporary workforce by improving flow to enable closure of wards at both the Alexandra and Worcestershire Royal Hospitals. We have not been able to close that capacity as planned and we now don't want to close that capacity to deal with the increased activity in winter. In recognition of this we have been allocated winter funds of £1.5m to provide additional bed ccapacity. We were pleased to see a sustained downward trend in our temporary staffing, particularly nursing. Our substantive nursing workforce continues to grow reducing reliance on expensive agency. Overall we remain fairly confident in achieving an outturn position aligned to our external plan of £(82.8)m, but we recommended the executives to accelerate execution of the ideas for financial recovery developed over summer. This would also put us in a better position for 2020/21.

**Medium Term Financial Plan**: The draft Medium Term Financial Plan (MTFP), in line with the Herefordshire & Worcestershire STP/Integrated Care System Plan sets out key financial planning assumptions over the next 5 years. It is considered as part of the private agenda.

# Finance & Performance Committee Assurance Report

## Executive Summary (cont.)

**Integrated Performance Report:** We received the IPR plus a report on Home First. The IPR showed no statistically significant change to Cancer 2WW, Breast symptomatic and RTT performance; however there remains a decline in Cancer 62 days and the number of patients waiting both 62+ and 104+ days. Diagnostics remains on track. We saw some signs that the impact of Home First was beginning to show, for example the use of ambulatory care and the number of patients seen and discharged within 12 hours. External funding has been used to improve the staffing of the medical 'take' which will have a significant impact on patient flow. It is unknown whether the impact of the higher ambulance conveyancing and increased attendances has been mitigated by Home First. However, whilst the Trust performance has deteriorated by 1.4%, NHS performance nationally has deteriorated by 6%. However we also challenged the Executive team that we are not seeing the biggest priority of the Trust being addressed with the dedication, energy and fighting spirit needed. This requires a different approach, with more dedicated (fulltime) people, who make things happen and pro-actively use the executives to remove the barriers, instead of explanations why things didn't work according to plan.

**Annual Plan**: There has been significant engagement with divisions in the development of the annual plan. Due to operational challenges, there has been slippage on the plan's development. Although understandable, this is a big risk for the preparation of 2020/21. In particular in relation to the Productivity and Efficiency improvement plan, there is insufficient progress. There is an item on the private board covering this and there is a seminar on 30 January for Board members to discuss in detail.

**Acute Services Review (ASR) Full Business Case:** This was presented to the Committee for noting. The full business case will be presented to the Trust board in May. This paper is covered in the annual plan item in private board.

**Liaison contract**: We approved Liaison be awarded the contract for provision of secondary NHS VAT consultancy, recovery and compliance service. This was a renewal of a contract and is a benefit to the Trust.

## Background

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

## Issues and Options

None.

## Recommendations

The Board is requested to:

- receive this report for assurance.
- approve the awarding to Liaison for provision of secondary NHS VAT consultancy, recovery and compliance service.

## Appendices

# QUALITY IMPROVEMENT STATEMENTS

| 1. SEPSIS six bundle - % of patients who received all elements of the sepsis six bundle within 60 minutes of arrival (audit – inpatient wards) | |
|---|---|
| Strategic Objective: Provide the best experience of care and best outcomes for patients. | |
| October performance (validated) is 45.00%. | |
| **How have we been doing?** | **What actions are being taken to make the improvements?** |
| • All Divisions have shown a decline in performance for October.<br>• We have not achieved the target in any month during 19/20.<br>• The provision of antibiotics within one hour is above trajectory for all Divisions with the exception of Surgery.<br>• The other elements of the Sepsis 6 have all shown improvement with the exception of Urine and Blood cultures. | • Enhanced ownership at divisional level such as :<br>  • Specialised Medicine – identified Wards for deep dive audit.<br>  • Urgent Care – Governance looking to identify issues recording Lactate and reminding staff of recording Urine monitoring (even when no catheter).<br>• Clarity regarding SEPSIS reporting will be provided by the Information team to help understanding for operational staff.<br>• The results of an audit to identify barriers to achieving the target will be presented to CGG in January. |
| **Assurance level – Level 2**<br><br>**Reason: We are still identifying the issues contributing towards non-compliance and therefore the action plan cannot be updated until these are understood.**<br><br>**Assurance level last month – Level 2** | **SRO: Mike Hallissey (CMO)** |

# QUALITY IMPROVEMENT STATEMENTS

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

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

| YTD Current performance (November) | YTD December Trajectory | January Trajectory | February Trajectory | 19/20 Year-end target |
|---|---|---|---|---|
| CDif – 40 | CDif – 40 | CDif – 45 | CDif – 49 | CDif – 53 |
| E-Coli – 41 | E-Coli – 44 | E-Coli – 49 | E-Coli – 54 | E-Coli – 59 |
| MSSA – 10 | MSSA – 9 | MSSA – 10 | MSSA – 10 | MSSA – 10 |
| MRSA -2 | MRSA -0 | MRSA - 0 | MRSA -0 | MRSA - 0 |

| How have we been doing? | What actions are being taken to make the improvements? |
|---|---|
| • During November we had 3 CDif cases, 7 E-coli cases, 1 MRSA and 1 MSSA.<br>• As a result of a NHSE/I visit on 28th November we have been de-escalated from red to a green rating.<br>• We have seen an improvement in facilities cleaning scores at the Alexandra Hospital.<br>• The new MRSA was a contaminated blood culture causing no symptoms, rather than a bacteraemia which would make the patient unwell. Rapid review and learning has taken place on the ward; with focus on staff training on blood culture technique.<br>• We have seen an improvement in Cdiff numbers in November, with 3 attributable cases vs an in-month target of 5. This puts us 4 cases over trajectory to date. | • Next NHSE/I visit is scheduled for 29th April 2020.<br>• We will continue to focus attention on all issues, with further clear actions in relation to **antimicrobial prescribing** needed.<br>• We will on a quarterly basis discuss prescribing reviews relating to red lapses of care at the Medical Safety Committee.<br>• We will have escalation actions in place within Divisions and corporately to increase the pace of delivery for improvement with cleaning services. |
| **Assurance level – Level 3**<br><br>**Reason: Specific actions for improvements on prescribing will impact on outcomes in Quarter 4**<br><br>**Assurance level last month – Level 3** | **SRO: Vicky Morris (CNO)** |

# QUALITY IMPROVEMENT STATEMENTS

| 3. ReSPECT training – awareness and authorship | |
|---|---|
| Strategic Objective: Provide the best experience of care and best outcomes for patients. | |
| Current performance in November for:<br>Awareness – 26.60% (1489/6308) – Target is 75%<br>Authorship 28.48% (276/969) with a target of 75%. | |
| **How have we been doing?** | **What actions are being taken to make the improvements?** |
| • Following an audit these themes have been identified as barriers to achieving compliance are:<br>  • Manual collation of who has completed the training includes erroneous records.<br>  • Lack of clarity and communication regarding who is required to complete the training.<br>  • Accessibility to the training materials. | • Executives to agree that ReSPECT to be added to ESR as a non-mandatory requirement.<br>• Poster regarding ReSPECT 'Useful information' including 'access to e-learning training' has been developed.<br>• ReSPECT is now included in the Internal Professional Standards project and contributes towards admission avoidance in the Winter Capacity Plan.<br>• We will be monitoring how many ambulance conveyances occur for patients with ReSPECT documentation.<br>• Note: Action expected to deliver improvements by the end Dec 2019 with an assurance level 4. |
| **Assurance level – LEVEL 2 (03/12/2019)**<br><br>**Reason: Less assurance as a deep dive audit indicated that the volume of completed training was inaccurate.**<br><br>**Assurance level last month - Level 3** | **SRO: Mike Hallissey (CMO)** |

# QUALITY IMPROVEMENT STATEMENTS

Brief summary of other assurance levels provided at Clinical Governance Committee:

| Subject Area | Assurance Level |
|---|---|
| Safety Alerts | Level 3 |
| Resus Audits | Level 5 |
| Volunteers Strategy | Level 6 |
| Patient Experience inc Friends and Family Test | Level 6 |

# Quality Governance Committee Assurance Report

| Accountable Non-Executive Director | Presented By | Author |
|---|---|---|
| Dr Bill Tunnicliffe<br>Non-Executive Director | Dame Julie Moore<br>Non-Executive Director | Kimara Sharpe<br>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 19 December 2019. A summary of key points discussed are as follows:

- **Integrated Quality report**: We received a presentation from the Deputy Director for Infection Prevention and Control. We were delighted with the rating of green from NHS EI and we congratulated Mrs Cooper on her work to achieve this. There are still ongoing issues but there is no consistent themes across the trust. Action is being taken in respect of handwashing and a new app is proving successful. The Trust will probably meet the year-end target for e coli but may not meet the target for c diff. We agreed with the assurance level of 3. the Integrated Quality Report showed that the sepsis bundle was still not being meet. The internal audit being carried out (reporting in January) would show the areas needing more support to improve documentation. We were concerned that not all staff had yet received ReSPECT training and we were pleased that face to face training was being instigated again.
- **Risk Management Strategy**: the Committee approved this Strategy and commend it to the Board. A risks management handbook will be available for staff.
- **Risk appetite**: We approved the statement in respect of quality and safety.
- **Never events:** We received an initial report on the two ophthalmology never events. No harm had come to the patients. The reports of the investigations would be available in January. We also heard details of two other wrong site surgery incidents, one in dermatology and one in gynaecology. We were assured that learning would take place and that a review of LOCSIPPs had been instigated by the CMO.
- **Cluster of perinatal/paediatric deaths**: This report was instigated by the division and showed no nothing untoward. We were assured with the methodology and content of the report.
- **Volunteering Strategy development**: there is considerable work on-going with the development of the strategy. Two meetings have been held with volunteers and the strategy will be presented at the February trust board meeting. It will go to QGC and People and Culture prior to that meeting.

## Background

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

## Recommendations

The Board is requested to receive this report for assurance.

## Appendices

# PEOPLE & CULTURE IMPROVEMENT STATEMENTS

Worcestershire Acute Hospitals NHS Trust

## 1. Appraisal Rates – Ensure all our staff have annual appraisal

Strategic Objective: Best People

| Current performance (November) against local target of 90% | December Trajectory | January Trajectory | February Trajectory | 19/20 Year-end target |
|---|---|---|---|---|
| Non-Medical Appraisal 82% | 83% | 84% | 85% | 86% |
| Medical Appraisal 92% | 93% | 94% | 95% | 97% |

| How have we been doing? | What actions are being taken to make the improvements? |
|---|---|
| • Non-Medical Appraisal rates have shown a 2% dip this month to 82%<br>• Trajectory reduced to take account of dip in performance<br>• Medical appraisal stayed the same at 92% which is above target<br>• Model Hospital benchmark is 85% | • L&D investigating concerns raised about the timeliness of uploading from the electronic appraisal link<br>• ESR sends email 4 months prior to expiry of appraisal to remind manager and individual<br>• Appraisal rates are covered in Divisional PRM meetings<br>• HR send monthly reports to Divisions for discussion at Divisional Board meetings<br>• Further ESR Self Service training for managers planned in 2020<br>• Target to be raised to 95% from April 2020. |
| **Assurance level – LEVEL 3 (was level 4)** | **SRO: Tina Ricketts (DPC)** |

# PEOPLE & CULTURE IMPROVEMENT STATEMENTS

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

Strategic Objective: Best Use of Resources

| Current performance (November) against local target of 100% | December Trajectory | January Trajectory | February Trajectory | 19/20 Year-end target |
|---|---|---|---|---|
| 91% | 92% | 93% | 94% | 95% |

| How have we been doing? | What actions are being taken to make the improvements? |
|---|---|
| • Consultant job planning compliance continues to improve with a 2% increase this month<br>• Compliance is 91% which is above the 90% target<br>• Trajectory anticipates improvement to 95% by year end.<br>• Model Hospital Benchmark is 100% | • Dedicated resource in HR medical resourcing team to upload job plans on e-job plan<br>• Outstanding job plans in SCSD and Surgery escalated to Divisional Directors to follow up. New HR Business Partners are supporting.<br>• E-job plan automated email notifications to be turned on from April 2020 once all job plans are live, which will support the next annual job plan round<br>• Target to be raised to 95% from April 2020. |
| **Assurance level – LEVEL 4 (was level 3)** | **SRO: Tina Ricketts (DPC)** |

# PEOPLE & CULTURE IMPROVEMENT STATEMENTS

Worcestershire Acute Hospitals NHS Trust

## 3. Mandatory Training Compliance – Ensure that all our staff are suitably trained

Strategic Objective: Best People

| Current performance (November) against local target of 90% | December Trajectory | January Trajectory | February Trajectory | 19/20 Year-end target |
|---|---|---|---|---|
| 89% | 91% | 91% | 92% | 93% |

| How have we been doing? | What actions are being taken to make the improvements? |
|---|---|
| • Mandatory training has shown a dip of 1% this month to 89% and is now below current target. This is mainly due to the change in eligibility for Prevent (WRAP) training as required by the CCG<br>• Model Hospital benchmark has increased from 89% to 90% in September<br>• Automated emails from ESR and RAG rated matrix are well received by staff in maintaining compliance.<br>• WRAP training has increased by 23% in December which demonstrates the effectiveness of the ESR functionality for on-line training. | • Mandatory Training compliance is covered in Divisional PRM meetings<br>• HR send monthly reports to Divisions for discussion at Divisional Board meetings<br>• HR Business Partners supporting further action within divisions.<br>• Target to be raised to 95% from April 2020 |
| **Assurance level – LEVEL 6 (no change)** | **SRO: Tina Ricketts (DPC)** |

# PEOPLE & CULTURE IMPROVEMENT STATEMENTS

Worcestershire Acute Hospitals NHS Trust

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

Strategic Objective: Best Use of Resources

| Current performance (November) against NHS average of 8.1% | December Trajectory | January Trajectory | February trajectory | 19/20 Year-end target |
|---|---|---|---|---|
| 9.28% Substantive plus bank for new wards | 9.25% | 9.0% | 8.75% | 8.5% |
| 8.29% Substantive vacancies only | 8.25% | 8.0% | 7.75% | 7.5% |

| How have we been doing? | What actions are being taken to make the improvements? |
|---|---|
| • Successful domestic and international recruitment campaigns continue to impact.<br>• Our overall vacancy rate including funded bank and agency for new wards has reduced by 2.87% since May 2019 and by 0.44% since last month.<br>• Our overall vacancy rate (including funded bank and agency for new wards) is now at 9.27% which is lower than our substantive vacancy rate for same period last year (10%)<br>• Our substantive vacancy rate (excluding new wards) is 8.29% which is a 0.35% reduction from last month | • Rolling Programme of centralised recruitment for Band 5 and Band 2 Nurses and all medical staff<br>• Our recruitment pipeline for nurses will reduce our vacancies from 290 currently to less than 93 by June 2020 as a result of increased domestic recruitment and international recruitment.<br>• Clinical fellow programme in place to reduce career grade vacancies |
| **Assurance level – LEVEL 3 (no change)** | **SRO: Tina Ricketts (DPC)** |

# PEOPLE & CULTURE IMPROVEMENT STATEMENTS

| 5. Sickness Absence Rates – Ensure that sickness absence is managed and that our staff are supported to maintain their health and wellbeing at work | | | | |
|---|---|---|---|---|
| Strategic Objective: Best Use of Resources | | | | |
| Current performance (November) against local target of 4% | December Trajectory | January Trajectory | February Trajectory | 19/20 Year-end target |
| Monthly Absence rate 4.26% | 4.3% | 4.3% | 4.2% | 4.2% |

| How have we been doing? | What actions are being taken to make the improvements? |
|---|---|
| • Our monthly sickness absence run rate has reduced by 0.10% to 4.36% this month<br>• Model Hospital average is 4.11% in September 2019 (which is the latest data)<br>• Short term sickness has reduced by 0.06% to 1.93%<br>• Long term sickness has reduced by 0.01% to 2.37% this month due to active intervention between HR and managers<br>• Deep dive undertaken for review by People and Culture Committee in December. | • Support, such as counselling, acupuncture, physiotherapy and the Self Care programme are all available to support staff reporting stress anxiety or depression and musculoskeletal issues which are the main reasons for long term absence<br>• Sickness absence rates are discussed in Divisional PRM meetings<br>• HR Business Partners working with divisions to ensure that they are conducting return to work interviews and sickness reviews in line with policy<br>• Target to be reduced to 4.0% from April 2020. |
| **Assurance level – LEVEL 4 (was level 3)** | **SRO: Tina Ricketts (DPC)** |

# PEOPLE & CULTURE IMPROVEMENT STATEMENTS

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

Strategic Objective: Best Use of Resources

| Current performance (November) against local target of 11% | December Trajectory | January Trajectory | February Trajectory | 19/20 Year-end target |
|---|---|---|---|---|
| Annual Turnover rate 11.33% | 11.25% | 11.15% | 11.00% | 11.00% |
| Monthly Turnover rate 0.92% | 0.91% | 0.90% | 0.90% | 0.90% |

| How have we been doing? | What actions are being taken to make the improvements? |
|---|---|
| • Annual turnover rates are continuing to improve, with a further reduction 0.18% improvement this month to 11.33%<br>• Turnover is 0.79% lower than same period last year and continues its steady improvement since May 2019.<br>• Our monthly turnover is 0.92% which is better than Model Hospital average of 0.96%<br>• Q2 Staff Friends and Families Test shows 69% of our staff would recommend the Trust as a place to work which is the highest rate in the last 2 years.<br>• Response rate to Staff Opinion Survey was 39% which is poor but the highest in recent years. | • 4ward culture programme to make this a better place to work.<br>• Phase 2 of 4ward in development.<br>• Further roll out of 'Happy Café's<br>• Launch of the Education Academy<br>• Target to be reduced from 12% to 11% from April 2020 |
| **Assurance level – LEVEL 6 (was level 5)** | **SRO: Tina Ricketts (DPC)** |

# People and Culture Committee Assurance Report

| Non-Executive Director lead | Presented to the September 2019 Board 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 17 December 2019. The summary of the key points discussed are as follows:

- **4ward advocates**: We had six advocates plus the lead advocate join us for the start of the meeting to understand more about their perception of 4ward. They were complimentary about the communication which has evolved from 4ward such as the Facebook page. From a negative point of view, the level of engagement of advocates is not as great as it could be. One of the barriers to this could be the lack of engagement of managers in the organisation. There is a perception that 4ward advocacy is seen as an extra to the job role. The advocates also are concerned that the role has diminished over the recent months. We were saddened to hear of some of the behaviours of middle management still being exhibited. It was agreed that there should be further consideration about how to demonstrate added value, ensuring courtesy and kindness; more formal linkage between Freedom to Speak Up and 4ward advocates. The executive leads have been tasked to review this as we review the next stage for 4ward.
- **Medical manpower**: The CMO informed us that there will be a task and finish group to review this in depth with a further report to this committee following a report to TME in February.
- **Integrated People and Culture Report**: Nationally work is being undertaken on the NHS employee offer and this work will be undertaken locally for a further report in February to the committee. We will also consider what we are expecting of leaders, again mirroring the national work. The Director of P&C is working nationally on international recruitment and the offer to international staff. In respect of the STP/ICS, three work streams have been set up to take forward the huge agenda. The lead for this work stream is the Chief Executive of the Health and Care Trust. We received assurance in respect of pensions for senior clinical staff. Staff friends and family – our overall response for q3 was 39%. The results for q2 showed an increase in staff recommending the Trust as a place to work and a place to have treatment.
- **Winter staffing**: We have been successful in recruiting for the renal ward and these staff will be redeployed until the specialist ward is open. We were assured that this meant that we would have safe staffing during this period and a ratio of at least 60% substantive nursing staff in newly opened wards.
- **Leadership training**: In December 2018 the Leadership & Management Development Plan was launched, aligned to the Skills for Health Leadership Qualities framework. The plan was developed to improve leadership capability and capacity across the Trust. The Committee was very pleased to see the number of staff taking up the range of opportunities now offered by the Trust for leadership development. Such opportunities range from an Open University masters (11 participants), University of Worcester (aimed at operational managers, level 5) (20 participants), two cohorts (totalling 36 participants) for ILM level 3 and bespoke supporting partnership with Wolverhampton Royal NHS Trust. These include courses for matrons, facilitator training, coaching refresher training and medical mentoring. There are numerous other courses available directly through the HR department. This work is significant progress, considering the Trust did not have such a plan two years ago. If anyone would like further details, please see the documents section of VBR where a summary is uploaded.
- **P&C metrics** – we are pleased that all metrics apart from sickness have improved.
- **Risk appetite** – we agreed with the risk appetite statements for workforce. We also reviewed the Clinical Innovation statement and we agreed with this as well.
- **Communications and Engagement Strategy**: We approved this and it is on the agenda for the Board.

# People and Culture Committee Assurance Report

## Executive Summary (cont.)

- **Deep dive – sickness:** We received a detailed analysis of the current issues relating to sickness. Back to work interviews and formal implementation of the sickness policy are crucial and the HR business partners will take these issues forward with the divisions. Further analysis is being undertaken to enable managers to manage staff appropriately. Workshops will be put on to support the implementation of the policy. We will have another report on this at our June meeting
- **Workforce Disability Equality Report**: This highlighted a number of data problems but we also need to undertake more work on the challenges that people are reporting. Unfortunately there are no national comparators at the current time. We received an excellent action plan to take forward this area of work.
- **Safe staffing**: We were assured that staffing was safe, after mitigation. There are more gaps and thus risks on wards due to Winter. Allocate has been extremely useful for the understanding of the gaps and the acuity of patients. We were pleased to see that the paper includes AHPs and we now have a new AHP lead who will be attending our committee in February. We are on target for the receipt of international nurses. This paper is on the Board agenda.
- **Flu vaccination:** as at Friday 13th December, 70.3% of front line staff had been vaccinated, compared to 73% at the same time last year. The lowest compliance group continues to be nurses and midwives. Work continues with the senior nurse team. We approved the Department of Health return on behalf of the Trust Board.

As Chairman of the Committee, I would like to thank the Director of P&C , her team and committee members for the work that has been undertaken in this area.

Other reports received:
- Recruitment and retention – we have been successful in recruitment both domestically and internationally. Further focus is needed on retention.
- Risk register – we approved a risk reduction for culture and for mandatory training.
- Work plan

## Background

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

## Recommendations

The Board is requested to:
- Receive this report for assurance

## Appendices

# Finance | Key Messages

| | | RAG |
|---|---|---|
| **Delivery of the External Financial Plan £(82.8)m** | The month 8 deficit of £(6.1)m is £(0.4)m adverse to the forecast prepared at Q2 of £(5.8)m (to deliver £(82.6)m). A pre risk adjusted forecast of £(82.6)m is aligned to our external target. This forecast shows that that the positive YTD variance of £2.9m reduces moving forward as a result of the challenge of CIP / Savings efficiency delivery against the back ended plan. Our ability to hit our internal target of £(73.7)m requires a material reduction in our agency and bank costs, as well as continued focus on improving flow and reducing ED attendances / activity through Home First Worcestershire, maintaining tightened governance and execution of the key elements of the financial recovery programme. | Level 4 > relatively confident that external plan can be achieved subject to level of winter pressure. |
| **Capital** | The Trust has a minimal £2.24m internal source of funding for the 2019/20 capital programme. This is after repaying the capital loans, accounting for IFRIC 12 and PFI capital repayments. The Full Year Forecast Capital position for the financial year shows a break-even position against available funds. At November 2019 – Month 8, year to date expenditure totals £5.3m, the majority of which is relating to the Acute Services Review "ASR" Aconbury East Scheme (£3.7m). The Capital Prioritisation Group reviewed the most urgent and critical capital schemes at its meeting in December. A recommendation of schemes to proceed has been made to ensure that all available funds are fully spent against the highest priority schemes by the end of the year.<br><br>A revised capital plan was submitted to NHSI on 2nd August including an increased urgent loan provision (from £10m to £13m) to address the risks associated with backlogs of capital works and asset replacement. The full £13m loan application has been re-submitted, following the receipt of queries, with a revised phasing of the loan across 2019/20 and 2020/21. Further capital has been earmarked from a national scheme to invest in Urgent and Emergency Care improvements as we head into winter. | Level 4 > to have sufficient capital funding. Plan complete – securing capital funds ongoing. |
| **Cash Balance** | As a result of the ongoing deficit position, we continue to rely on additional cash support from the Department of Health and Social Care (DHSC) and request cash in line with financial performance on a monthly basis. At the end of November the cash balance was £16.1m (£12.7m net of un-cleared payments) which is significantly over the £1.9m minimum balance required owing to the timing of due payments, the year to date favourable variance to plan and timing of receipt of 2018/19 PSF cash. Future loan requests have been recalculated to manage the cash balance down and meet the minimum month end balance requirements. The Trust has received £3.078m working capital cash support in November 2019. The 2018-19 capital loan of £5.64m has now been approved and £2.4m of this has been drawn down to date.<br><br>Cash limitations will prevent repayments of existing and future revenue support loans without refinancing existing borrowings, or a change to the existing financing regimes for Trusts that are in financial difficulties. NHSI/E have recently confirmed that revenue loan principal repayments due during 2019/20 have been re-profiled into 2020/21. Capital loans are repaid through the capital programme. | Level 6 > Plan to access cash and deferral of loan repayments. |

# Finance | Key Messages

| | |
|---|---|
| **2019/20 Plan** | For 2019/20 the Trust committed to delivering a deficit of no more than £(82.8)m with a stretch target of £(73.7)m. This stretch target requires delivery, all other things being equal, of £22.5m of savings/margin improvement. The Trust has not signed up to the revised control total set by NHSI of £(64.4)m [£58.4m+£6m] (excluding PSF, FRF and MRET funding). Whilst we recognise that it is disappointing that we have not been able to submit a plan closer to the control total, we believe that the submission reflects a credible plan based on the existing plan information and assumptions available to us at the time. Notwithstanding the aforementioned, we continue to aim to achieve the £(73.7)m 2018/19 internal stretch out-turn target. |
| **I&E Position** | For November, month 8 of 2019/20 is a deficit of £(6.1)m, £(1.2)m adverse to the £(5.0)m deficit plan. The cumulative position at the end of month 8 is a deficit of £(53.3)m, £2.9m positive to the submitted plan. The reduction in the favourable YTD variance in month is mostly due to a shortfall in patient care income against plan and insufficient levels of CIP delivery. The impact of these adverse variances has been reduced by the shifting of costs for new capacity and not spending on business cases. (Electronic Prescribing & Medicines Administration – EPMA and proposed expansion of Managed Equipment Service - MES)<br><br>**The internal target is to have a deficit no bigger than the 2018/19 out-turn of £(73.7)m deficit. Using the £22.5m Savings target) as a proxy to deliver £(73.7)m the I&E deficit position in Month 8 would be £(2.2)m adverse and £(1.8)m adverse year to date. In order to get closer to our internal target it will be vital to: continue to prioritise our efforts on improving flow; reducing ED attendances & activity through Home First Worcestershire; maintain and further strengthen expenditure governance; and improve execution of efficiency and productivity opportunities.** |
| **Income** | The combined income (including Other Operating Income and after adjusting for the blended payment mechanism) was £1.5m below plan in November (YTD position is £2.1m above plan excluding 18/19 Post Balance Sheet Event - PSF). If the £2.3m blended adjustment did not apply (20% Marginal Rate), income would be £4.4m above the year to date plan. Patient Care Income was £0.5m below plan in month (excluding drugs & devices) before adjusting for the blended payment marginal rate (£0.5m in November).<br><br>Inpatients were £0.1m above plan in November (before the blended payment adjustment): Emergency activity was £0.5m above plan in month, primarily driven by an increase in admissions. Day-case and Electives were £0.4m below plan; both Day case and Elective inpatients performance was lower than planned levels. The endoscopy improvement target (incorporated within the annual plan to achieve the diagnostic waiting standards) was not met in November. Whilst activity was comparable to October, the planned levels were higher in November. Outpatients were £0.3m below plan: The activity run-rate deteriorated in November compared to October across a number of specialties. Other Income was £0.3m below plan: Contractual adjustments £0.4m and Maternity £(0.7)m (phasing of the plan and reduction in number of births). |
| **Expenditure** | Pay and non pay costs (excluding Non PbR and finance charges) exceeded plan by £(0.3)m in November. This adverse variance is largely as a result of the alignment and slippage against the submitted CIP plan, premium staffing and non-pay overspends.<br><br>Pay expenditure reduced by £0.3m from £25.1m to £24.8m in November (of which £0.2m was temporary pay mainly due to the cessation of supernumerary periods predominantly for nursing). Overall workforce levels have remained static. Increases in the substantive nursing workforce have resulted in a corresponding decrease in agency posts demonstrating adherence to the one in one out concept. The combined agency and bank spend is £3.9m in November and represents 15.7% of the pay bill. This value is a £240k decrease compared to last month, specifically within bank. Agency expenditure for month 8 of £2.2m sustaining last month's reduction. Nursing has been a key driver as a result of substantive recruitment and reduced levels of specialling. In turn we continue to see a reduction in our spend with TIER 2 agency, particularly within the Specialist Medicine Division.<br><br>Non pay spend (excluding Non PbR and finance charges) reduced by £0.4m from £12.0m to £11.6m. The majority of this decrease follows non recurrent costs reported in October (month 7) within Estates & Facilities following receipt of un-forecast variable costs incurred for laundry, catering and waste. |
| **CIP** (Savings Improvement Plans) | In November, month 8 2019/ 20, a nominal £6.3m (note £22.5m Full Year delivery required) of CIP delivery (year to date) has been achieved. The operational forecast assumes c. £12m (£11m reported in M6) FYE CIP delivery in the 2019/20 financial year. We remain focused on maximising the savings plans and are continuing every effort to drive further improvements to our financial position, whilst ensuring a credible plan for delivery. As a result the internal savings/CIP target remains at £22.5m of which opportunities to the FYE value of c. £21.5m have been identified to date with £16.2m removed from budgets. |

# Assurance Levels

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

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

# Integrated Performance Report

# SPC Charts

## November 2019
Month 8

16th January 2020

# Best Services for Local People

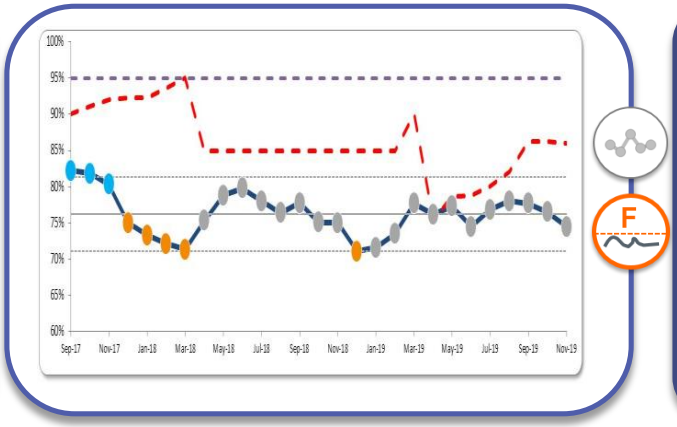
Worcestershire Acute Hospitals NHS Trust

## Month 8 [November] | 2019-20 Operational Performance Summary

**Responsible Director: Chief Operating Officer** | Validated for Nov-19 as at **3rd January 2020**

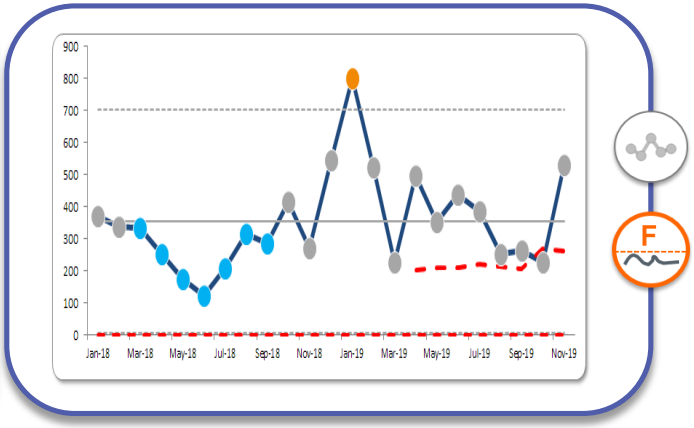
**4 Hour EAS (all)**

74.47%



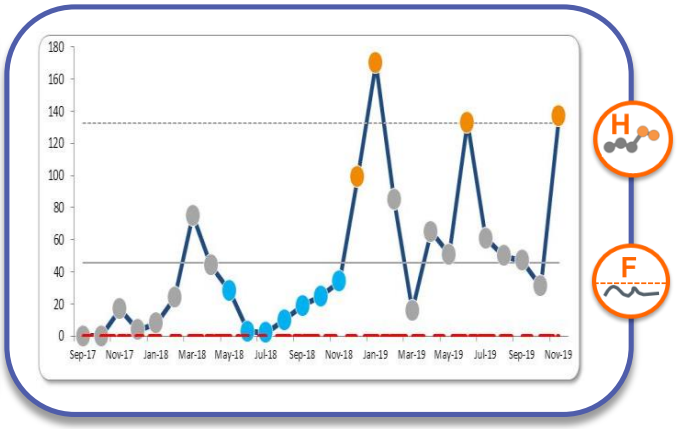

**60 minute Ambulance Handover Delays**

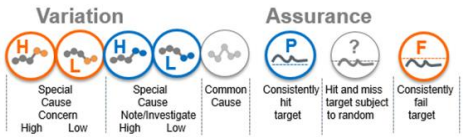
528




**12 Hour Trolley Breaches**

137



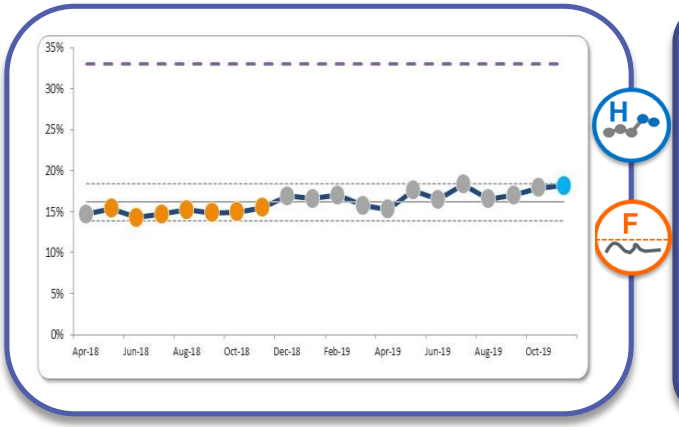
# Month 8 [November] | 2019-20 Operational Performance Summary

**Responsible Director: Chief Operating Officer** | Validated for Nov-19 as at **3rd January 2020**

NHS Worcestershire Acute Hospitals NHS Trust

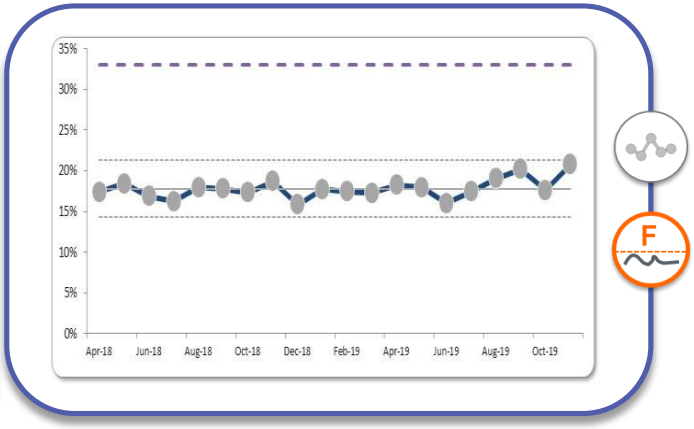
**Discharge before midday (WRH)**

**18.00%**



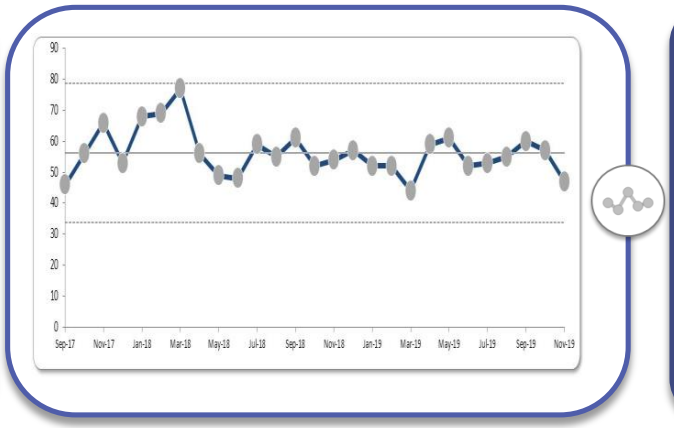

**Discharge before midday (ALX)**

**17.70%**



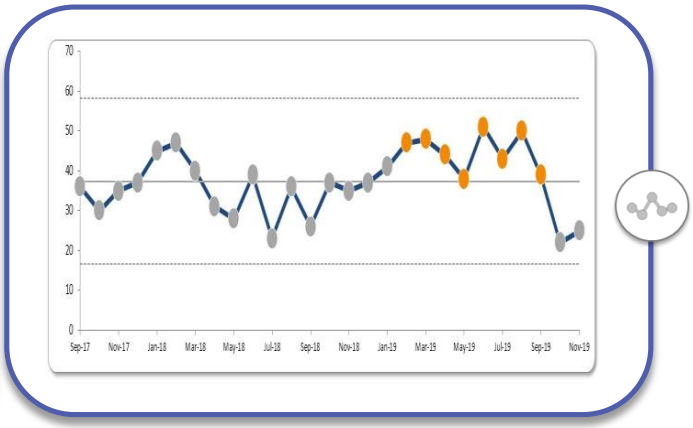

**Long Length of Stay Patients (21+ days) (WRH)**

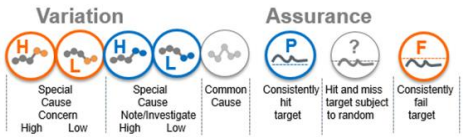
**47**




**Long Length of Stay Patients (21+ days) (ALX)**

**25**



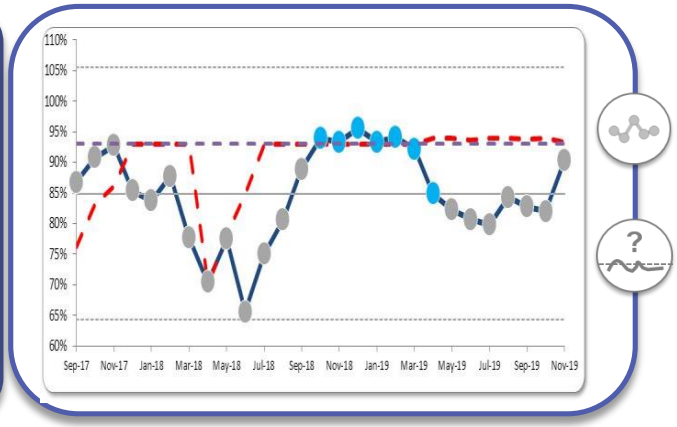
# Month 8 [November] | 2019-20 Operational Performance Summary

**Responsible Director: Chief Operating Officer** | Unvalidated for Nov-19 as at **3rd January 2020**

NHS Worcestershire Acute Hospitals NHS Trust

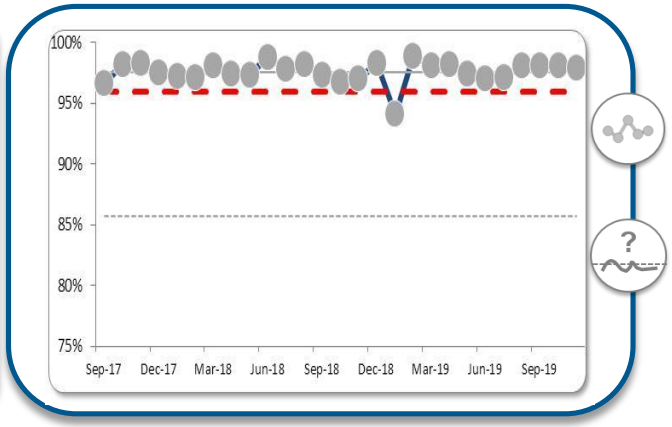
**Cancer 2WW All**

90.38%



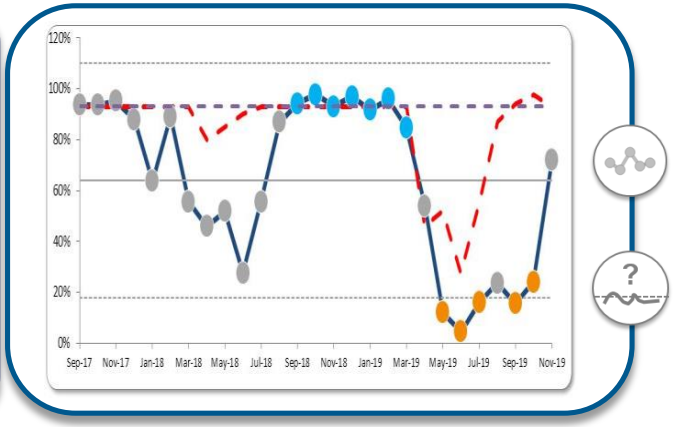

**Cancer 31 Day All**

97.93%



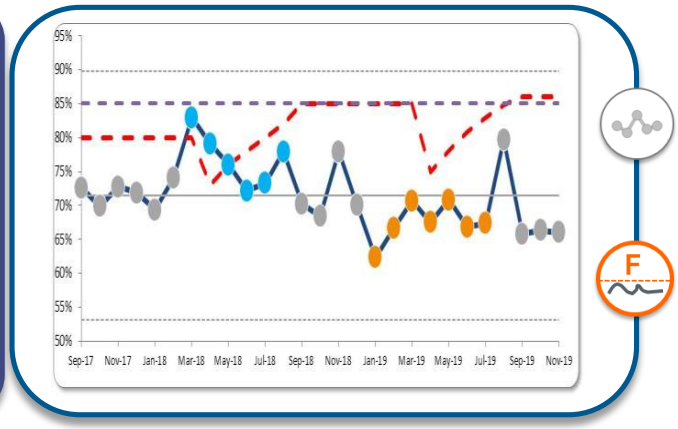

**Cancer 2WW Breast Symptomatic**

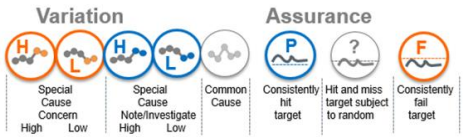
72.22%




**Cancer 62 Day All**

66.01%



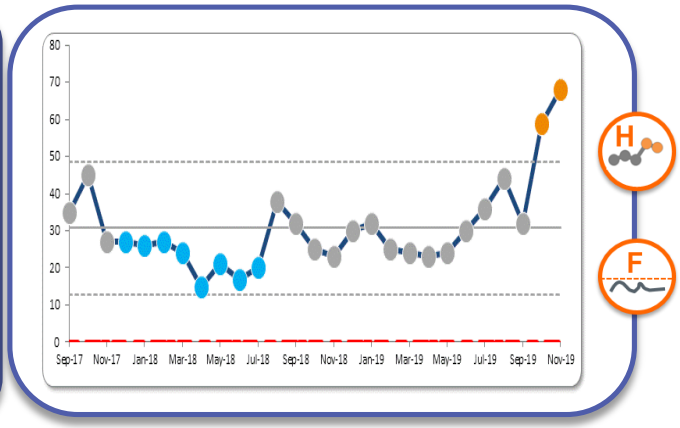
# Month 8 [November] | 2019-20 Operational Performance Summary

**Responsible Director: Chief Operating Officer** | Validated for Nov-19 as at **3rd January 2020**

NHS Worcestershire Acute Hospitals NHS Trust

**62+ Day Waiters**

241

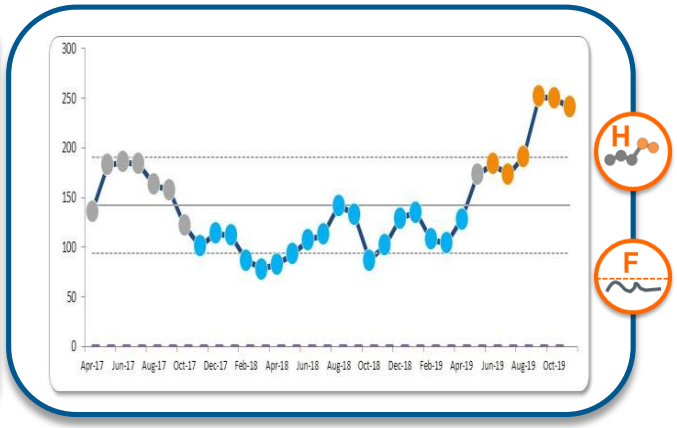



H

F

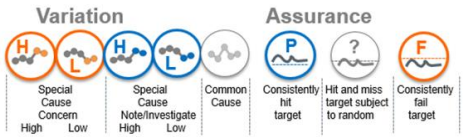
**104+ Day Waiters**

68




H

F



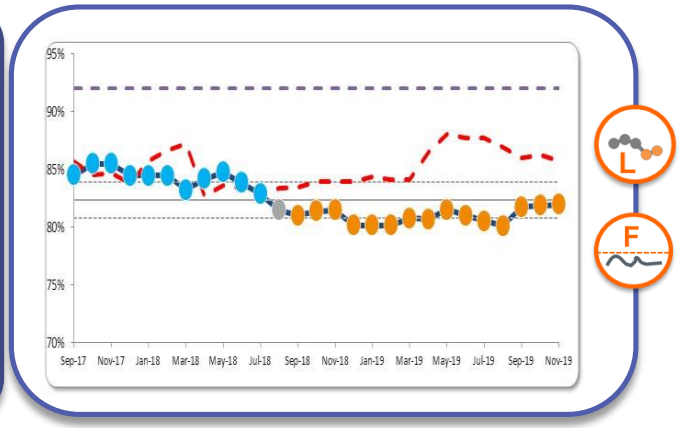
# Month 8 [November] | 2019-20 Operational Performance Summary

**Responsible Director: Chief Operating Officer** | Validated for Nov-19 as at **3rd January 2020**

NHS Worcestershire Acute Hospitals NHS Trust

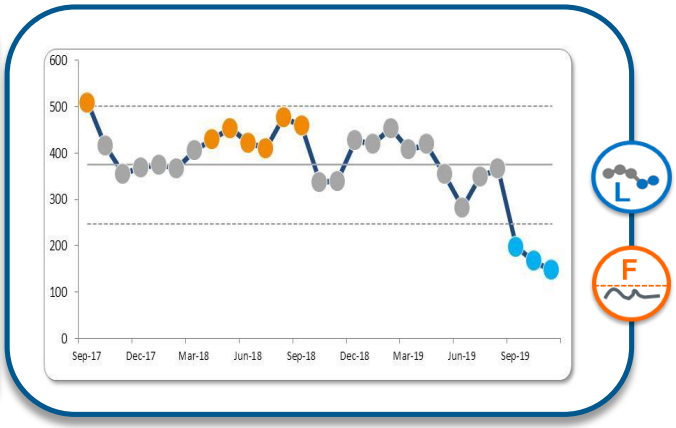
**RTT Incomplete**

81.94%



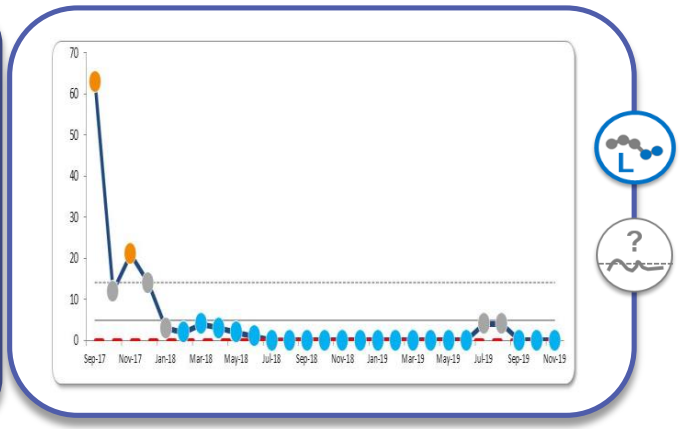

**40+ week waits (includes agreed exceptions)**

147



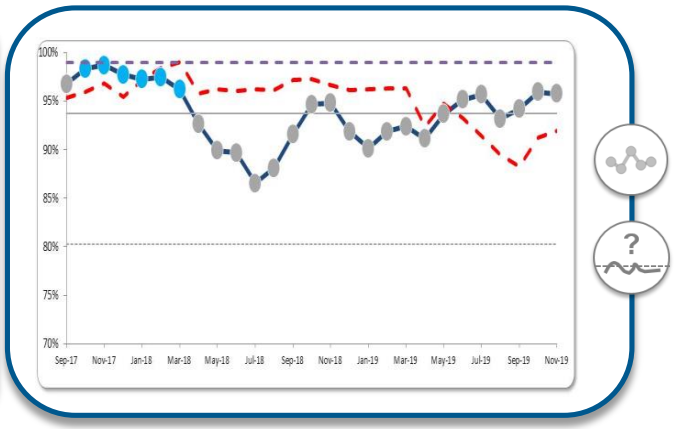

**52+ week waits**

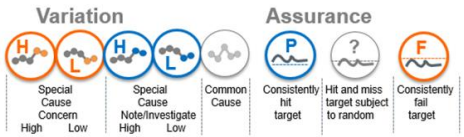
0




**Diagnostics**

95.78%



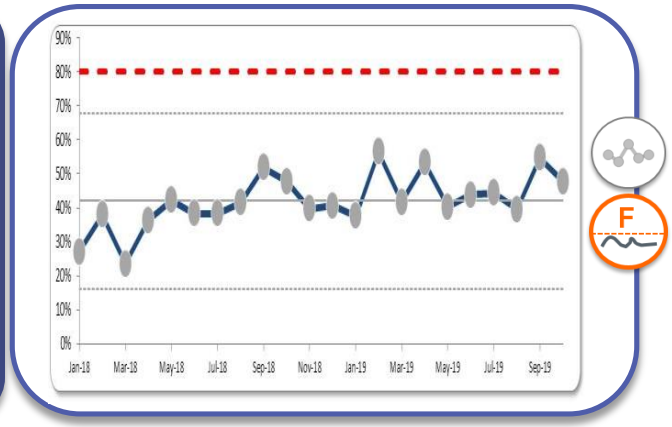
# Month 8 [November] | 2019-20 Operational Performance Summary

**Responsible Director: Chief Operating Officer** | Validated for Oct-19 as at **3rd January 2020**

NHS Worcestershire Acute Hospitals NHS Trust

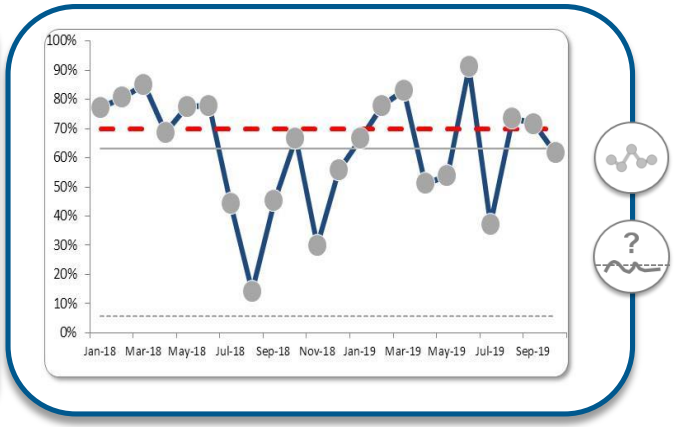
**Stroke : % CT scan within 60 minutes**

47.7%



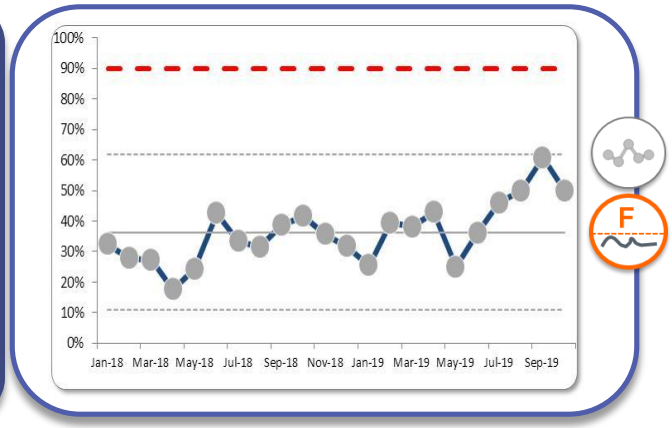

**Stroke: % seen in TIA clinic within 24 hours**

61.6%



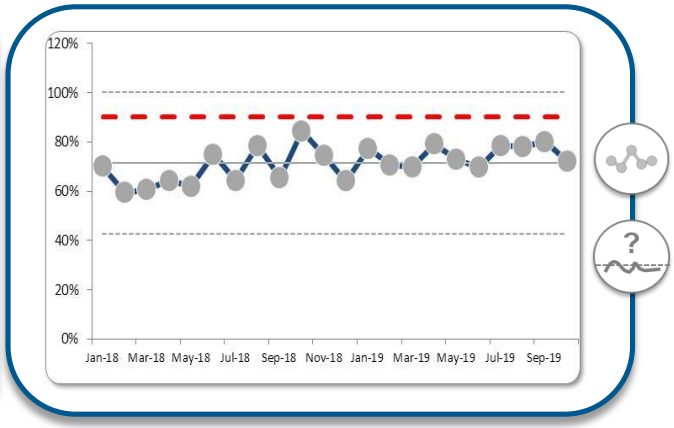

**Stroke : % Direct Admission to Stroke ward**

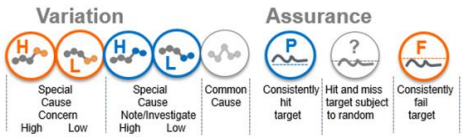
50.0%




**Stroke: % patients spending 90% of time on stroke unit**

72.1%




*Please note – Stroke Data is month in arrears due to coding and validation processes

# Operational | Submitted Trajectories (19/20) | M8 [November]

Worcestershire Acute Hospitals NHS Trust

| | Performance Metrics | Operational Standard | | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| EAS | 4 Hours (all) | 95% | Actual | 76.18% ✓ | 77.28% ✗ | 74.43% ✗ | 76.82% ✗ | 77.96% ✗ | 77.69% ✗ | 76.49% ✗ | 74.47% ✗ |
| | | | Trajectory | 75.41% | 78.60% | 78.78% | 80.10% | 82.10% | 86.21% | 86.24% | 86.00% |
| | 15-30 minute Amb. Delays | - | Actual | 1,703 ✗ | 1,767 ✗ | 1,738 ✗ | 1,925 ✗ | 1,828 ✗ | 1624 ✗ | 1940 ✗ | 1826 ✗ |
| | | | Trajectory | 1420 | 1251 | 1149 | 1112 | 855 | 831 | 673 | 655 |
| | 30-60 minute Amb. Delays | - | Actual | 728 ✗ | 608 ✓ | 671 ✗ | 751 ✗ | 646 ✗ | 578 ✗ | 705 ✗ | 813 ✗ |
| | | | Trajectory | 609 | 626 | 522 | 445 | 428 | 416 | 292 | 284 |
| | 60+ minutes Amb. Delays | 0 | Actual | 496 ✗ | 354 ✗ | 438 ✗ | 386 ✗ | 252 ✗ | 264 ✗ | 228 ✓ | 528 ✗ |
| | | | Trajectory | 203 | 209 | 209 | 222 | 214 | 208 | 269 | 262 |
| RTT | Incomplete (<18 wks) | 92% | Actual | 80.18% ✗ | 81.51% ✗ | 81.02% ✗ | 80.54% ✗ | 80.10% ✗ | 81.75% ✗ | 81.88% ✗ | 81.94% ✗ |
| | | | Trajectory | 86.47% | 88.06% | 87.72% | 87.69% | 86.93% | 86.01% | 86.25% | 85.81% |
| | 52+ WW | 0 | Actual | 0 ✓ | 0 ✓ | 0 ✓ | 4 ✗ | 5 ✗ | 0 ✓ | 0 ✓ | 0 ✓ |
| | | | Trajectory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CANCER | 2WW All | 93% | Actual | 84.87% ✗ | 82.21% ✗ | 80.75% ✗ | 79.91% ✗ | 84.32% ✗ | 82.76% ✗ | 82.03% ✗ | 90.38% ✗ |
| | | | Trajectory | 93.93% | 93.90% | 93.64% | 93.94% | 94.02% | 93.83% | 93.96% | 93.37% |
| | 2WW Breast Symptomatic | 93% | Actual | 54.12% ✓ | 12.00% ✗ | 4.58% ✗ | 16.07% ✗ | 23.77% ✗ | 15.52% ✗ | 24.06% ✗ | 72.22% ✗ |
| | | | Trajectory | 45.96% | 51.76% | 27.66% | 55.68% | 87.01% | 94.20% | 97.81% | 93.02% |
| | 62 Day All | 85% | Actual | 69.58% ✗ | 70.16% ✗ | 65.41% ✗ | 67.07% ✗ | 79.70% ✗ | 65.86% ✗ | 66.37% ✗ | 66.01% ✗ |
| | | | Trajectory | 74.93% | 78.06% | 80.91% | 82.91% | 84.90% | 86.04% | 86.04% | 86.04% |
| | 104 day waits | 0 | Actual | 23 ✗ | 23 ✗ | 30 ✗ | 36 ✗ | 44 ✗ | 32 ✗ | 56 ✗ | 68 ✗ |
| | | | Trajectory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 31 Day First Treatment | 96% | Actual | 98.11% ✓ | 97.85% ✓ | 96.62% ✗ | 97.69% ✗ | 98.11% ✗ | 98.10% ✓ | 98.09% ✓ | 97.93% ✓ |
| | | | Trajectory | 97.39% | 97.32% | 98.80% | 97.82% | 98.15% | 97.35% | 96.73% | 96.99% |
| | 31 Day Surgery | 94% | Actual | 93.55% ✗ | 93.75% ✗ | 93.75% ✗ | 75.00% ✗ | 85.19% ✗ | 81.48% ✗ | 76.00% ✗ | 89.66% ✗ |
| | | | Trajectory | 96.43% | 97.06% | 96.88% | 100.00% | 100.00% | 95.00% | 100.00% | 100.00% |
| | 31 Day Drugs | 98% | Actual | 100% ✓ | 100% ✓ | 100% ✓ | 100% ✓ | 100% ✗ | 90.91% ✗ | 100% ✓ | 100% ✓ |
| | | | Trajectory | 90.91% | 100% | 96.43% | 100% | 100% | 100% | 100% | 100% |
| | 31 Day Radiotherapy | 94% | Actual | 100% ✓ | 100% ✓ | 96.15% ✗ | 100% ✓ | 100% ✓ | 98.18% ✗ | 74.19% ✗ | 100% ✓ |
| | | | Trajectory | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | 62 Day Screening | 90% | Actual | 92.00% ✓ | 92.00% ✓ | 52.00% ✗ | 88.89% ✗ | 94.44% ✓ | 81.03% ✓ | 84.62% ✓ | 72.22% ✗ |
| | | | Trajectory | 85.19% | 85.19% | 90.00% | 90.70% | 76.60% | 73.21% | 65.38% | 78.26% |
| | 62 Day Upgrade | - | Actual | 79.17% ✓ | 70.00% ✓ | 75.00% ✓ | 62.50% ✗ | 75.00% ✗ | 52.94% ✗ | 75.00% ✓ | 76.92% ✓ |
| | | | Trajectory | 70.00% | 62.50% | 59.09% | 83.33% | 80.00% | 90.91% | 60.00% | 75.00% |
| Diagnostics (DM01 only) | | 99% | Actual | 91.14% ✗ | 93.67% ✗ | 95.46% ✓ | 95.68% ✓ | 93.17% ✓ | 94.21% ✓ | 95.96% ✓ | 95.78% ✓ |
| | | | Trajectory | 92.37% | 94.74% | 91.42% | 91.42% | 89.52% | 88.25% | 91.28% | 91.91% |
| STROKE | CT Scan within 60 minutes | - | Actual | 53.30% ✗ | 40.30% ✗ | 43.90% ✗ | 44.30% ✗ | 39.50% ✗ | 54.70% ✗ | 47.70% ✗ | - - |
| | | | Trajectory | 80.00% | 80.00% | 80.00% | 80.00% | 80.00% | 80.00% | 80.00% | 80.00% |
| | Seen in TIA clinic within 24hrs | - | Actual | 51.10% ✗ | 53.90% ✗ | 91.20% ✓ | 37.10% ✗ | 74.40% ✓ | 71.60% ✓ | 61.60% ✗ | - - |
| | | | Trajectory | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% | 70.00% |
| | Direct Admission | - | Actual | 42.90% ✗ | 25.00% ✗ | 36.20% ✗ | 46.00% ✗ | 50.00% ✗ | 60.70% ✗ | 50.00% ✗ | - - |
| | | | Trajectory | 90.00% | 90.00% | 90.00% | 90.00% | 90.00% | 90.00% | 90.00% | 90.00% |
| | 90% time on a Stroke Ward | - | Actual | 79.00% ✗ | 73.00% ✗ | 69.60% ✗ | 78.50% ✗ | 78.00% ✗ | 80.00% ✓ | 72.10% ✗ | - - |
| | | | Trajectory | 80.00% | 80.00% | 80.00% | 80.00% | 80.00% | 80.00% | 80.00% | 80.00% |

# Best Experience of Care and Best Outcomes for our Patients

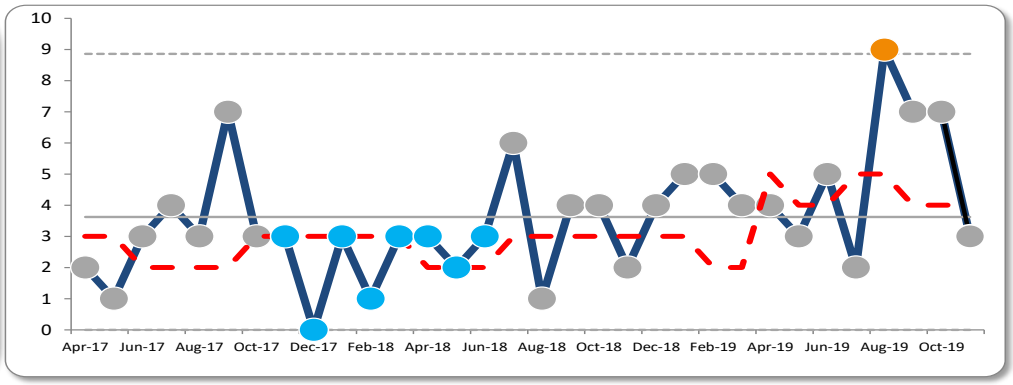
# Month 8 [November] | 2019-20 Quality & Safety Summary
## Care that is Safe

**Responsible Director: Chief Nursing Officer, Chief Medical Officer** | for November 19 as at **31st December 2019**

Worcestershire Acute Hospitals NHS Trust

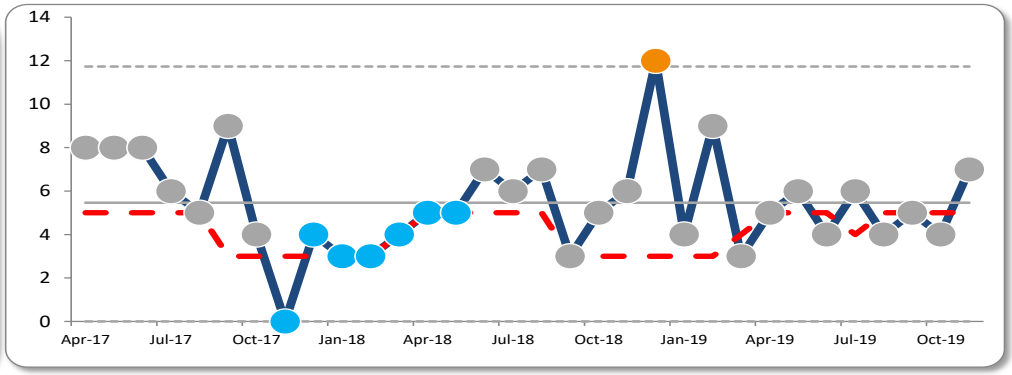
**Number of patients developing Clostridioides difficile**

3



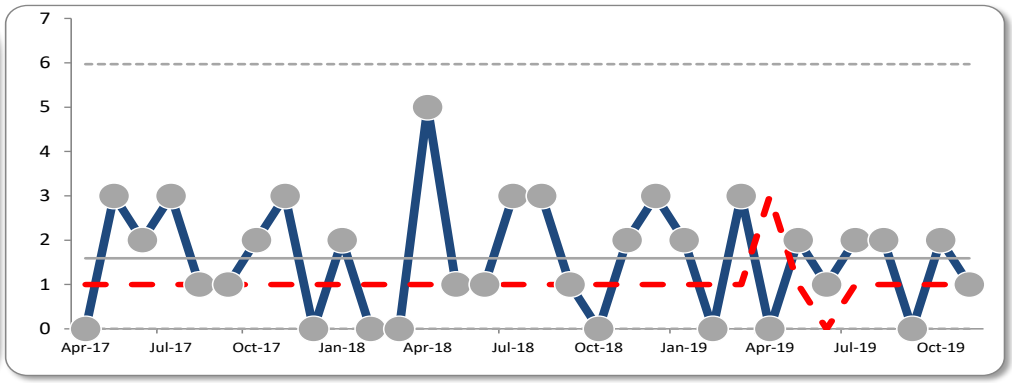

**Number of patients developing Ecoli bacteraemia**

7



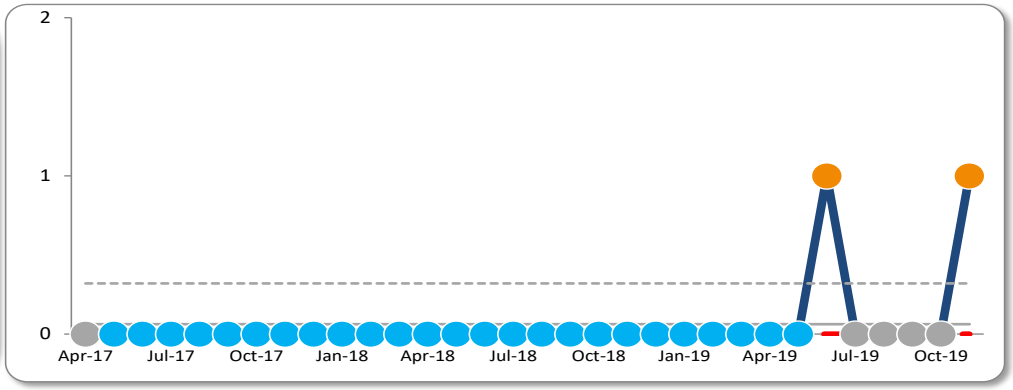

**Number of patients developing MSSA bacteraemia**

1




**Number of patients developing MRSA bacteraemia**

1




Variation: Special Cause Concern High/Low; Special Cause Note/Investigate High/Low; Common Cause

Assurance: Consistently hit target; Hit and miss target subject to random; Consistently fail target

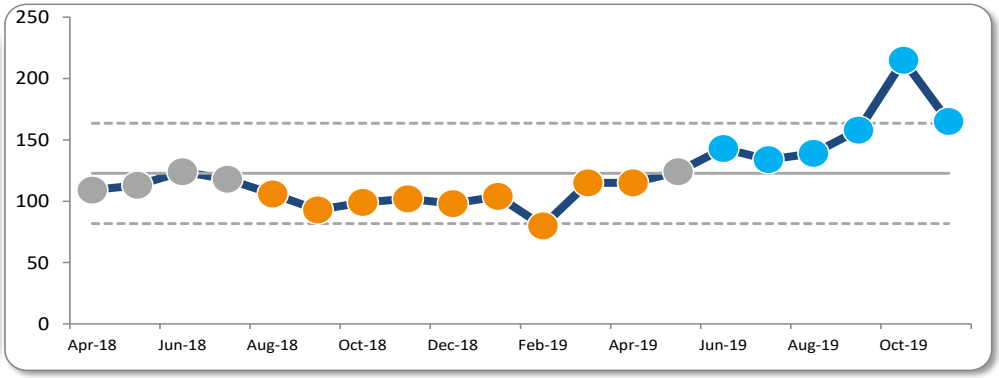
# Month 8 [November] | 2019-20 Quality & Safety Summary
## Care that is Safe

**Responsible Director: Chief Nursing Officer, Chief Medical Officer |** for November 19 as at **31st December 2019**

Worcestershire Acute Hospitals NHS Trust

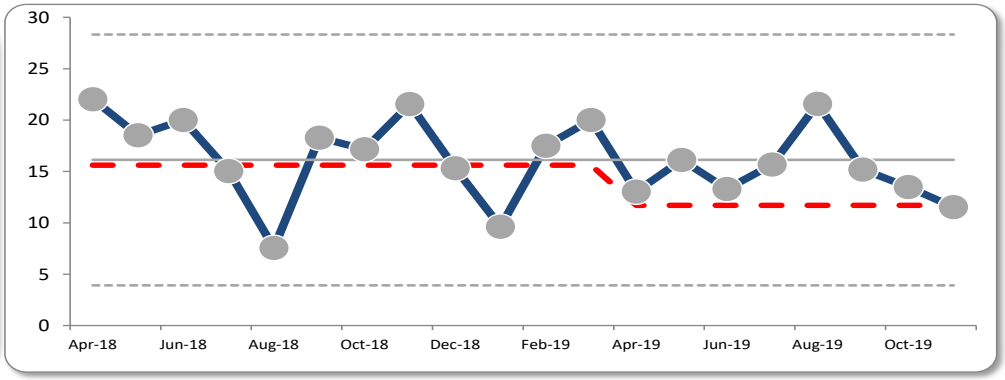
**Total Medicine incidents reported**

165



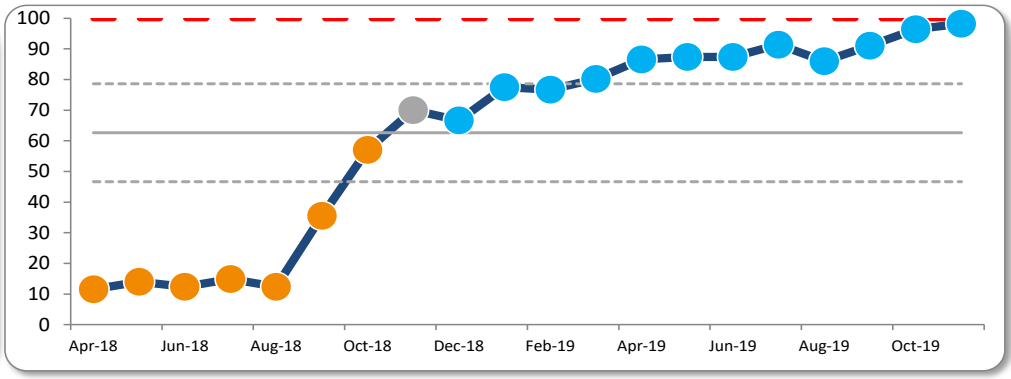

**Medicine incidents causing harm (%)**

11.5



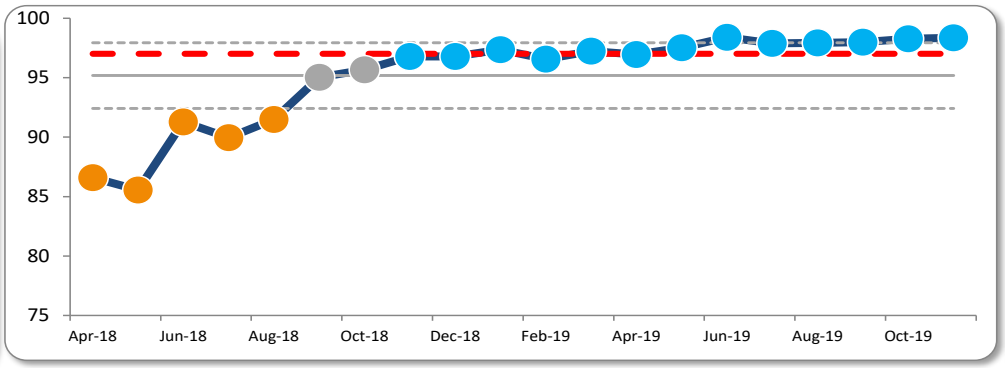

**Hand Hygiene Audit Participation (%)**

98.2




**Hand Hygiene Compliance (%)**

98.4




# Month 8 [November] | 2019-20 Quality & Safety Summary

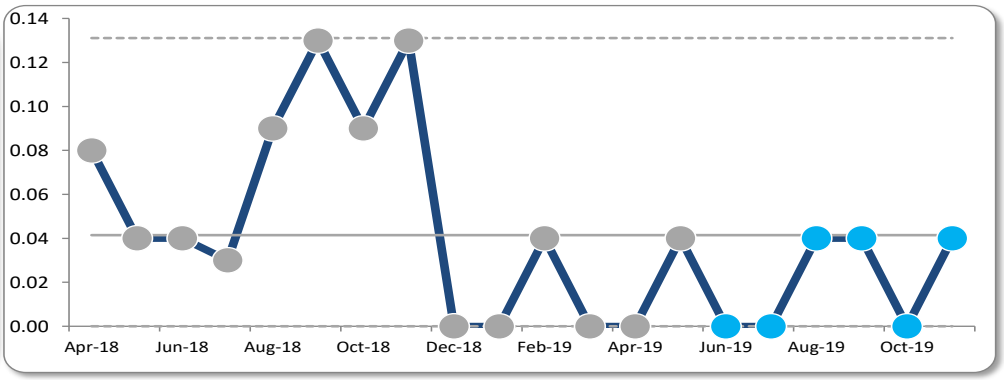
## Care that is Safe

**Responsible Director: Chief Nursing Officer, Chief Medical Officer |** for November 19 as at **31st December 2019**

Worcestershire Acute Hospitals NHS Trust

**Falls per 1,000 bed days causing harm**

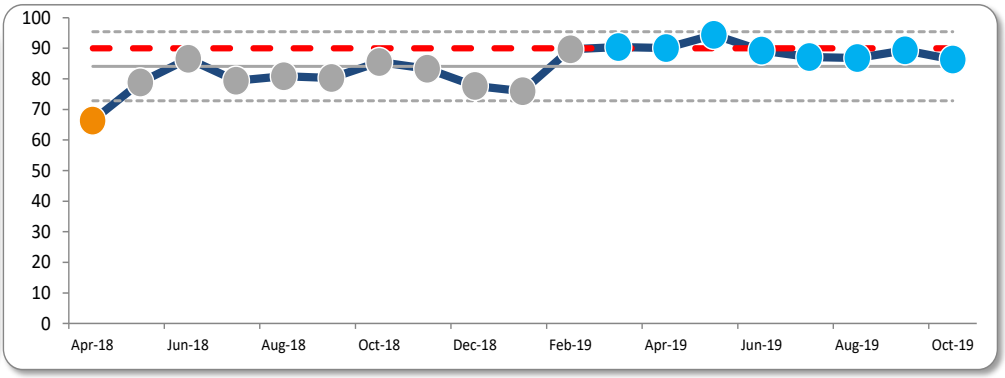
**0.04**




**Sepsis Screening Compliance (audit) (%)**

**86.4**

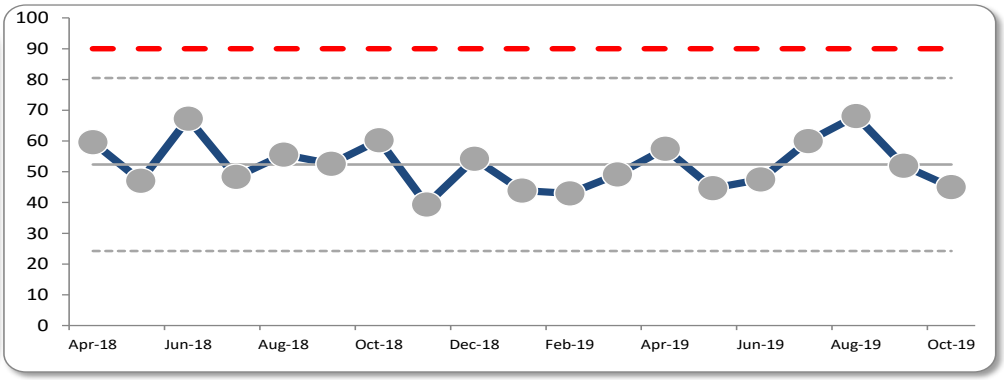
October 2019




**Sepsis 6 Bundle Compliance (audit) (%)**

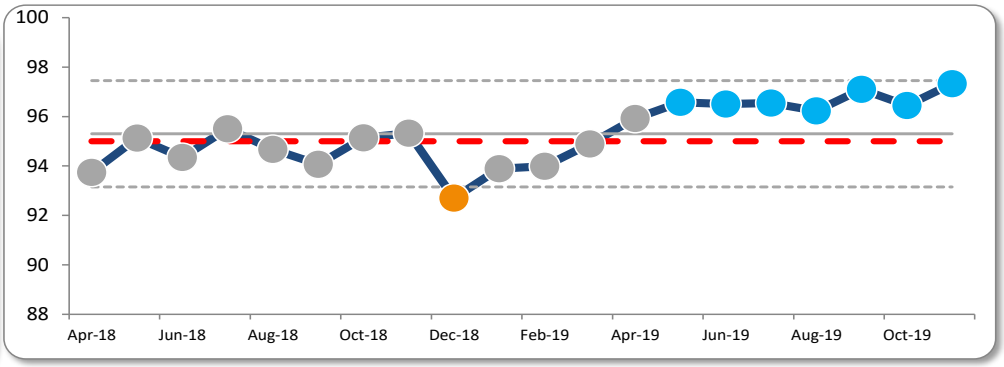
**45.0**

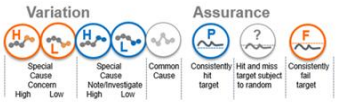
October 2019




**VTE Assessment Compliance (%)**

**97.3**



# Month 8 [November] | 2019-20 Quality & Safety Summary
## Care that is Safe

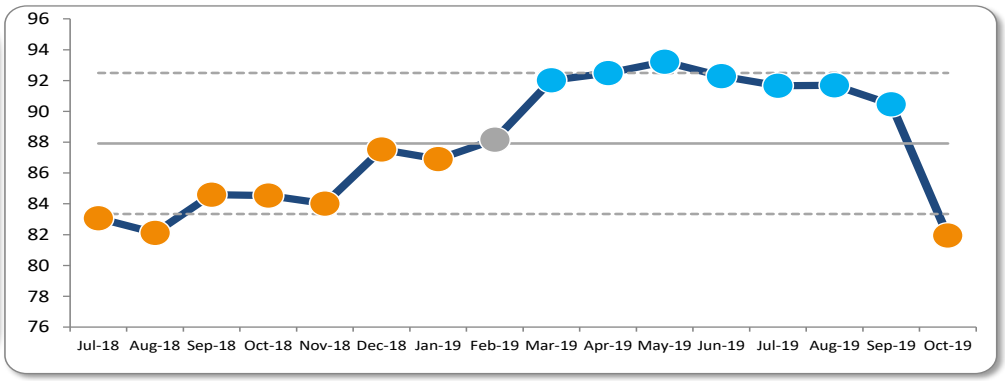
**Responsible Director: Chief Nursing Officer, Chief Medical Officer** | for November 19 as at **31st December 2019**

Worcestershire Acute Hospitals NHS Trust

**ICE reports viewed [radiology] (%)**

82.0

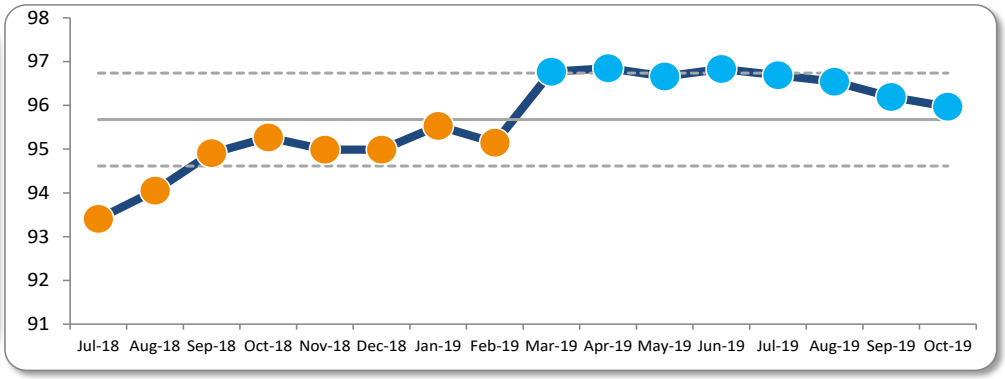
October 2019




**ICE reports viewed [pathology] (%)**

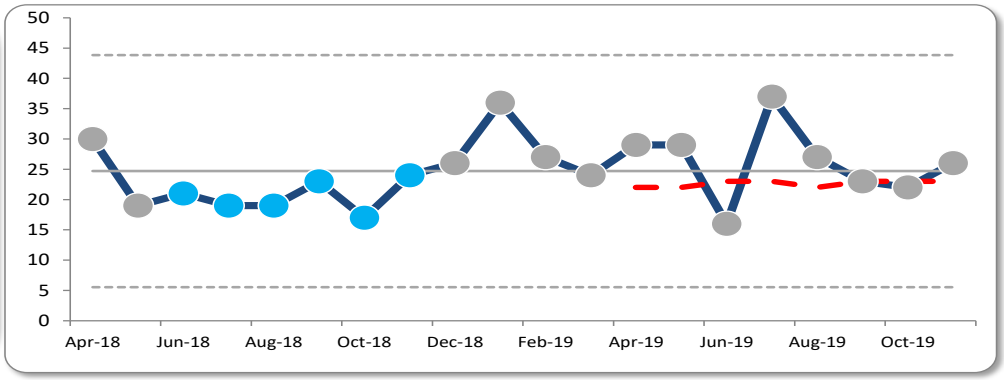
96.0

October 2019



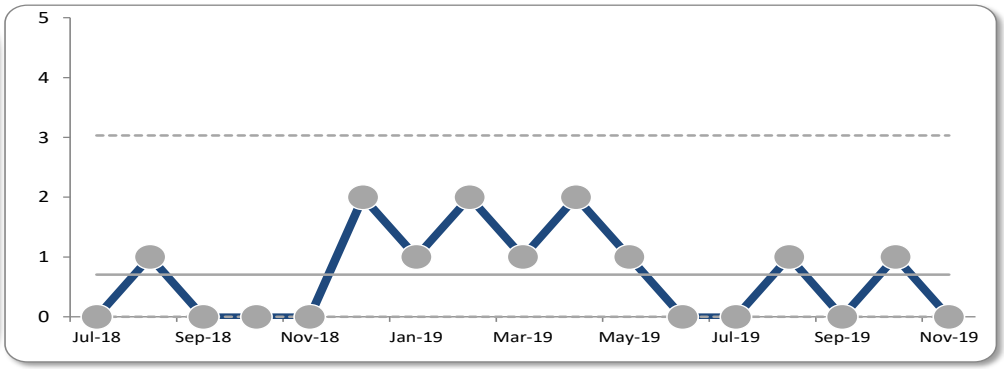

**All Hospital Acquired Pressure Ulcers**

26




**Serious Incident Pressure Ulcers**

0




Variation: Special Cause Concern High/Low; Special Cause Note/Investigate High/Low; Common Cause

Assurance: Consistently hit target; Hit and miss target subject to random; Consistently fail target

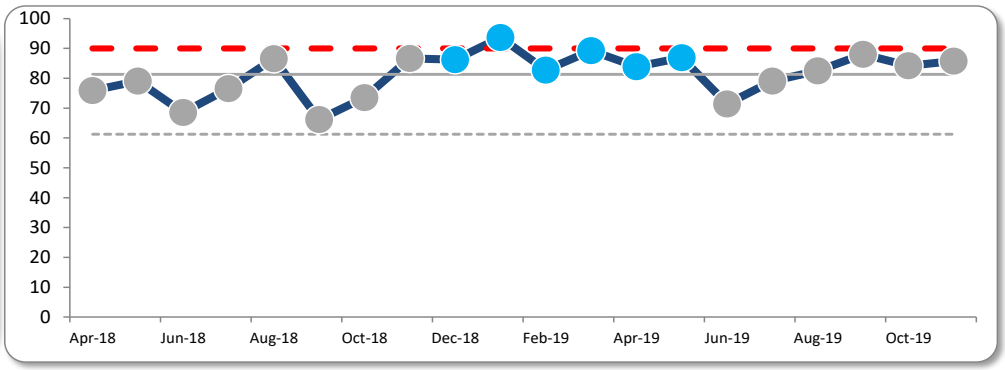
# Month 8 [November] | 2019-20 Quality & Safety Summary
## Care that is Safe

**Responsible Director: Chief Nursing Officer, Chief Medical Officer** | for November 19 as at **31st December 2019**

Worcestershire Acute Hospitals NHS Trust

**#NOF time to theatre </=36 hours (%)**

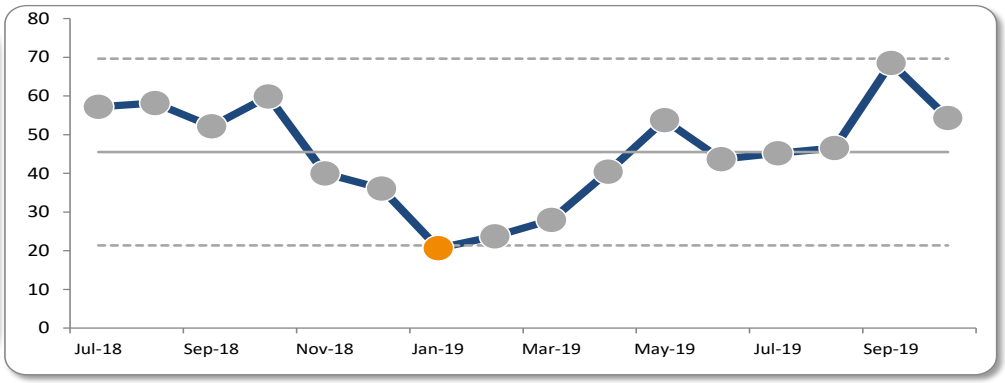
85.7




**Mortality Reviews completed </=30 days (%)**

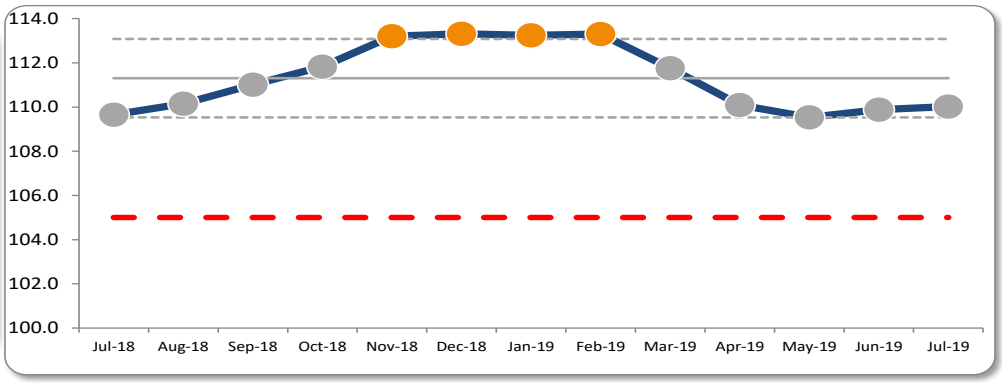
54.3

October 2019



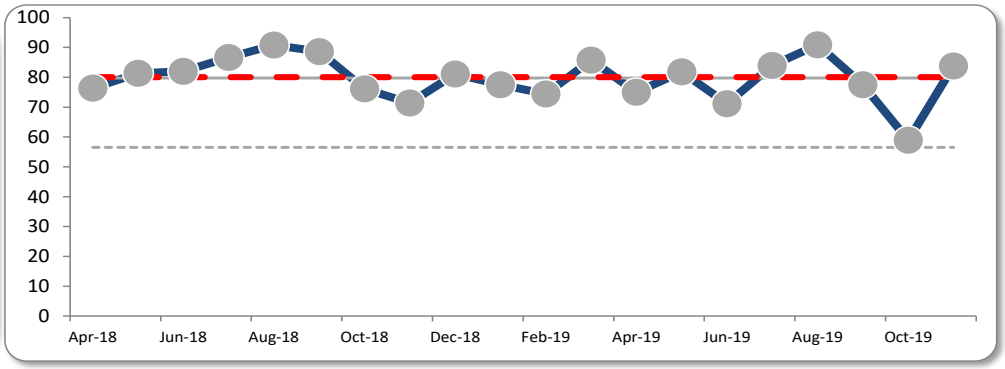

**HSMR 12 month rolling average [Aug-18 – Jul-19]**

110.02




**Complaints Responses </= 25 days (%)**

83.8



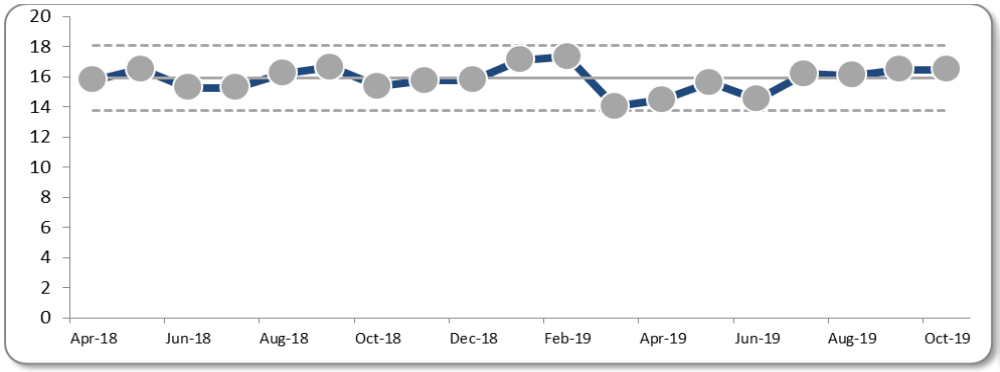

# Month 8 [November] | 2019-20 Quality & Safety Summary
## Care that is Safe

**Responsible Director: Chief Nursing Officer, Chief Medical Officer** | for November 19 as at **31st December 2019**

Worcestershire Acute Hospitals NHS Trust

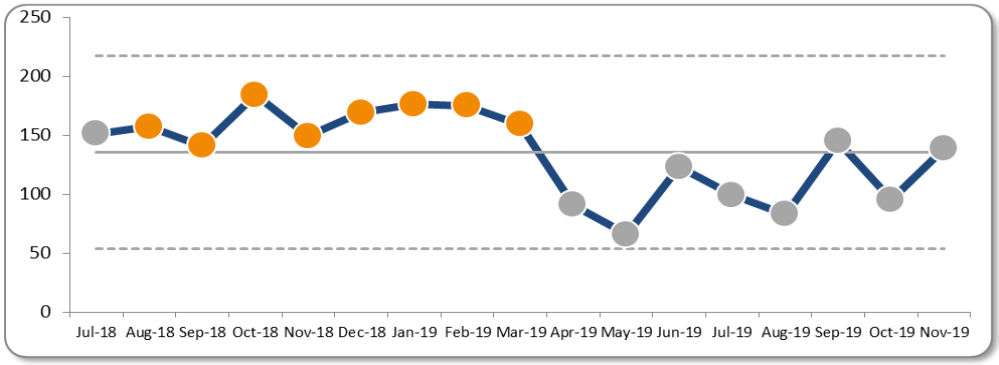
**Discharges before midday (%)**

17.2



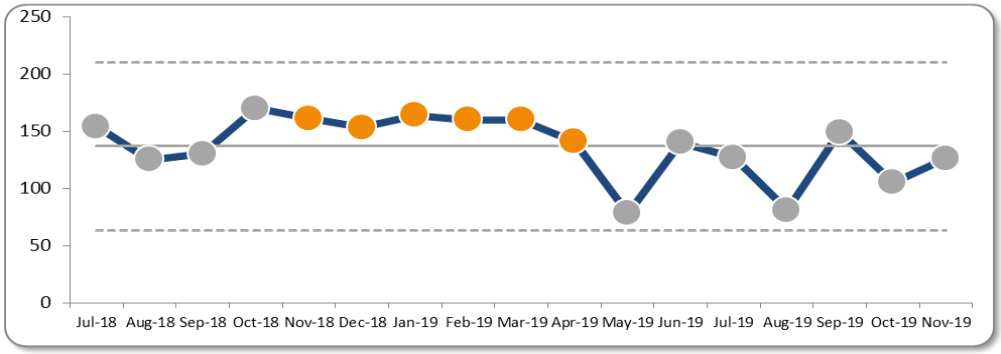

**Risks overdue review**

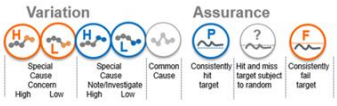
139




**Risks with overdue actions**

126



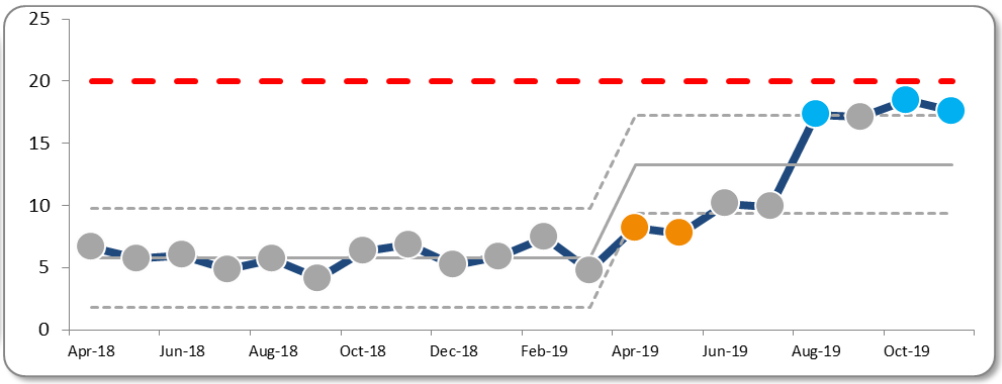
# Month 8 [November] | 2019-20 Quality & Safety Summary
## Care that is Safe

**Responsible Director: Chief Nursing Officer, Chief Medical Officer** | for November 19 as at **31st December 2019**

Worcestershire Acute Hospitals NHS Trust

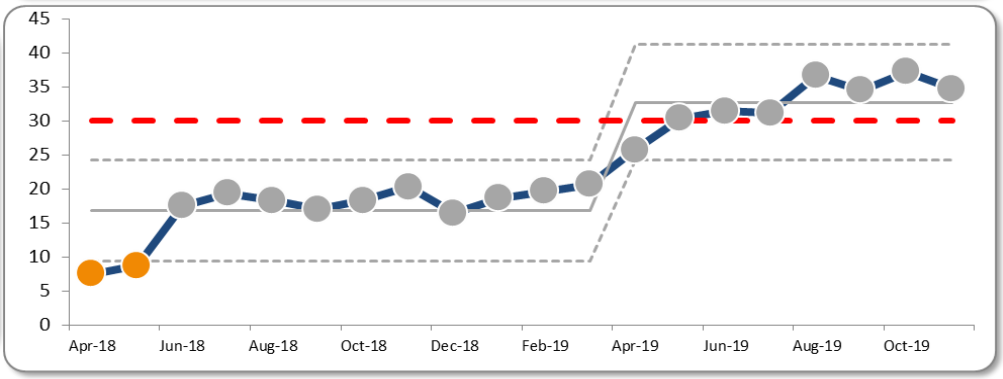
**Accident & Emergency Response Rate Friends & Family Test (%)**

17.6



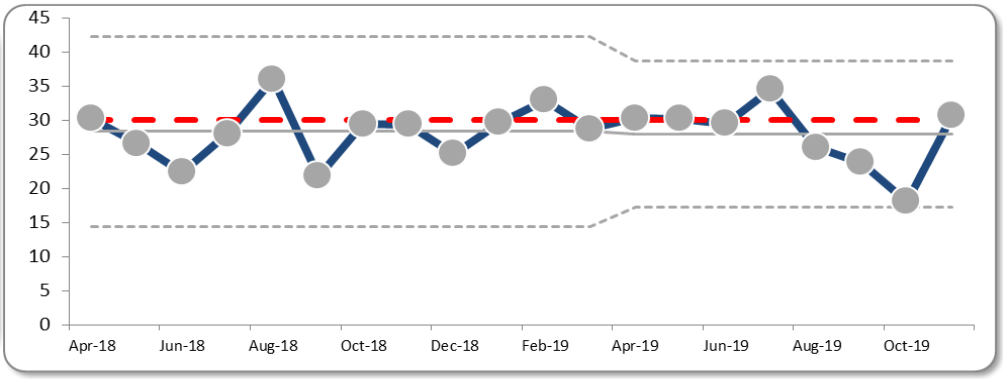

**Inpatient Response Rate Friends & Family Test (%)**

34.7



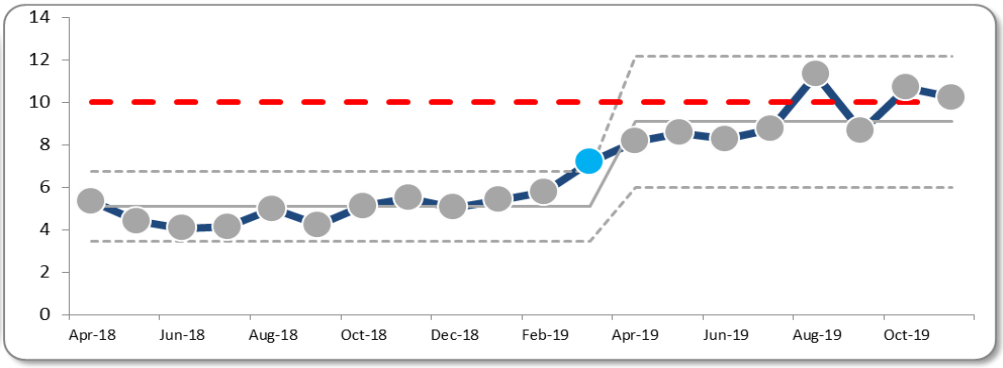

**Maternity Response Rate Friends & Family Test (%)**

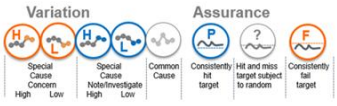
30.7




**Outpatients Response Rate Friends & Family Test (%)**

10.3



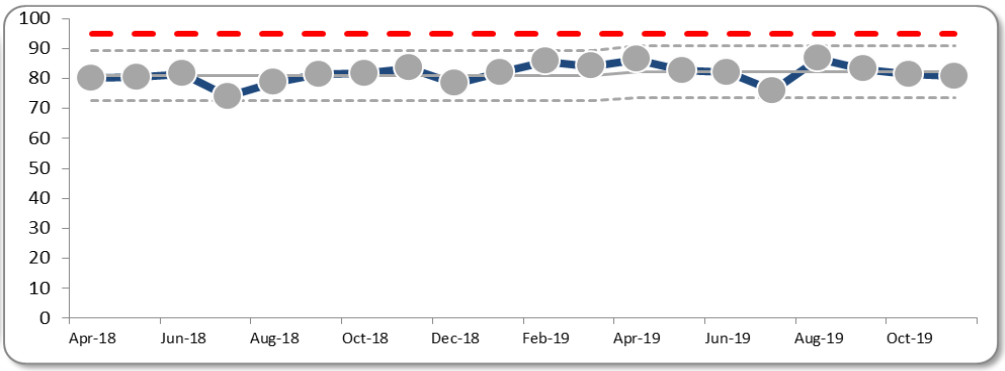
# Month 8 [November] | 2019-20 Quality & Safety Summary
## Care that is Safe

**Responsible Director: Chief Nursing Officer, Chief Medical Officer** | for November 19 as at **31st December 2019**

Worcestershire Acute Hospitals NHS Trust

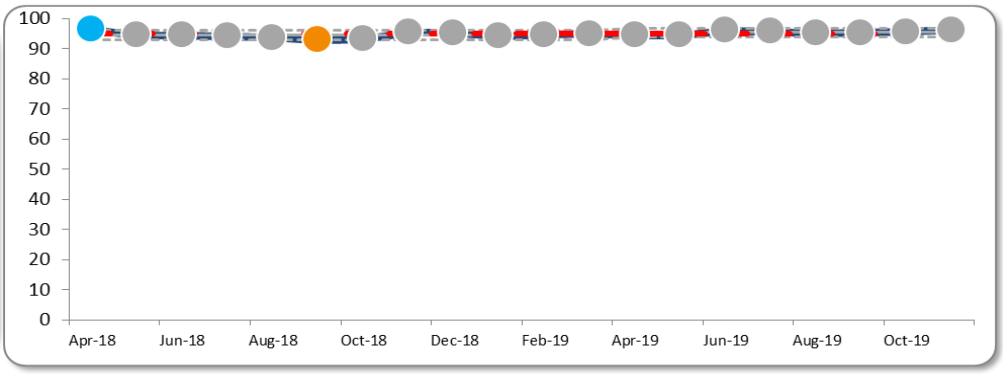
**Accident & Emergency Recommended Rate Friends & Family Test (%)**

80.7



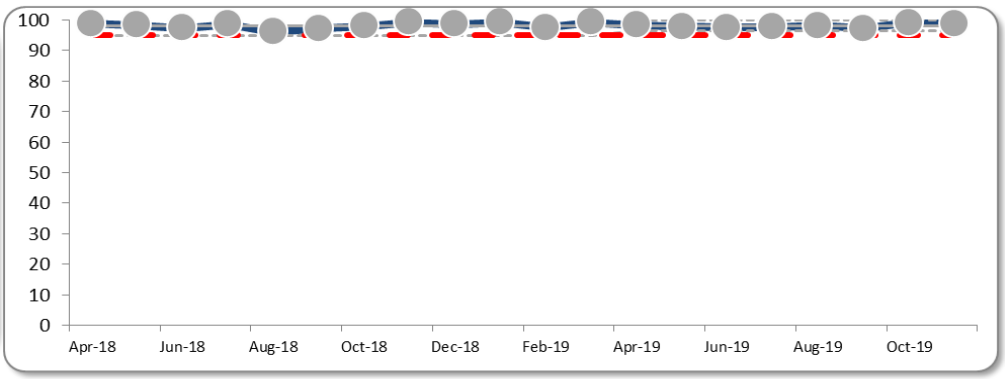

**Inpatient Recommended Rate Friends & Family Test (%)**

96.2



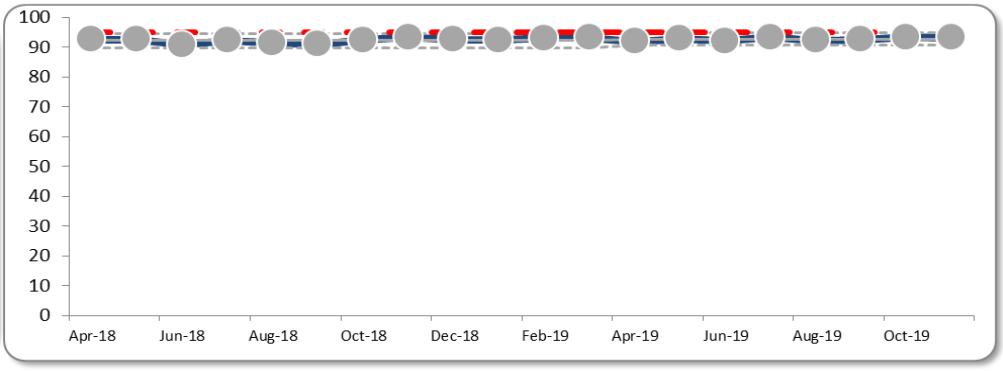

**Maternity Recommended Rate Friends & Family Test (%)**

98.7




**Outpatients Recommended Rate Friends & Family Test (%)**

93.1




# Quality & Safety| Submitted Trajectories (19/20) | M8 [November]

Worcestershire Acute Hospitals NHS Trust

| Performance Metrics | | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 |
|---|---|---|---|---|---|---|---|---|---|
| Cdiff | Actual | 4 ✓ | 3 ✓ | 5 ✗ | 2 ✓ | 9 ✗ | 7 ✗ | 7 ✗ | 3 ✓ |
| | Trajectory | 5 | 4 | 4 | 4 | 5 | 4 | 4 | 5 |
| Ecoli | Actual | 5 ✓ | 6 ✗ | 4 ✓ | 6 ✗ | 4 ✓ | 5 ✓ | 4 ✓ | 7 ✗ |
| | Trajectory | 5 | 5 | 5 | 4 | 5 | 5 | 5 | 5 |
| MSSA | Actual | 0 ✓ | 2 ✗ | 1 ✓ | 2 ✗ | 2 ✗ | 0 ✓ | 2 ✗ | 1 ✓ |
| | Trajectory | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| MRSA | Actual | 0 ✓ | 0 ✓ | 1 ✗ | 0 ✓ | 0 ✓ | 0 ✓ | 0 ✓ | 1 ✗ |
| | Trajectory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hospital Acquired Deep Tissue injuries | Actual | 8 - | 11 - | 3 - | 8 - | 6 - | 9 - | 6 - | 8 - |
| | Trajectory | - | - | - | - | - | - | - | - |
| Falls per 1,000 bed days causing harm | Actual | 0 ✓ | 0.04 ✓ | 0 ✓ | 0 ✓ | 0.04 ✓ | 0.04 ✓ | 0.04 ✓ | 0.08 ✗ |
| | Trajectory | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 |
| % medicine incidents causing harm | Actual | 13.04% ✗ | 16.13% ✗ | 13.29% ✗ | 15.67% ✗ | 23.19% ✗ | 15.19% ✗ | 13.49% ✗ | 11.52% ✓ |
| | Trajectory | 11.71% | 11.71% | 11.71% | 11.71% | 11.71% | 11.71% | 11.71% | 11.71% |
| Hand Hygiene Audit Participation | Actual | 86.55% ✗ | 87.39% ✗ | 87.39% ✗ | 91.38% ✗ | 85.96% ✗ | 91.07% ✗ | 96.43% ✗ | 98.21% ✗ |
| | Trajectory | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Hand Hygiene Compliance to practice | Actual | 96.95% ✗ | 97.52% ✓ | 98.39% ✓ | 97.88% ✓ | 97.92% ✓ | 97.98% ✓ | 98.28% ✓ | 98.35% ✓ |
| | Trajectory | 97% | 97% | 97% | 97% | 97% | 97% | 97% | 97% |
| VTE Assessment Rate | Actual | 95.92% ✓ | 96.58% ✓ | 96.51% ✓ | 96.55% ✓ | 96.23% ✓ | 97.10% ✓ | 96.45% ✓ | 97.33% ✓ |
| | Trajectory | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| Sepsis Screening compliance | Actual | 90.05% ✓ | 94.39% ✓ | 89.24% ✗ | 87.16% ✗ | 86.83% ✗ | 89.30% ✗ | 86.35% ✗ | - - |
| | Trajectory | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| Sepsis 6 bundle compliance | Actual | 57.50% ✗ | 44.66% ✗ | 47.47% ✗ | 60.00% ✗ | 68.09% ✗ | 51.96% ✗ | 45.00% ✗ | - - |
| | Trajectory | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| #NOF time to theatre <=36 hrs | Actual | 83.87% ✗ | 86.89% ✓ | 71.43% ✗ | 79.10% ✗ | 82.46% ✗ | 88.00% ✓ | 84.21% ✗ | 85.71% ✓ |
| | Trajectory | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| Mortality Reviews completed <=30 days | Actual | 40.45% - | 53.74% - | 43.65% - | 45.18% - | 46.58% - | 68.57% - | 54.31% - | - - |
| | Trajectory | - | - | - | - | - | - | - | - |
| HSMR 12 month rolling average | Actual | 110.15 - | 109.60 - | 109.96 - | 110.02 - | - - | - - | - - | - - |
| | Trajectory | - | - | - | - | - | - | - | - |
| Complaints responses <=25 days | Actual | 75.00% ✗ | 81.82% ✓ | 71.19% ✗ | 83.93% ✓ | 90.91% ✓ | 77.50% ✗ | 58.93% ✗ | 83.78% ✓ |
| | Trajectory | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |
| ICE viewed reports [pathology] | Actual | 96.85% - | 96.66% - | 96.83% | 96.69% - | 96.54% - | 96.19% - | 95.97% - | - - |
| | Trajectory | - | - | - | - | - | - | - | - |
| ICE viewed reports [radiology] | Actual | 92.49% - | 93.22% - | 92.28% - | 91.67% - | 91.69% - | 90.46% - | 81.95% - | - - |
| | Trajectory | - | - | - | - | - | - | - | - |

# Best People

NHS Worcestershire Acute Hospitals NHS Trust

| KPI | Variation/Assurance and Corrective Action |
|---|---|
| Non Medical appraisal | There has been 2% deterioration in performance this month to 82%. Reminders continue to be sent to individuals and managers through ESR Self Service. Some concerns have been raised about the timeliness of updating ESR from the electronic link which are being investigated by L&D. The target for appraisal will rise to 95% from April so further work is required within Divisions to meet this target. |
| Mandatory Training | There has been a further 1% deterioration in Mandatory Training compliance this month which has dropped below target at 89%. This is primarily due to the change in eligibility following the CCG's instruction that ALL clinical staff require WRAP training. The target will rise to 95% from April 2020 so further work is required within Divisions to meet this target. |
| Medical appraisal | Although no change this month at 92%, we have exceeded both the Trust target of 90% and Model Hospital average of 85%, and continue on an upward trajectory. Reminders through ESR Self Service and dedicated resource in HR to support medical appraisal and revalidation have been effective. |
| Consultant Job Plans | Team job planning and e-job planning within the Allocate suite of solutions has produced a 36% improvement since January 2019. There has been a 2% increase this month to 91% compliance for consultants. Performance continues to be addressed through the monthly performance review meetings. |
| Vacancies | Our vacancy rate has improved again this month from 9.72% to 9.27% (including funded bank and agency) due to further domestic and international recruitment. The national substantive NHS vacancy rate was 8.1% in March 2019 (office of national statistics). |
| Increase in total hours worked | Our total hours worked have reduced by 1.28 wte this month. There has been a further increase of 24.3 wte worked this month by substantive staff resulting in a reduction of bank and agency hours worked. Agency has reduced by 21.87 wte. See Finance report |
| Increase in Staff in Post | There are 377 wte additional staff in post since April 2016 across all staff groups, which demonstrates successful recruitment campaigns. |
| Establishment Growth | Our establishment has grown by 477 wte since April 2017 which has impacted on our vacancy rates. Establishment has grown by 3.98 wte this month - see Finance report. |
| Monthly Sickness Absence Rate | Sickness rates are 4.26% this month against Model Hospital benchmark of 4.11% and Trust target of 4%. This includes a 0.06% reduction in short-term sickness and a 0.01% reduction in long-term sickness. |
| Annual Staff turnover | Turnover has been reducing month on month since May 2019 and is now 11.33%. The target will reduce to 11% from April 2020. |
| Staff FFT positive feedback | Q3 staff opinion survey closed on 29th November 2019 with 39% participation rate which is the highest for a number of years. Results are due out in February 2020. 69% of respondents in Q2 SFFT said that they would recommend the Trust as a place to work. |

## People and Culture KPI's M8 – November 2019

## Variation

| Icon | Description |
|---|---|
|  | Special cause variation - cause for concern (indicator where high is a concern) |
|  | Special cause variation - cause for concern (indicator where low is a concern) |
|  | Common cause variation |
|  | Special cause variation - improvement (indicator where high is good) |
|  | Special cause variation - improvement (indicator where low is good) |

## Assurance

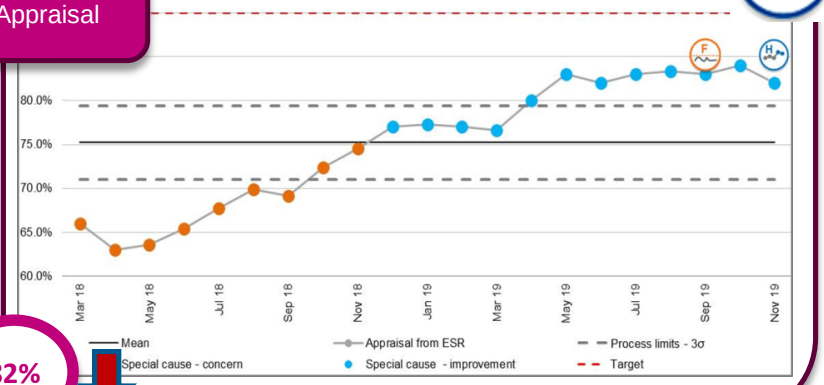
| | |
|---|---|
|  | The system is expected to consistently fail the target |
|  | The system is expected to consistently pass the target |
|  | The system may achieve or fail the target subject to random variation |

# Month 8 | 2019-20 Engaged & Skilled Workforce Summary

Responsible Director: Director of People & Culture | as at 30th November 2019

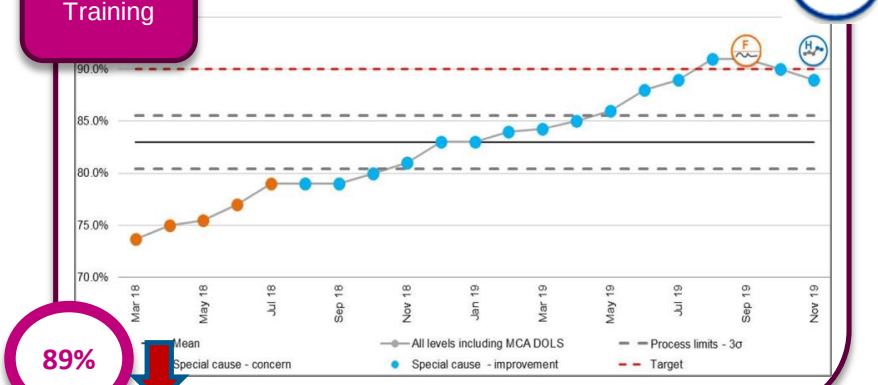
Worcestershire Acute Hospitals NHS Trust

## Non Medical Appraisal



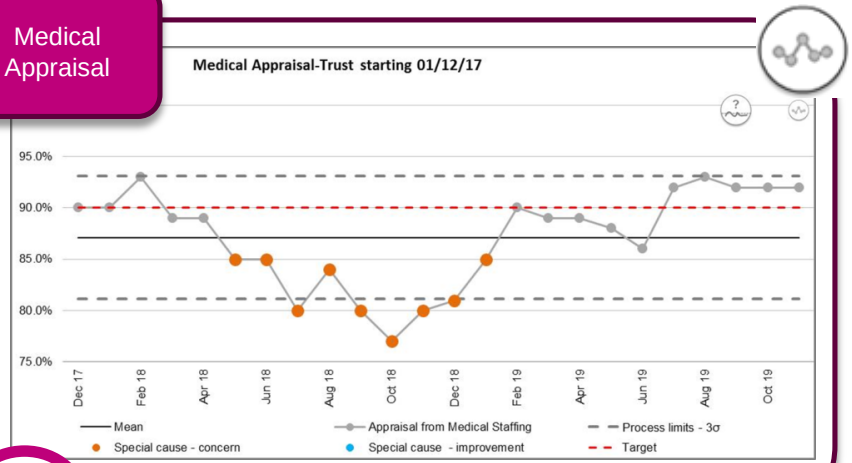

82%

## Mandatory Training



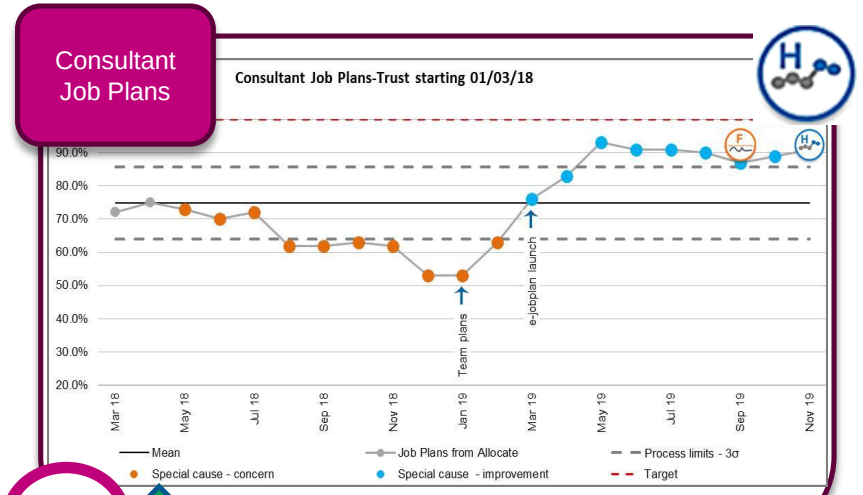

89%

## Medical Appraisal

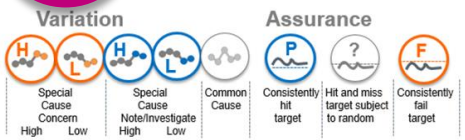



92%

## Consultant Job Plans




91%



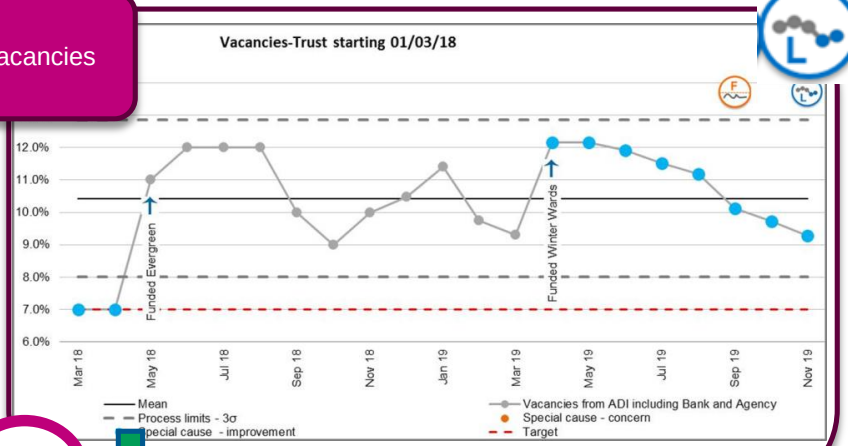

Arrow depicts direction of travel since last month. **Green** is improved, **Red** is deteriorated and **amber** unchanged since last month.

# Month 8 | 2019-20 Engaged & Skilled Workforce Summary

Responsible Director: Director of People & Culture | as at 30th November 2019

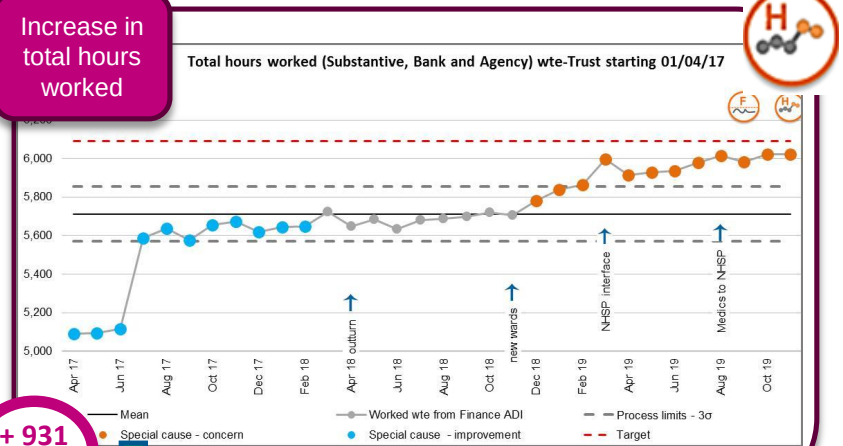
Worcestershire Acute Hospitals NHS Trust

## Vacancies



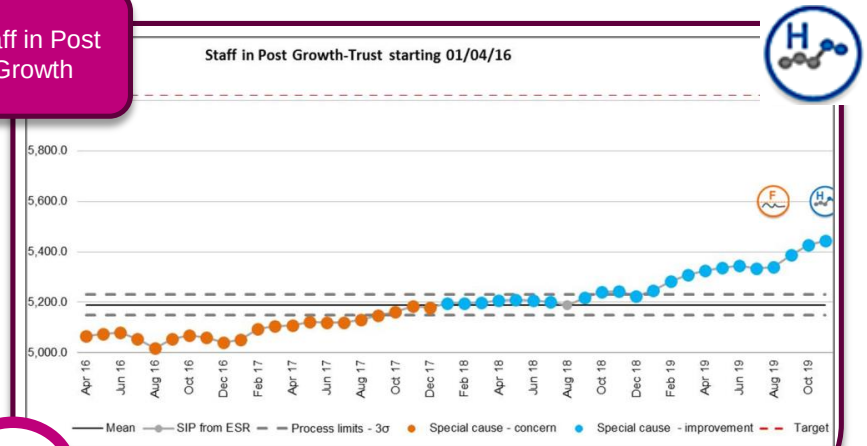

9.27%

## Increase in total hours worked



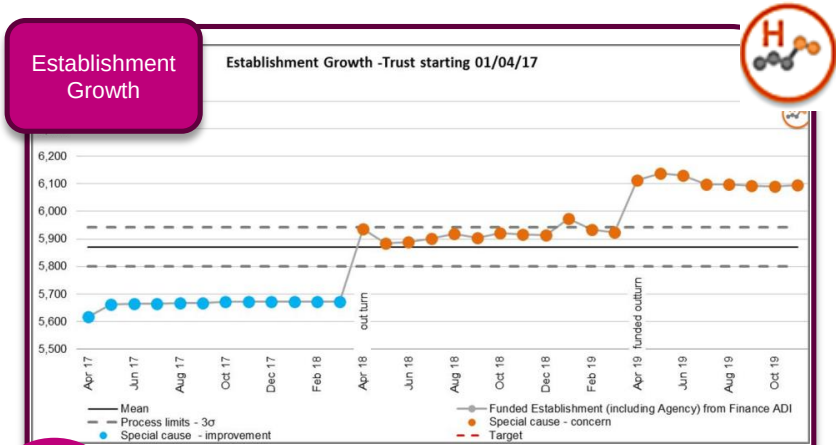

+ 931 wte

## Staff in Post Growth

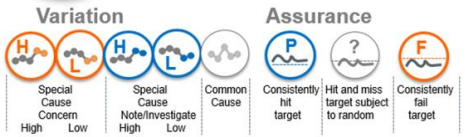



+377 wte

## Establishment Growth




+ 477 wte



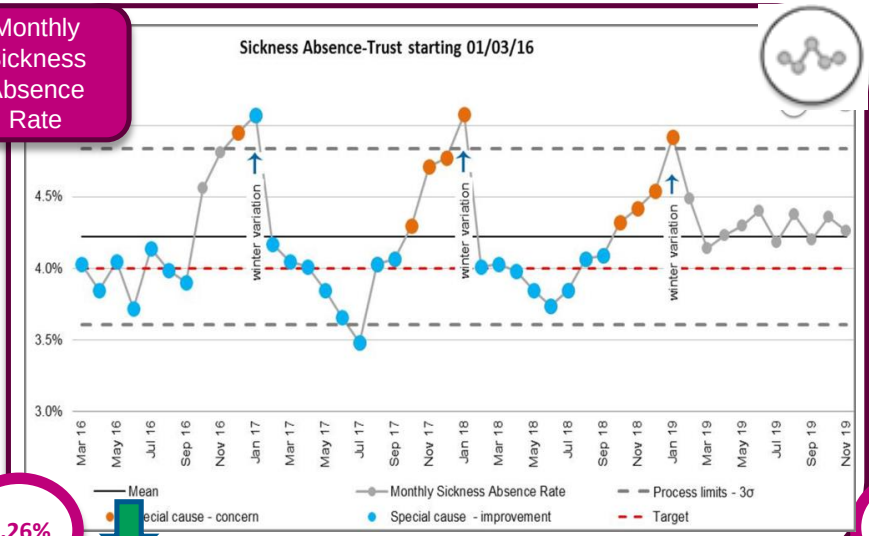

Arrow depicts direction of travel since last month. **Green** is improved, **Red** is deteriorated and **amber** unchanged since last month.

# Month 8 | 2019-20 Engaged & Skilled Workforce Summary

Responsible Director: Director of People & Culture | as at 30th November 2019

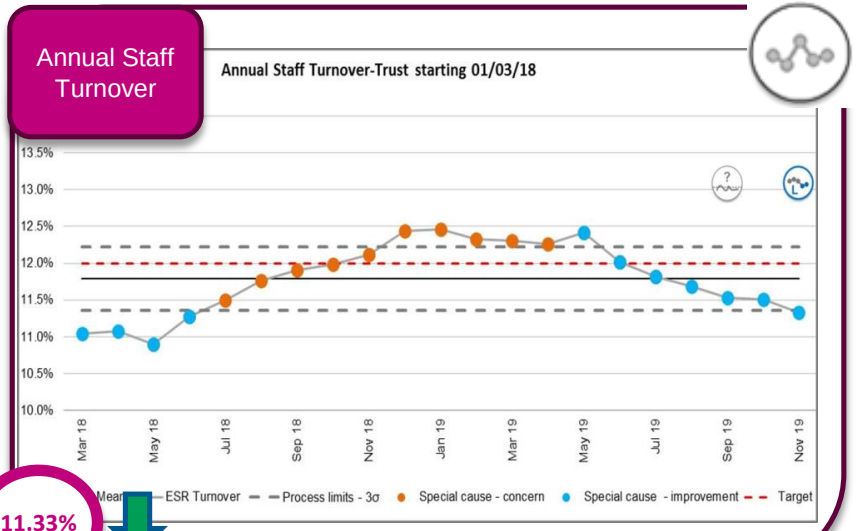
NHS Worcestershire Acute Hospitals NHS Trust

## Monthly Sickness Absence Rate

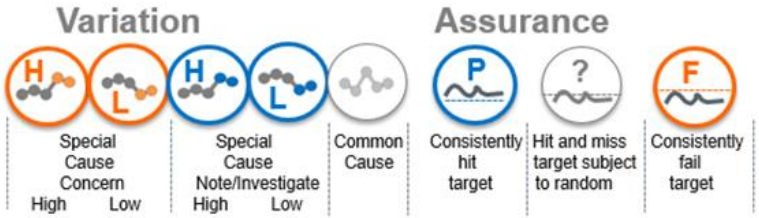



4.26%

## Annual Staff Turnover

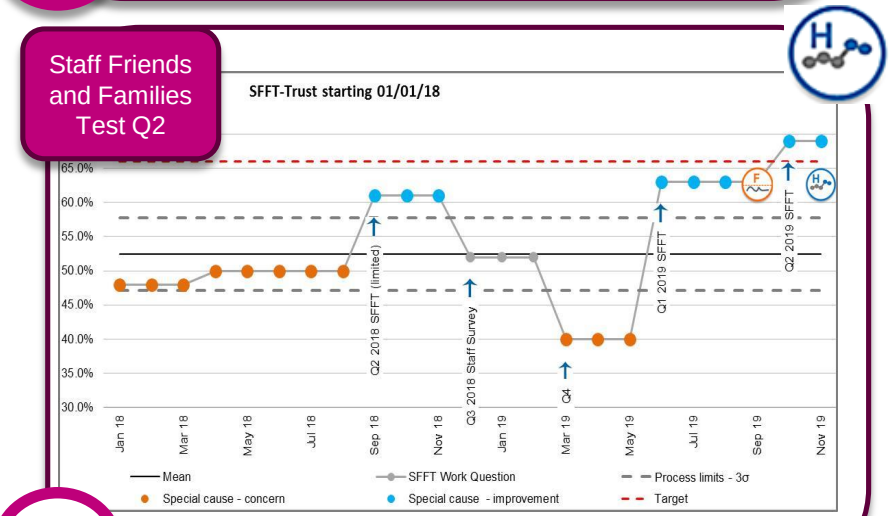



11.33%




Arrow depicts direction of travel since last month. **Green** is improved, **Red** is deteriorated and **amber** unchanged since last month.

## Staff Friends and Families Test Q2




69%

# Best Use of Resources

NHS Worcestershire Acute Hospitals NHS Trust

## Risk Rating Summary

| | Metric Definition | How we did YTD at M8 | Risk Rating | | Previous Month YTD | Full Year Plan (Forecast) |
|---|---|---|---|---|---|---|
| Are we spending more than the income we receive? | I&E surplus or deficit / total revenue. | (18.70%) | 4 | Adjusted financial performance deficit of **£53,268** (£53,268k/ total operating income £284,675k = **(18.70%)** | 4 | 4 |
| How close are we to our financial plan? | YTD actual I&E surplus/deficit in comparison to YTD plan I&E surplus/deficit. | 1.20% | 1 | I&E margin YTD actual of **(18.70%)** less I&E margin YTD plan of **(19.90%) = 1.20%** | 1 | 1 |
| How many days' worth of cash do we have? | Measures the days of operating costs held in cash, cash-equivalent and liquid working capital forms. | (115.59) | 4 | Working Capital of (£151,020k) / YTD Operating Expenditure of £318,800 multiplied by the number of YTD days (244) = (115.59) | 4 | 4 |
| Do we have sufficient income to cover the interest owed on our borrowings? | Degree to which the organisation's generated income covers its financing obligations. | (2.042) | 4 | Revenue available for capital service (£33,508k)/ capital service **£16,410k**= **(2.042)** | 4 | 4 |
| Is our agency spend within the imposed limits? | Total agency spend compared to the agency ceiling. | (68.12%) | 4 | Total agency spend of **£19,381k** less agency ceiling of **£11,528k** / divided by agency ceiling of **£11,528k** = **(68.12%)** | 4 | 3 |

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

| | |
|---|---|
| Meeting | Trust board |
| Date of meeting | 16 January 2020 |
| Paper number | Enc E1 |

# Risk Management Strategy (RMS)

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Vicky Morris<br>Chief Nursing Officer | | |
| **Presented by** | Vicky Morris<br>Chief Nursing Officer | **Author /s** | Dee Johnson<br>Risk Manager |

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

| **Report previously reviewed by** | | |
|---|---|---|
| Committee/Group | Date | Outcome |
| TME | 11-12-19 | Approved |
| QGC | 18-12-19 | Approved |

| | |
|---|---|
| **Recommendations** | Trust board is requested to approve the revised RMS including the risk appetite statements. |

| | |
|---|---|
| **Executive summary** | This strategy sets out the Trust's risk management framework and the arrangements for the identification, evaluation, ownership, management and reporting of risks and the key responsibilities for individuals, directorates, divisions and committees.<br><br>It describes the Trust's appetite for risk for a range of circumstances and objectives.<br><br>The form and functions of the Board Assurance Framework, which is informed by strategic risks and the risk register structure for operational risks, are also set out.<br><br>The strategy is written in the context of good governance, business planning, performance management and assurance.<br><br>Changes are as follows:<br>Amendments to risk description, escalation process, changes to reflect current governance structure, addition of frequency of review, authority for managing risks and monitoring process.<br><br>Aims and ambitions added in as an additional part |

| **Assurance level** | **Significant** | *x* | **Moderate** | | **Limited** | | **None** | |
|---|---|---|---|---|---|---|---|---|

| Trust Strategy | | |
|---|---|---|

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NHS Trust

# Risk Management Strategy

| | |
|---|---|
| **Department/Service:** | Clinical Governance and Risk Management |
| **Originator:** | Dee Johnson – Patient Safety, Senior Investigation and Risk Manager |
| **Accountable Director:** | Vicky Morris, Chief Nursing Officer |
| **Approved by:**<br>**Ratified by:**<br>**Endorsed by:** | Risk Management Group (RMG)<br>Quality Governance Committee<br>Trust Board |
| **Date of Approval:**<br>**Date Of Ratification:**<br>**Date Endorsed:** | 4th July 2018<br>19th July 2018<br>17th July 2018 |
| **Review Date:**<br>**This is the most current document and is to be used until a revised version is in place** | Every 3 years or sooner if circumstances dictate |
| **Target Organisation(s)** | Worcestershire Acute Hospitals NHS Trust |
| **Target Departments** | All Departments |
| **Target staff categories** | All Staff |

**Strategy Overview:**

This strategy sets out the Trust's risk management framework and the arrangements for the identification, evaluation, ownership, management and reporting of risks and the key responsibilities for individuals, directorates, divisions and committees.

It describes the Trust's appetite for risk for a range of circumstances and objectives.

The form and functions of the Board Assurance Framework, which is informed by strategic risks and the risk register structure for operational risks, are also set out.

The strategy is written in the context of good governance, business planning, performance management and assurance.

**Key amendments to this Document:**

| Date | Amendment | By: |
|---|---|---|
| Jul 05 | Revision with more detail about Risk Registers, targeted training, revised risk management objectives, Directorate Performance reviews etc. | C. Rawlings |
| Nov 06 | Revision includes actions to meet the requirements of the pilot NHSLA Risk Management Standards, including the need for risk management strategies for all areas and a revised risk escalation process. | C. Rawlings |

| Date | Amendment | By: |
|---|---|---|
| Jan 08 | Editing to define the strategy and policy elements. Revision of the means of monitoring compliance with / implementation of this strategy. Revised objectives. Requirement for Directorate Risk Coordinators removed although GMs, CDs or equivalents have a responsibility for managing risk by having processes in place and allocating specific roles in supporting them. Addition of identification of partnership risks | C Rawlings |
| July 08 | Revisions made for FT application. Review and changes include: risk scoring matrix; risk escalation process; corporate risk register process; training requirements; monitoring arrangements; creation of the Risk Validation Group | C. Rawlings |
| Sep 08 | – Board Assurance Framework section re-established at section 5. Risk Validation Group added to risk management process in Appendix B Inclusion of Chief Operating Officer to replace Director of Operations. DoF associated with business risks and COO with business continuity risks. | C. Rawlings |
| Jul 09 | Revisions made to accommodate the changes to the Trust's Management and Committee structures Risk Scoring Matrix (Appendix C) revised and re-issued Board Secretary now responsible for the BAF | C. Rawlings |
| Sep 09 | Objectives revised and provided in appendix D | Executive Team |
| Jul 10 | Minor changes made to: reflect operational structure and responsibilities and the extended life of the ERMC; Clarification of the Executive Team role in receiving new significant risks; Addition of Fraud risk identification; amendment to the escalation process. Approved by Executive Team | C. Rawlings |
| Jun 12 | Revisions made to reflect operational structure, Monitor requirements and to separate this document out into a strategy and separate 'policy'. Monitoring / KPIs improved. | C. Rawlings |
| Sep 12 | Clarification of 6.3 training. Minor change approved by Chairman | C. Rawlings |
| Jul 14 | Revision and explanation of the risk management framework Widespread changes to the process and responsibilities to reflect the new Trust structure Description of the new approach to the Board Assurance Framework Revised risk scoring matrix | C. Rawlings |
| Feb 15 | Revised likelihood definitions and formatting of Appendix 3 Risk Scoring Matrix | J.King |
| Apr 15 | Minor update following annual review, titles, committees and implementation plan updated. | J.King |
| Nov 16 | Minor amendments to reflect the changes to the Trust governance structure and Trust Risk Officer post | W. Huxley Marko |
| April 17 | Amendments to escalation process for adding risks to the Corporate Risk Register | C.Geddes |

| Date | Amendment | By: |
|---|---|---|
| May 17 | Amendments to objectives, references and risk description. Additions made to reflect changes to structure. | S Lloyd |
| April 18 | Amendments to roles and responsibilities, the addition of risk profiling, updated objectives and updated references. | S Lloyd / C Geddes/V Morris |
| Aug 19 | Amendments to risk description, escalation process, changes to reflect current governance structure, addition of frequency of review, authority for managing risks and monitoring process. | D Johnson |
| Dec 19 | Aims and ambitions added in as an additional part | Vicky Morris |

**Contents page:**

## Introduction

1. Risk is an inherent part of the delivery of healthcare. This risk management strategy outlines the Trust's approach to risk management throughout the organisation.

2. Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them.

3. This Board approved strategy for managing risk identifies the accountability arrangements, the resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

4. Successful risk management involves:
   - Identifying and assessing risks
   - Taking action to anticipate or manage risks
   - Monitoring risks and reviewing progress in order to establish whether further action is necessary or not
   - Ensuring effective contingency plans are in place.

## Aim

5. The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. The strategy seeks to ensure that:

   - The Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected.
   - The implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk based upon the support and leadership offered by the Trust Board.

## Ambitions and implementation

- This strategy is based on achieving the 5 ambitions set out below. From January 2020 to March 2025 the Trust will aim to achieve the following Risk Management Ambitions:

  1. To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Board to Ward).
  2. To promote a risk culture of monitoring and improvement, which ensures risks to the delivery of Trust's strategic ambitions are identified and addressed.
  3. To refine processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust.
  4. To support service users, carers and stakeholders through reduction of risks to service delivery and improved service provision.
  5. To support the Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislation

responsibilities, including standards of clinical quality, NHSI compliance requirements and Trust's licence.

## Scope

6. The objective of the risk management strategy is to promote an integrated and consistent approach across all parts of the organisation to managing risk.

7. The strategy applies to all Trust staff, contractors and other third parties, including honorary contract holders, working in all areas of the Trust. Risk Management is the responsibility of all staff and managers at all levels and they are expected to take an active lead to ensure that risk management is a fundamental part of their operational area linking ward/ Dept. risks through to corporate risks and reference to the Board assurance Framework.

8. The Trust encourages an open culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined in this strategy.

9. Managers at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance and the organisation will provide ongoing risk management training to ensure adequate awareness and skills for staff at all levels to manage risk effectively.

## Definitions

10. Definitions related to this strategy are set out in Appendix 1.

## Risk Statement

11. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

12. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and management is not surprised by risks that could, and should, have been foreseen.

13. Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

14. Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

15. Senior management will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.

16. Line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

17. All Staff should have an awareness and understanding of the risks that affect patients, visitors, and staff and are encouraged to identify risks.

18. Staff will be competent at managing risk. In order to facilitate this, staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally.

19. There will be active and frequent communication between staff, stakeholders and partners.

**Risk Appetite Statement**

20. The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. Figure 1 sets out an example risk appetite. In practice, an organisation's risk appetite should address several dimensions:
    - The nature of the risks to be assumed;
    - The amount of risk to be taken on;
    - The desired balance of risk versus reward.

21. On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:
    - Risk to patients
    - Organisational risk
    - Reputational risk
    - Opportunistic risk

These categories of risk are more fully explained in Appendix 2.

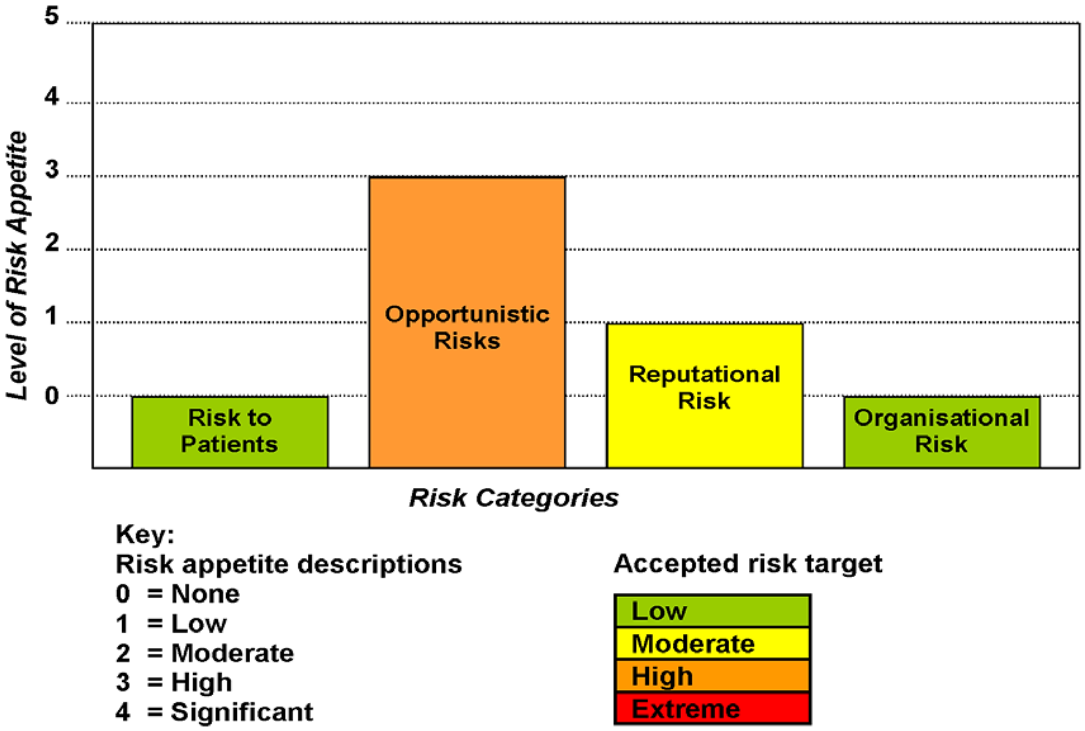



**Figure 1: Example risk appetite by area**

22. The risk appetite statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

23. Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

24. The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the Board to determine the organisational capacity to control risk. The review will consider:
    - Risk leadership
    - People
    - Risk policy and strategy
    - Partnerships
    - Risk management process
    - Risk handling
    - Outcomes

25. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk.

## Roles and Responsibilities for Risk Management

26. Each area of the Trust must undertake an ongoing and robust assessment of risks that may have an impact upon the delivery of high quality, effective and safe care.

27. All staff are responsible for risk management All who work at the Trust are responsible for the delivery of high quality, safe care, ensuring their own actions contribute to the well-being of patients, staff, visitors and the Trust.

28. All staff must:
    - Attend and follow individual training requirements and not use any equipment, undertake practices or processes which deviate from mandatory or statutory requirements for health and safety.
    - Locate, observe and adhere to all policies and procedures, relevant to their role, that have been made available by the Trust.
    - Contribute to the identification, management, reporting and assessment of risks, taking positive action to manage risks appropriately. This is a statutory requirement.
    - Comply with the incident and near miss reporting procedures
    - Be aware of the Trust's risk management strategy and processes and comply with them.

29. Appendix 3 sets out the full list of specific risk management responsibilities for the Trust.

## Risk Management Process

30. Risks are adverse events that 'might happen', which could stop the Trust achieving its objectives or impact upon its success.

31. Risk Management is the proactive identification, classification and control of events and activities to which the Trust is exposed. See Appendix 1 for further definitions related to this strategy.

32. The Trust adopts a structured approach to risk management, whereby risks are identified, assessed and controlled and if appropriate, escalated or de-escalated through its governance mechanisms.

## Risk Management Cycle

33. The Trust has a risk management cycle that ensure risks are identified, assessed, controlled and where required escalated. The main stages of the cycle are:
    - Clarifying objectives
    - Identifying risks to objectives
    - Assessing and scoring the risk
    - Identifying controls and their effectiveness
    - Identifying and record actions to mitigate risks
    - Escalation and de-escalation of risks.

**Stage 1: Clarifying Objectives**

34. Clarifying objectives enables staff to recognise and manage potential risks, threats or opportunities that may prevent the achievement of strategic and local objectives.

35. In order to clarify:

- Strategic (Corporate) Objectives, determine which Trust Strategic Objective(s) is relevant to the whole Trust, Division, Directorate, Service area.
- Local Objectives, determine objectives that are only relevant to the Division, Directorate, Service area.

**Stage 2: Identifying Risks to Objectives**

36. Where appropriate, working collaboratively with colleagues with consideration of the following suggested questions, will enable stakeholders to more accurately identify risk:
    - What are the risks which may prevent the delivery of your objectives?
    - What risks have an impact on the delivery of high quality, safe care?
    - What could happen or what could go wrong?
    - How and why could this happen?
    - What must we do to enable continued success in achieving objectives?
    - Who else might provide a different perspective on your risks?
    - Is it an operational risk or a risk to a strategic objective?

37. Once the objectives are clarified, risks are more easily identified. Risks can also be identified via a number of sources.

38. Risks should be defined in a clear, concise and consistent manner to ensure common understanding by all. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

39. A poorly described risk is a recognised problem in risk management. Common errors include describing the impact of a risk and not the risk itself, writing it as a statement that is the opposite of the objective, or does not impact on the achievement of the objective.

40. The key to understanding the true meaning of a risk is ensuring that the risk has a clear description. As a rule, always ensure the risk is fully visible by stating what might happen to prevent achieving the objective, in what way and the impact of this on the objective if it were to happen.

41. When considering the risk, it is helpful to think about it in line with the objective. For example:

    - What might trigger a threat to the objective? (IF 'x' were to occur)
    - What is the nature of the threat to the objective? (*THEN* 'y' will happen)
    - What might the impact be on the objective? (*RESULTING IN* 'z' outcome)

42. The risk can then be clearly described using: 'IF', 'THEN', 'RESULTING IN' as follows:

    "***IF*** the Trust is unable to recruit and retain appropriately trained physiotherapists ***THEN*** the Trust may be required to cancel outpatient clinics ***RESULTING IN*** longer waiting times for patients leading to complaints and poor outcomes for patients.

43. The summary of the risk must be clear for others to read, understand, and be clear on what needs to be addressed. It stimulates initiatives for what can be put in place to stop or reduce the chances of the risk materialising.

**Stage 3: Assessing and scoring the risk**

44. The same risk scoring is used in Worcester Acute Hospitals NHS Trust for all risk processes, including risk assessment, risk registers and incident reporting. Risks are calculated according to the following formula:
    - Likelihood x Consequence = Risk

45. Likelihood determines the chances of the risk being realised. Section 2 of Appendix 4 sets out the descriptors of the likelihood of a risk occurring.

46. Consequence determines what is most likely to be the outcome or impact if the risk were realised. Section 1 of Appendix 4 sets out categories to aid measurement of the consequence if a risk occurs.

47. Based on the two judgements, the potential future risk is calculated using the risk matrix in Section 3 of Appendix 4. This provides the 'initial risk score' and represents the risk if no controls were in place. Section 4 of Appendix 4 also sets out the measures to be taken based on the risk score.

48. Once a risk has been quantified (scored), then how the risk should be dealt with has to be determined; not all risks can be dealt with in the same way. The following options should be considered:
    - **Tolerate** – Where all reasonably practicable control measures have been implemented, but the risk remains; the likelihood and consequence of a risk happening is accepted at its current score, monitored, reviewed and a contingency plan is put in place to manage the risk if it occurs.
    - **Transfer** – shift the responsibility or burden for loss to another party, e.g. purchase insurance against the risk or sub-contract to another party, moving the risk to them.
    - **Treat** – put systems in place to reduce the likelihood or consequence of the risk to an acceptable level
    - **Terminate** – undertake the activity in a different way to remove the risk, or take an informed decision not to become involved in the risk, e.g. stop doing the activity creating the risk
    - **Take the opportunity** - actively taking advantage or the uncertainty, using it as an opportunity to benefit.
    - **Contingency planning -** should also be put in place if a risk is rated red or orange (extreme or high) and the risk cannot be reduced to an acceptable level. This ensures recovery after events occur that cannot be controlled.

49. Good risk management is about being risk aware and able to handle the risk, not risk averse.

50. In most cases the chosen option will be to *treat* the risk. When considering the action to take associated costs must be considered, as this may have a bearing on the how the decision. The key questions are:
    - Is the action to be taken to treat the risk proportionate to the risk it is controlling?
    - Does the response to the risk or planned actions introduce new risks, or affect other people in ways which they need to be informed about?

**Stage 4: Identifying controls and their effectiveness**

51. Each risk can be addressed in a number of ways using 'controls' Controls are the actions put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk, if it materialises. Contingency plans should also be included as controls.

52. Each control should be examined to determine if it has been successful in reducing the risk. There must be evidence available to verify that the control is working. This is termed 'assurance'. Appendix 5 sets out examples of possible sources of assurance.

53. The scoring of the risk should be re-calculated, taking into account the controls in place. This is called the 'current risk score'.

54. Where it is apparent that the control is not reducing the likelihood or consequence, this means the control is not fully effective. Each control that is not fully effective (gap in control) requires an action to increase its effectiveness.

55. Multiple controls may be required to manage each risk to an acceptable level. Controls can be added to a risk at any time, particularly where existing controls are considered to be fully effective and the risk score remains above an acceptable level.

**Stage 5: Identify and record actions to mitigate risks**

56. Where a control is not fully effective, or additional controls have been identified, actions must be put in place to increase the effectiveness of the existing control(s) or implement the new controls. Each action must have an owner (action owner) and a target date for completion.

57. Actions must describe the steps that need to be taken to fully implement the control so it is effective in managing (controlling) the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

58. All risks and controls are to be described in accordance to the Trust standard and recorded on the risk register following assessment.

**Stage 5: Escalation and De-escalation of Risks**

59. Risk escalation is where a risk is specifically drawn to the attention of the next level of the organisation for management. It is expected that risks rated below 8 are managed on the risk register at the level the risk was identified.

60. Risks can be considered for escalation at 8 or above, where there are concerns that the residual or target risk will not be achieved. Figure 2 sets out the process outlined below.

61. Where a specialty/ward/department risk is rated at 8 or above, after appropriate scrutiny from the divisional governance risk lead or manager, it will be reported into the divisional risk management or governance group, highlighting the gaps in controls and/or assurance. If the risk score is approved, the group can then determine if the risk should be escalated to the divisional/Trust Service risk register. The risk should be reassessed in the context of the division and either agree to accept the risk onto the divisional risk register or provide advice to the risk owner on the effective management of the risk. If after this, the risk is 15 or above at a divisional level, the next step of the escalation process should be applied as below.

62. Where a divisional/Trust service risk is assessed as scoring 15 or above, the division will first approve the new risk rating and escalate to the relevant Executive via the corporate clinical governance and risk management team, highlighting the gaps in control and/or assurance that warrant escalation. The relevant Executive Director or Risk Management Group will assess the risk from a corporate perspective in the context of the organisation. Upon completion, the risk will be agreed for addition to the corporate risk register (or Board Assurance Framework, if strategic) or advice will be provided by the Executive Director or Risk Management Group on the effective management of the risk.

63. Although the Risk Management Group or relevant Executive Director will make a decision on those risks proposed for inclusion on the Corporate Risk Register, these will, in most circumstances be:
    - Emerging risks which span across multiple Divisions and are not already subject to corporate oversight
    - Risks where the action required does not fall within the full control of the Division
    - Risks which are overseen by Specialist Groups due to their nature
    - Risks that have a current risk score of 15 or above.

64. Risks must sit on one of the five divisional or Trust Service risk registers. Ownership will be dictated by the individual risk owner. Where a risk may affect or be relevant to another division, the risk owner is to notify that division. When this is identified, one of the following approaches for management of the risk will apply:
    - One division will lead, involving the other division(s) as required;
    - Both divisions will record the risk and manage their portion of the risk in line with this strategy
    - If the risk relates to a specialty that crosses divisions, it will either sit with the relevant division for the specialty or be agreed for management via a specialist group, where applicable (e.g. risks related to cancer)
    - One division will own the risk and actions will be added against staff, with full agreement, in a number of other divisions.

65. Risks that have been returned with advice for effective management should continue to be managed on the register it was escalated from, and the recommended frequency of review applied as outlined in 71.

66. Risks that have previously been escalated can only be re-escalated under the following circumstances:
    - There are new gaps in controls or assurance identified
    - Wider system changes or regulations affect the significance of the risk
    - All controls are fully implemented and the target risk is not achieved

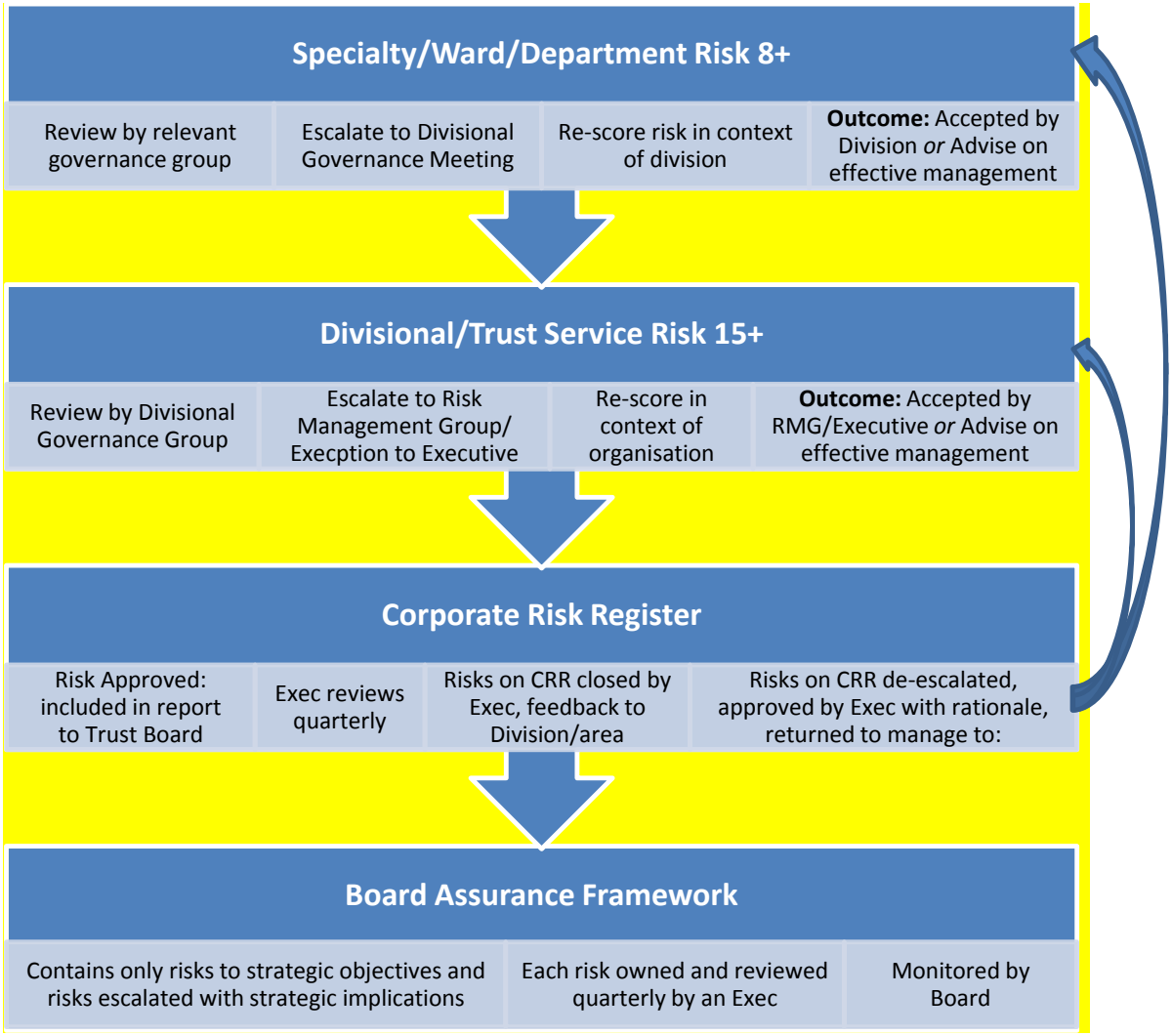



**Figure 2: Escalation and De-escalation process**

67. Once an escalated risk has reached the accepted target for the risk, following mitigating actions or a change in the nature of the risk, it will be de-escalated. When a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

### Documentation of Risks Using Risk Registers

68. Risk Registers are stored electronically on the Trust's electronic database (Datix).

69. Headings in the risk register that must be completed are:
    - Risk Title
    - Source of risk
    - Type of risk
    - Principal objectives
    - Strategic risks (links to Board Assurance Framework)

- Division
- Directorate
- Department/ward/service
- Risk description
- Initial risk rating (with no controls in place)
- Risk owner
- Controls
- Adequacy of controls
- Gaps in controls
- Current Risk rating (with current controls in place)
- Assurances on controls
- Gaps in assurance
- Actions (to fully implement controls if insufficient or mitigate gaps in assurance)
- Target risk rating (if actions successfully implemented)
- Date of next review

70. The Risk Management Handbook provides specific detail on populating the risk register.

### Review of Risk Registers

71. The risk environment is constantly changing and as such assumptions and assessments of risks should be regularly reviewed.

72. The Trust requires all risks to be reviewed according to the level of its current risk. Table 1 sets out the frequency of review for all risk registers at all levels of the organisation:

**Table 1: Frequency of review for risks**

| Level of risk | Frequency of review |
|---|---|
| Low (1-3) | At least annually |
| Moderate (4-6) | At least six monthly |
| High (8-12) | At least quarterly |
| Extreme (15-25) | At least monthly |

73. Risk registers should be reviewed at a minuted meeting, as follows:
- Corporate Risk Register – Risk Management Group prior to Trust Board review
- Divisional Risk Register – Divisional Risk Management Group/Divisional Quality Governance Meeting
- Specialty/Wards/Department Risk Register – At the appropriate governance group/team meeting
- Specialist Group Risk Registers – At the appropriate specialist group meeting.

### Authority Levels for Managing Risk

74. The Trust has adopted authority levels and ownership for managing risk related to its objectives. This is set out in Table 2, as follows:

**Table 2: Authority levels for managing risks**

| Risk posed to a… | Who owns the risk |
|---|---|
| Strategic Objective | Board |
| Trust Objective | Executive Director |
| Divisional Objective | Divisional Management Team |
| Specialty Objective | Specialty Triumvirate |
| Ward/Department/Team Objective | Ward/Department/Team Manager |

## Risk Profile

75. A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing Risk Register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk. The risk profile allows the risk tolerance at the level of reporting to be considered.

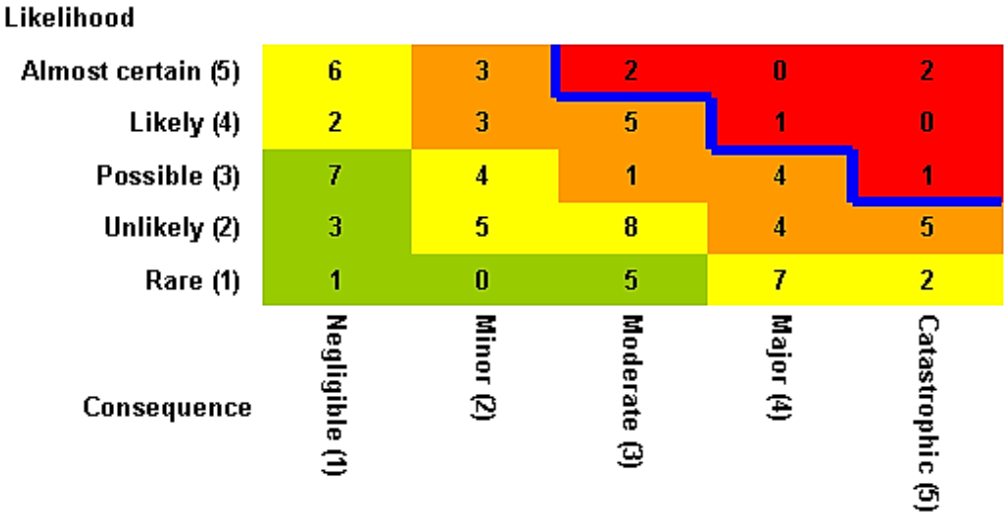



**Figure 3: Example risk profile**

## Project and Programme Risk

76. Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the approach. Risk registers or logs will still be maintained for risks to programmes or projects as part of project documentation.

77. Project and programme opportunities and threats are generally identified:
- If a programme, through the escalation of risks from projects within the programme
- During project or programme start up
- By other projects or programmes with dependencies or interdependencies with this project or programme
- By operational areas affected by the project or programme.

78. Although a project or programme should adhere to the Trust Risk Management Strategy it should also have its own risk management guidelines, which should:
    - Identify the individual programme/project owners within the programme
    - Identify additional benefits of adopting risk management in the project/programme
    - Identify the nature and acceptable level of risk within the programme and associated projects.
    - Clarify rules of escalation from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project to the divisional or corporate level
    - Identify mechanisms for monitoring the successful applications of this strategy within the programme and its projects
    - Identify how inter-project dependencies will be monitored and managed
    - Clarify relationships with associated strategies, policies, and guidelines.

79. Project and programme risk management must be designed to work across appropriate organisational boundaries in order to accommodate and engage stakeholders.

80. In many of the risks identified at project and programme level it will be possible to work out the financial cost of the risk materialising and the cost of mitigating the risk. Both these figures will be relevant to the calculation of risk targets. If, for example, a risk will have a big financial impact and it is likely to actually happen, how much are you prepared to spend to counter it?

## Governance Structure

81. A chart depicting the Committee reporting structure is highlighted in Figure 4.

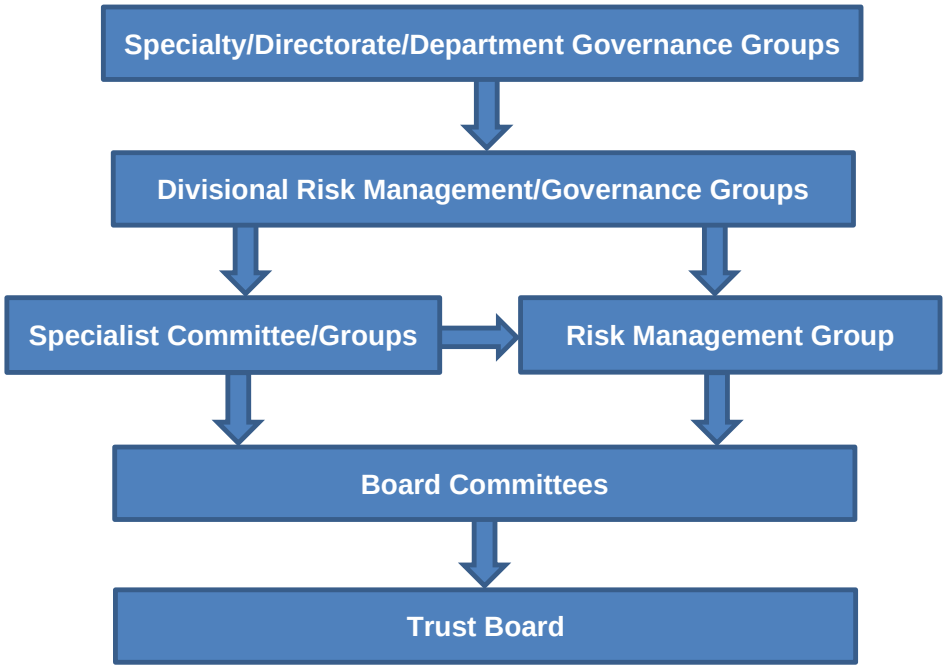



**Figure 4: Committee Risk Reporting Structure**

82. The Trust's governance structure identifies the relevant Committees and their relationship to the Board in providing assurance of the robustness of risk processes and to support the Board of Directors. Specific responsibilities in relation to this strategy, for the management of risk and assurance on its effectiveness are monitored by the following Committees and further detailed in Appendix 6:
    - Trust Board
    - Trust Management Executive Group (TME)
    - Audit and Assurance Committee (A&A)
    - Finance and Performance Committee (F&P)
    - Quality Governance Committee (QGC)
    - People and Culture Committee (P&C).

83. Each Division, Clinical Directorate, and Corporate area will have a management forum where risk is discussed, including the risk register, actions, and any required escalation.

84. Risks are correspondingly monitored at operational level (Ward, Department and Service) through the following team meetings and forums:
    - Divisional or Corporate Management,
    - Directorate Management, and
    - Directorate and Divisional Management Team.

85. Risk Management by the Board is underpinned by a number of interlocking systems of control: The Board reviews risk principally through the following three related mechanisms:
    - The **Board Assurance Framework** (BAF) sets out the strategic objectives, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF can be used to drive the Trust Board agenda. Appendix 7 provides more information.
    - The **Corporate Risk Register** is a high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.
    - The **Annual Governance Statement** is signed by the Chief Executive as the Accountable Officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the Annual Accounts process and brought to the Board with the Accounts.

### Horizon Scanning

86. Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

87. By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

88. The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:
    - Legislation
    - Government white papers
    - Government consultations
    - Socio-economic trends
    - Trends in public attitude towards health
    - International developments
    - Department of Health publications
    - Local demographics
    - Seeking stakeholders' views.

89. All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

90. Board members have the responsibility to horizon scan and formally communicate matters in the appropriate forum relating to their areas of accountability.

## Training

91. Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

92. Training required to fulfil this strategy will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trust's Statutory and Mandatory Training Policy, which can be accessed on the Learning and Development pages on the Trust intranet.

93. Specific training will be provided in respect of high level awareness of risk management for the Board. Risk awareness sessions are included as part of the Board's Development Programme.

94. Training will be available on risk assessment, particularly the scoring or grading of risks, and how to use the risk register.

95. The specific training required by staff group is outlined in Appendix 8.

## Monitoring Compliance

96. The Risk Management Strategy is subject to monitoring as set out below.

**Table 3: Monitoring Process**

| Item monitored | Monitoring Method | Responsibility for monitoring | Frequency of Monitoring | Group of Committee |
|---|---|---|---|---|
| Divisional Risk Management Groups and Trust Risk Management Group | Audit of terms of reference, schedules of business and minutes to determine if the functionality is appropriate. | Risk and Governance team | Annual | Risk Management Group |
| Annual Governance Statement | Internal / External Audit | Risk and Governance team | Annual | Audit Committee |
| Risk Management Process | Internal Audit | Risk and Governance team/Divisions | Annual | Audit Committee |

## Review

97. This strategy will be reviewed by the Head of Clinical Governance and Risk Management, with input from key executives in line with the timescale recorded in the document review date, or sooner if circumstances dictate.

98. All documents in existence prior to the issue of this policy will remain in effect until such time as they are reviewed, replaced or cancelled.

## References and Related Documents

99. References relating to this strategy are:

- Home Office Risk Management Policy and Guidance, Home Office (2011)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- NHS Audit Committee Handbook, Department of Health (2011)
- UK Corporate Governance Code, Financial Reporting Council (2010)
- Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance, Audit Commission (2009)
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)
- Risk Management Assessment Framework, HM Treasury (2009)
- Understanding and Articulating Risk Appetite, KPMG, (2008)
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011)
- The Care Quality Commission Fundamental Standards: The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013

- Home Office Risk Management Policy and Guidance, Home Office (2011)
- UK Corporate Governance Code, Financial Reporting Council (2010).

## Internal Supporting Policies and Procedures

100. The Trust has the following policies and documents which also relate to risk management and should be referred to for further information:

| | |
|---|---|
| Health and Safety Strategy (which includes security management) | WAHT-CG-808 |
| Incident Reporting Policy | WAHT-CG-008 |
| Risk Assessment Procedure | WAHT-CG-002 |
| Concern and Complaints Policy and Process | WAHT-PS-005 |
| Serious Incident Investigation Policy | WAHT-CG-009 |

## Equality Impact Assessment

101. As part of its development; this strategy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

**List of Appendices**

## Appendix 1- Categories of Risks

**Risks to patients**

1. The Trust recognises there is inherent risk as a result of being ill or injured, and the responsibility of the Trust is to inform patients and relatives and work to reduce that risk where possible. The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good healthcare and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery. In order to deliver safe, effective, high quality services, the Trust will encourage staff to work in collaborative partnership with each other and patients and carers to minimise risk to the greatest extent possible and promote patient well-being.

**Organisational risks**

2. The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.

3. The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance frameworks whilst maximising our performance within value for money frameworks.

4. A range of risk assessments will be conducted throughout the Trust to support the generation of a positive risk culture.

**Reputational risk**

5. The Board of Directors models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment. The Trust endeavours to work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

**Opportunistic risks**

6. The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in the Integrated Business Plan, whilst respecting and abiding by its statutory obligations.

7. Taking action based on the Trust's stated risk appetite will mean balancing the financial budget and value for money in a wide range of risk areas to ensure safety and quality is maintained.

## Appendix 2 - Definitions

| | |
|---|---|
| Action Owner | Individual with overall responsibility for implementing an action related to a risk. |
| Assurance | Evidence and certainty to Directors, Non Executives and management that risks are being effectively managed |
| Consequence | The potential impact if the adverse effect occurs as a result of the hazard |
| Control(s) | Mechanisms in place to manage the risk in order to reduce the likelihood and/or consequence |
| Current Risk | The level of risk taking into account the controls currently in place |
| Initial Risk | The level of risk before any control activities are applied |
| Internal Control | A method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. |
| Likelihood | The chance or possibility of something happening |
| Residual Risk | The level of risk 'left over' after controls or contingency plans have been put in place |
| Risk | An adverse event that 'might happen', which could stop the Trust achieving its objectives or impact upon its success. |
| Risk Appetite | The level of risk the Trust is prepared to accept, tolerate or be exposed to at any point in time in pursuit of its objectives |
| Risk Management | The proactive identification, classification and control of events and activities to which the Trust is exposed including monitoring and review, |
| Risk Maturity | The overall quality of the Trust risk management framework |
| Risk Owner | Individual with overall responsibility for the management and control of an individual risk. |
| Risk Profile | The overall exposure of the organisation (or a given level of the organisation) to risks. |
| Risk Rating | The total score calculated by cross referencing the consequence and likelihood scores on the risk matrix |
| Risk Register | The tool for recording identified risks and monitoring actions and plans against them |
| Risk Tolerance | The threshold above which the Trust is not prepared to accept in the pursuit of its objectives. |

## Appendix 3 - Roles and Responsibilities

Risk management is a task carried out by managers. Responsibilities are therefore set out under specific management roles. However, some cross-cutting risks apply across the organisation and lie outside the remit of any one business unit. In this case a Trust committee will be assigned its ownership, management and reporting.

## Key Duties

**Chief Executive**
The accountable officer with overall responsibility for risk management including Health and Safety. As such, the Chief Executive must take assurance from the systems and processes for risk management and ensure that these meet statutory requirements and the requirements of the regulators.

**Company Secretary/Data Protection Officer**
The Company Secretary is responsible for the production and maintenance of the high level committees' terms of reference, working with the Chairman and non-executives to maintain high standards of governance. The role is responsible for ensuring that the Trust operates in accordance with statutory regulations and that there is appropriate stewardship and corporate governance of the business of the Trust. The Company Secretary is responsible for informing the Board, through the Chair, of the Trust's governance matters including processes and systems. The Company Secretary is responsible for ensuring the Trust complies with relevant legislation and regulation and ensures that the Board is adequately informed as to the significant risks facing the organisation through the management and presentation of the Board Assurance Framework. The role also encompasses the statutory function of Data Protection Officer (required under the General Data Protection Regulations).

**Chief Nursing Officer (CNO)**
The Board lead for quality, risk management, patient experience, nursing and midwifery practice, Infection Prevention, Safeguarding, and also professional lead for Allied Health Professionals and Clinical Health Scientists. He/she is accountable to the Chief Executive for risks arising from these areas. He/she is responsible for the Trust's risk management and incident reporting system, administration and maintenance of the Datix system, the production of incident reports and for the management and investigation of complaints and liaison with the Coroner. He/she will ensure the identification and management of risk and work closely with the Trust Board secretary who oversees progress against the Board Assurance Framework for the Board.

**Chief Medical Officer (CMO)**
The Board lead for patient safety, clinical quality, clinical effectiveness, education and research and medical practice (including professional lead for pharmacists). The CMO is responsible for the management of the Central Alert System, arrangements for incident investigation, clinical audit, overseeing compliance with NICE guidelines and the Human Tissue Act. Caldicott Guardian responsibility sits within the office of the CMO and has been delegated to the Deputy Chief Medical Officer. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

**Chief Finance Officer (CFO)**
The board lead for finance, information, business planning and performance. He/she shall ensure that activities are controlled and monitored through effective audit and accounting mechanisms that are open to public scrutiny and presented annually.

He/she shall ensure that risks arising from activities related to Information Technology, and Estates and Facilities management are identified and managed and coordinate compliance with relevant Fire and Safety legislation and related regulations.

He/she shall also fulfil the function of **Senior Information Risk Officer (SIRO)** and so be responsible for the Information Risk Policy, management of information risks and provision of leadership and training for Information Asset Owners. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

**Chief Operating Officer**
The Chief Operating Officer is the Board lead for operational performance and Health and Safety ensuring compliance with health and safety policies/procedures and all relevant legislation and regulation. He/she is accountable to the Chief Executive and has a specific responsibility for identifying, recording, advising on and coordinating actions around operational, performance risks, and emergency planning. He/she shall at all times He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

**Director of People and Culture**
The Director of People and Culture is responsible for risks arising from the workforce. He/she will ensure the identification and management of risk and oversee progress against the Board Assurance Framework for his/her areas of responsibility.

**Medical Directors/Directors of Operations/Directors of Nursing (Divisional)**
With reference to the Trust's risk appetite, Medical Directors/Directors of Operations/Directors of Nursing at divisional level are responsible for applying the Risk Management Strategy within their divisions – this includes the identification, assessment, response, reporting and review of all risks to the achievement of objectives and delivery of services in line with the requirements set out in this document. They shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

**All Clinical Directors, Directorate Managers, Ward Managers, Departmental Managers, General Managers or Heads of Service**
Clinical Directors, Directorate Managers, Ward Managers, Departmental Managers, General Managers or Heads of Service are responsible for identifying, assessing, responding, reporting and reviewing risks within their ward, department or service. They shall ensure risks are identified, evaluated, controlled, decisions on treatment/tolerance escalated where necessary, reviewed and updated at least quarterly. In addition, they will ensure that all their employees have an understanding of the risks to their service and at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

**All Employees, partners and contractors** have a responsibility to:

- Observe and comply with the policies and procedures of WAHT;
- Take reasonable care for the health, safety and welfare of themselves and others;

- Co-operate on matters of risk management and health and safety;
- Participate in induction and all relevant mandatory training as defined by the Trust policies;
- Comply with the requirements of WAHT policy, procedure and approved guidance;
- Report all identified hazards and adverse incidents;
- Undertake reasonable actions as required to reduce or eliminate risks associated identified hazards or adverse incidents.

**Head of Clinical Governance and Risk Management**

The Head of Clinical Governance and Risk Management is accountable to the Chief Nursing Officer. He/she is specifically responsible for providing systems to support the Trust's risk management activities including:

- Developing risk management strategy, procedures and guidance, leading on their implementation and embedment.
- Providing a strategy and assurance systems for risk management and patient safety.
- Providing direction and support to lead managers, Executive Directors, Divisional Directors and support staff to implement and maintain systems for risk management and patient safety and .prepare for assessments and inspections.
- Leading on the Corporate Risk Register, with an accompanying paper for the relevant committees to review.
- Ensuring the provision of expert advice on risk management and patient safety as required
- Ensuring the provision of risk management training and patient safety as required

He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

**Patient Safety, Senior Investigation and Risk Manager**

The Patient Safety, Senior Investigation and Risk Manager is accountable to the Head of Clinical Governance and Risk Management and supports them in the implementation and embedment of the risk management strategy. They are responsible for:

- The Trust's Risk Management database
- The incident reporting system
- Influencing senior management to develop both a risk and safety culture within the Trust
- Overseeing the management of serious incidents and reporting to external agencies
- Managing the teams providing corporate level support for patient safety and risk management
- Facilitating the training and support for Trust staff to improve their understanding of risk management and patient safety and the effective use of tools and techniques to deliver effective systems and achieve the desired outcomes.
- Preparing the Corporate Risk Register, with an accompanying paper for the relevant committees to review.
- Provision of expert advice on risk management and patient safety as required.

**Health and Safety Manager, and Local Security Management Specialist**

The Health and Safety Manager, and Local Security Management Specialist is accountable to the Chief Operating Officer and is responsible for the:

- Development of the Health and Safety Strategy, Health and Safety policies, procedures and guidelines

- Leadership, co-ordination and overseeing compliance with Health and Safety legislation and regulations
- Provision of expert advice to managers and staff on all aspects of health and safety management
- Provision of training on health and safety and security management as required
- Overseeing the management of non-clinical incidents
- Reporting notifiable incidents to relevant external agencies or regulators as required
- Liaison with WAHT's PFI partners, service providers and enforcing authorities (for example Environmental Health, HSE).
- The post also encompasses the role of Local Security Management Specialist as required by NHS Standard Contract.

He/she shall at all times ensure compliance with health and safety policies/procedures and all relevant legislation and regulation.

**Non-executive Directors**

The Non-executive Directors have an important part to play in risk management. They are represented on, and chair, the Audit and Assurance Committee and the Quality Governance Committee. Both these committees provide reports to the Board on the suitability and effectiveness of systems to manage risk.

## Appendix 4 - Risk Matrix

| SECTION 1 | HARM/CONSEQUENCE SCORING |
|---|---|

| | Consequence score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Impact on the safety of patients (physical/psychological harm)** | Minimal injury requiring no/minimal intervention or treatment. | Minor injury or illness, requiring minor intervention<br>Increase in length of hospital stay by 1-3 days | Moderate injury requiring professional intervention<br>Increase in length of hospital stay by 4-15 days<br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/ disability<br>Increase in length of hospital stay by >15 days<br>Mismanagement of patient care with long-term effects | Incident causing death<br>Multiple permanent injuries or irreversible health effects<br>An event which impacts on a large number of patients |
| **Impact on the safety of staff or public (physical/psychological harm)** | No time off work | Requiring time off work for <7 days | Requiring time off work for 7-14 days<br>RIDDOR/agency reportable incident | Requiring time off work for >14 days<br>Major injury leading to long-term incapacity/ disability | Incident causing death<br>Multiple permanent injuries or irreversible health effects |
| **Quality/ complaints/ audit** | Peripheral element of treatment or service suboptimal<br>Informal complaint/ inquiry | Overall treatment or service suboptimal<br>Formal complaint (stage 1)<br>Local resolution<br>Single failure to meet internal standards<br>Minor implications for patient safety if unresolved<br>Reduced performance rating if unresolved | Treatment or service has significantly reduced effectiveness<br>Formal complaint (stage 2) complaint - Local resolution (with potential to go to independent review)<br>Repeated failure to meet internal standards<br>Major patient safety implications if findings are not acted on | Non-compliance with national standards with significant risk to patients if unresolved<br>Multiple complaints/ independent review<br>Low performance rating<br>Critical report | Unacceptable level or quality of treatment<br>Gross failure of patient safety if findings not acted on<br>Non-coronial Inquest/ ombudsman inquiry<br>Gross failure to meet national standards |
| **Human resources/ organisational development/staffing/ competence** | Short-term low staffing level that temporarily reduces service quality (< 1 day) | Low staffing level that reduces the service quality | Late delivery of key objective/ service due to lack of staff<br>Unsafe staffing level or competence (>1 day)<br>Low staff morale<br>Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/service due to lack of staff<br>Unsafe staffing level or competence (>5 days)<br>Loss of key staff<br>Very low staff morale<br>Non-attendance to mandatory training /key training | Non-delivery of key objective/service due to lack of staff<br>Ongoing unsafe staffing levels or competence<br>Loss of several key staff<br>Repeated non-attendance to mandatory training /key training |
| **Statutory duty/ inspections** | No or minimal impact or breech of guidance/ statutory duty | Breech of statutory legislation<br>Reduced performance rating if unresolved | Single breech in statutory duty<br>Challenging external recommendations/ improvement notice | Enforcement action<br>Multiple breeches in statutory duty<br>Improvement notices<br>Low performance rating<br>Critical report | Multiple breeches in statutory duty<br>Prosecution<br>Complete systems change required<br>Zero performance rating<br>Severely critical report |
| **Reputation** | Rumours<br>Potential for public concern | Local media coverage –<br>short-term reduction in public confidence | Local media coverage –<br>long-term reduction in public confidence | National media coverage with <3 days service well below reasonable public expectation | National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) |
| **Business objectives/ projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget<br>Schedule slippage | 5–10 per cent over project budget<br>Schedule slippage | Non-compliance with national 10–25 per cent over project budget<br>Schedule slippage<br>Key objectives not met | Key objectives not met<br>Incident leading >25 per cent over project budget<br>Schedule slippage |

| | | | | | |
|---|---|---|---|---|---|
| **Finance including claims** | Small loss<br>Risk of claim remote | Loss of 0.1–0.25 per cent of budget<br>Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget<br>Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br>Claim(s) between £100,000 and £1 million<br>Purchasers failing to pay on time | Non-delivery of key objective/ Loss of >1 per cent of budget<br>Loss of contract / payment by results<br>Claim(s) >£1 million |
| **Service/business interruption Environmental impact** | Loss/interruption of >1 hour<br>Minimal or no impact on the environment | Loss/interruption of >8 hours<br>Minor impact on environment | Loss/interruption of >1 day<br>Moderate impact on environment | Loss/interruption of >1 week<br>Major impact on environment | Permanent loss of service or facility<br>Catastrophic impact on environment |

## SECTION 2 - LIKELIHOOD OF OCCURRENCE

| Likelihood | 1 - Rare | 2- Unlikely | 3 - Possible | 4 - Likely | 5 - Almost certain |
|---|---|---|---|---|---|
| Frequency (general) How often might it/does it happen | This will probably never happen/recur | Do not expect it to happen/recur but it is possible it may do so | Might happen or recur occasionally | Will probably happen/recur but it is not a persisting issue | Will undoubtedly happen/recur, possibly frequently |
| Frequency (timeframe) | Not expected to occur for years | Expected to occur at least annually | Expected to occur at least monthly | Expected | Expected to occur at least daily |
| Probability Will it happen or not | <0.1 per cent | 0.1-1 per cent | 1-10 per cent | 10 – 50 per cent | >50 per cent |
| Proximity (timeframe) | Twelve months plus | Nine to twelve months | Six to nine months | Three to six months | Zero to three months |

## SECTION 3 - RISK SCORING MATRIX

| | | Likelihood | | | | |
|---|---|---|---|---|---|---|
| | | 1 - Rare | 2 - Unlikely | 3 - Possible | 4 - Likely | 5 - Almost certain |
| Consequence | 1 Negligible | 1 | 2 | 3 | 4 | 5 |
| | 2 Minor | 2 | 4 | 6 | 8 | 10 |
| | 3 Moderate | 3 | 6 | 9 | 12 | 15 |
| | 4 Major | 4 | 8 | 12 | 16 | 20 |
| | 5 Catastrophic | 5 | 10 | 15 | 20 | 25 |

## SECTION 4 - ACTION AND REPORTING REQUIREMENTS

| Score | Risk | Action | Reporting Requirements |
|---|---|---|---|
| 1-3 | Risk is within tolerance | Managed through normal control measures at the level it was identified | Record on risk register at the level the risk was identified |
| 4-6 | | Review control measures at the level it was identified | Record on risk register at the level the risk was identified |
| 8-12 | Risk Exceeds tolerance | Actions to be developed, implemented and monitored at the level the risk was identified | Record on Risk Register at the level the risk was identified<br>Report to next level of management |
| 15-25 | | **Immediate action required**<br>Treatment plans to be developed, implemented and monitored at the level the risk was identified | Record on Risk Register at the level the risk was identified<br>Report to next level of management<br>With Executive Director approval - enter onto Corporate Risk Register |

## Appendix 5 – Sources of Assurance

| Internal sources of assurance | External sources of assurance |
|---|---|
| Internal audit | Intelligent Monitoring Report |
| Performance reports to Board and its Committees | Friends and Family Test |
| Clinical audit | Care Quality Commission inspection reports |
| Quality Audits | External audit |
| Ward environmental risk assessments | CCG reports/reviews |
| Staff satisfaction surveys | Area Team reports |
| Staff appraisals | HSE Reports |
| Training records | Royal College visits |
| Results of internal investigations | Deanery visits |
| Serious Incident investigation reports | External benchmarking |
| Complaints records and reports | Patient-Led Assessments of the Care Environment (PLACE) |
| Infection control reports | National and regional audits |
| Information governance toolkit self-assessment | Peer reviews |
| Patient advice and liaison services Reports (PALS) | Feedback from service users |
| Staff sickness reports | External advisors |
| Internal benchmarking | Local networks (for example, cancer networks) |
| Local Counter Fraud work | Dr Foster reports |
| Local Security Management Specialist work | NHSI and NHSE feedback |
| Patient-Led Assessments of the Care Environment (PLACE) | PHSO reports. |
| Health and safety reports | |
| Maintenance records | |

## Appendix 6 – Committees and Governance Structures

**Trust Board** - Executive and Non-Executive Directors share responsibility for the success of the organisation including the effective management of risk and compliance with relevant legislation. They have a collective responsibility as a Board to:

- Protect the reputation of the WAHT and everything of value;
- Provide leadership on the management of risk;
- Reduce, eliminate and exploit risk in order to increase resilience;
- Determine the nature and extent of the significant risks it is willing to take in achieving its strategic objectives
- Ensure the approach to risk management is consistently applied; and all reasonable steps have been taken to manage them effectively and appropriately.

Following review at Trust Management Executive, the Trust Board will receive the CRR update quarterly indicating escalation and rationale for changes in risk scores to the CRR.

**Trust Management Executive (TME)**

This Group is responsible for driving the strategic agenda and business objectives for the Trust. It will ensure that the risks are identified and mitigated as well as ensuring that the Trust achieves its performance targets. The committee is responsible for the management of risk and the principal management committee attended by the Executive and Divisional Directors. TME will receive the minutes of the RMG meeting every quarter, highlighting progress to divisional and corporate risks. Any updates to the Board Assurance Framework and Corporate Risk Register will also be provided and agreed.

The TME will make decisions about the treatment or tolerance of risks that lie beyond a Division's ability or responsibility to control effectively, informing the Board of its decisions and, when the nature of the risk requires it, requesting the Board to make a decision.

**Risk Management Group (RMG)**

This group is responsible for providing oversight and scrutiny of the management of risk throughout the Trust and as part of its role within the TME. The divisions (including corporate teams) will present a report to each meeting outlining risks of 15 and above, paying particular attention to those where they have specific concerns about and where senior support is required. The group will consider its possible inclusion on the corporate risk register (15 and above). The Company Secretary and the Head of Clinical Governance and Risk Management will also provide a report on the Board Assurance Framework and Corporate Risk Register respectively to allow for discussion at this group and to ensure that the controls and actions are effective in managing the risk.

**Clinical Governance Group (CGG)**

This group is responsible for reviewing risks that are linked to:

- Mortality review
- Clinical audit and effectiveness
- Patient care and public engagement
- Infection, prevention and control
- Safeguarding
- Medicines management
- Patient safety, incident investigation and learning
- Resuscitation and the deteriorating patient.

**Quality Governance Committee (QGC)**
The Quality Governance Committee will receive an executive summary each month detailing assurance and escalation relating to governance and risk management functions discussed at CGG.

**Finance and Performance Committee (F&P)**
The Finance and Performance Committee is responsible for overseeing the identification, evaluation, response to and monitoring of financial risk.

**People and Culture Committee (P&C)**
The People and Culture Committee is responsible for overseeing the identification, evaluation, response to and monitoring of risks to the workforce. Risks will feed into the Risk Management Group.

**Audit and Assurance Committee (AAC)**
Audit and Assurance Committee is an oversight committee responsible for seeking assurance on the management of risk reviews the establishment and maintenance of an effective system of internal control and risk management, including the Board Assurance Framework (BAF).

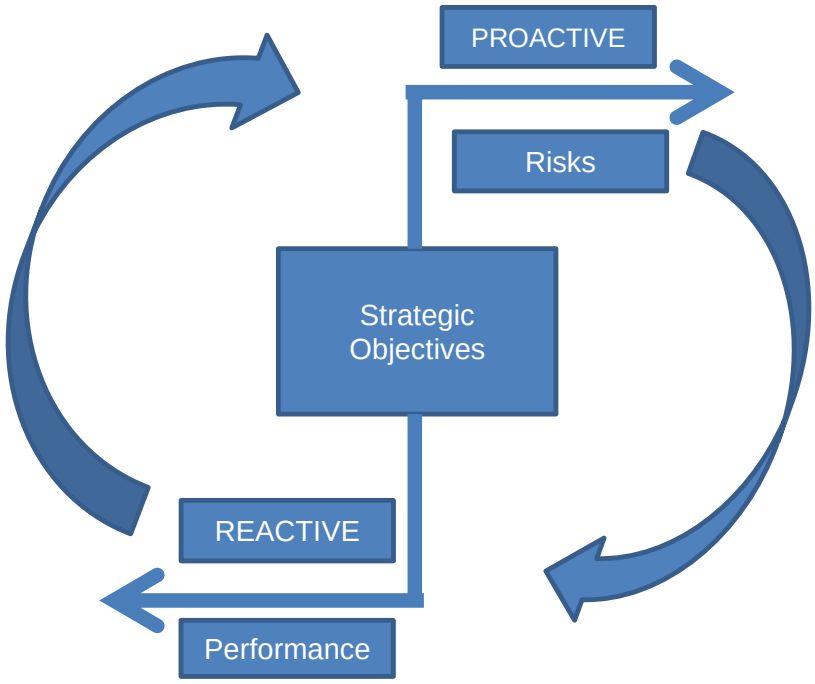
The AAC will receive the corporate risk register on a quarterly basis along with the BAF. Non-executive scrutiny and challenge will take place around the organisations:

- Appetite for risk;
- Ability to identify and manage strategic and operational risk, and;
- Future strategic risks, namely assurance around identification and mitigation with a forward view of at least two years.

## Appendix 7 – The Board Assurance Framework

The Board Assurance Framework is an information tool that allows for detailed analysis of all strategic risks which could impact on the Trust achieving its objectives. It requires the Trust to consider the effectiveness of each control through a process of obtaining assurances that the mitigation is in place and operating effectively. This will also identify which of the Trust's objectives are at risk because of gaps in controls or assurance.

The Trust is working towards an integrated Assurance Framework report which brings together information on achievement of milestones/targets, performance and risks to enable the Board to evaluate progress in meeting objectives. This will form the assurance cycle, considering both reactive (performance) and proactive (risk) information.




### Board Assurance Framework Reporting and Review

The Board Assurance Framework is reviewed by the:

- Risk Management Group – every quarter
- Trust Board – every two months following detailed review by assurance committees
- Audit and Assurance Committee will receive the approved BAF every two months, to review its relevance and effectiveness
- Audit and Assurance Committee will commission an annual review of the effectiveness against practice.

## Appendix 8 - Risk Management Training

Risk management training will be delivered by the Patient Safety and Risk Team in collaboration with the Divisional Quality Governance Teams and Health and Safety Lead. The training programme will be reviewed on an annual basis and will be based around the framework set out below.

### Training Content

**Level 1 - All staff (corporate induction)**

- Incident Reporting
- Risk awareness.

**Level 2** - **Managers**

- Incident Reporting (Managerial Responsibilities and policy requirements)
- Undertaking local Investigations
- Risk Register/risk assessment
- General risk awareness
- Using Datix

**Level 3 - Senior Managers and Divisional Governance Leads**

- Incident Reporting (Managerial Responsibilities and policy requirements)
- Incident Investigation Management
- Root Cause Analysis
- The risk management process
- Risk awareness/assessment
- Management of risk for senior managers
- Risk registers
- Using Datix

**Level 4 - Board Members and Senior Managers**

- Risk Awareness for Board members
- Risk Appetite/Tolerance
- The Corporate risk register
- The Board Assurance Framework.

## Appendix 9 - Impact Assessments

### Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the policy/guidance affect one group less or more favourably than another on the basis of:** | | |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender | No | |
| | • Transgender | No | |
| | • Religion or belief | No | |
| | • Sexual orientation including lesbian, gay and bisexual people | No | |
| | • Age | No | |
| | • Disability | No | |
| **2.** | **Is there any evidence that some groups are affected differently?** | No | |
| **3.** | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | No | |
| **4.** | **Is the impact of the policy/guidance likely to be negative?** | No | |
| **5.** | **If so can the impact be avoided?** | n/a | |
| **6.** | **What alternatives are there to achieving the policy/guidance without the impact?** | n/a | |
| **7.** | **Can we reduce the impact by taking different action?** | n/a | |

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

## Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | Title of document: | Yes/No |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | No |
| **2.** | Does the implementation of this document require additional revenue | No |
| **3.** | Does the implementation of this document require additional manpower | No |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | No |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | Yes – but covered in the implementation plan and to be delivered within existing resource |
| | Other comments: | |

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.

## Risk Appetite

Risk appetite is the level of risk our Trust Board deems acceptable or unacceptable based on the specific risk categories and circumstances facing the Trust. This allows us to measure, monitor and adjust as necessary, the actual risk positions against the agreed risk appetite.

Using the Good Governance Institute risk appetite matrix the Trust Board has adopted a risk appetite statement which is the amount of risk it is willing to accept in seeking to achieve its purpose of Putting Patients First and the four strategic objectives which contribute to the achievement of that purpose:

- Best Services for Local People
- Best Experience of Care and Outcomes for Our Patients
- Best Use of Resources
- Best People

As well as the overall risk appetite statement, separate statements are provided for each risk category in the table below, with links to the strategic objective to which they are most relevant.

Worcestershire Acute Hospitals NHS Trust (WAHT) recognises that our long term sustainability depends upon

- a focus on our purpose of Putting Patients First,
- the delivery of our four strategic objectives and
- building confidence in the quality, safety and efficiency of our services with our patients, carers, staff, partners and the public.

We will not accept risks that have a materially negative impact on service quality, patient safety or the sustainability of services.

| Strategic Objective | Risk Category | Risk Appetite | Score |
|---|---|---|---|
| Best Services for Local People | Clinical Innovation (as established within our Clinical service strategy) | WAHT has a MODERATE risk appetite for clinical innovation that does not compromise the quality of safety care. | 12-15 |
| Best Services for Local People | Compliance/Regulatory | WAHT has a LOW risk appetite for non-compliance/regulatory risk which may compromise the Trusts compliance with Statutory duties and regulatory requirem<br><br>The Trust sees regulatory compliance as important in optimising service quality and financial sustainability. The Trust Board will take a cautious approach to risks in this area. | 8-12 |
| Best services for Local People | Partnerships | WAHT has a HIGH risk appetite for partnerships which may support and benefit the people we serve. | 20-25 |
| Best Experience of Care and Outcomes for our Patients | Safety/Quality/ Outcomes | WAHT has a LOW risk appetite for any clinical practice, actions or decisions which may compromise the delivery of outcomes for our service users.<br><br>The quality of our staff is measured by clinical outcomes, patient safety and patient experience which is | 8-12 |

| | | | |
|---|---|---|---|
| | | paramount.<br><br>We are strongly averse to risks that could result in poor quality patient care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice. | |
| Best Use of Resources | Financial/Value for money | WAHT has a LOW risk appetite for financial/VFM in that we will strive to deliver our services within budgets modelled in our financial plans and will only consider exceeding these constraints if there is an associated risk to patient safety or quality of care. All such financial responses will be undertaken ensuring optimal value for money in the utilisation of public funds. | 8-12 |
| Best Use of Resources | Reputation | WAHT has a MODERATE risk appetite for actions and decisions which may adversely impact on the reputation of the organisation initially, provided those decisions are taken in the interest of improving safety, quality or sustainability of services. | 12-15 |
| Best People | Workforce | WHAT has a MODERATE risk appetite for any decisions or service changes which may have a detrimental impact on Trust ability to recruit and retain staff. | 12-15 |

NHS
Worcestershire Acute Hospitals NHS Trust



| | |
|---|---|
| Meeting | Trust board |
| Date of meeting | 16 January 2020 |
| Paper number | E2 |

# Communications and Engagement Strategy

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

| | | | |
|---|---|---|---|
| **Accountable Director** | Richard Haynes, Director of Communications and Engagement | | |
| **Presented by** | Richard Haynes | **Author /s** | Communications Team |

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

| **Report previously reviewed by** | | |
|---|---|---|
| Committee/Group | Date | Outcome |
| Principles and timeline reviewed by People and Culture Committee | 26 February 2019 | Principles and timeline supported |
| Trust Management Executive (TME) | 20 March 2019 | Discussion and feedback on draft 1.0 |
| People and Culture Committee | 23 April 2019 | Discussion and feedback on draft 2.0 |
| Trust Board | 9 May 2019 | Update on progress and subsequent circulation of draft 3.0 and 4.0 to Board colleagues for informal discussion/feedback |
| Trust Management Executive | Nov 2019 | Approved |
| People and Culture Committee | Dec 2019 | Approved |

| | |
|---|---|
| **Recommendations** | Trust Board is requested to:<br>• Approve the strategy |

| | |
|---|---|
| **Executive summary** | Attached for the board's approval is a (pre-design) version of our Communications Strategy.<br><br>Delivery of the strategy, once approved, will be led by the Director of Communications and Engagement, supported by the communications team, with progress reported through TME and People & Culture Committee. Updates will also be presented through the routine report to Board from the Communications and Engagement Director.<br><br>The pause in progressing the Communications Strategy as outlined in the timeline above was to allow time for completion of the Trust's Clinical Service Strategy which is key to shaping the future direction of |

| | |
|---|---|
| Meeting | Trust board |
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| | |
|---|---|
| | our organisation and will be a priority area of focus for communications and engagement support during the development and delivery of detailed implementation plans |

| **Risk** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Key Risks** | Board Assurance Framework Risk 12: If we have a poor reputation THEN we will be unable to recruit or retain staff RESULTING IN loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care | | | | | | | | |
| **Assurance** | Implementation of the strategy will be monitored through TME and People & Culture Committee as well as regular communications updates to Trust Board<br><br>In addition, a detailed annual communications plan for 2020/21, aligned to the Strategy, will be developed as part of the Trustwide annual planning process.<br><br>This will in turn inform annual objective setting and PDR processes for the Director of Communications and members of the communications team. | | | | | | | | |
| **Assurance level** | **Significant** | | **Moderate** | *x* | **Limited** | | **None** | | |
| **Financial Risk** | Managed within agreed budgets | | | | | | | | |

| | |
|---|---|
| Meeting | Trust board |
| Date of meeting | 16 January 2020 |
| Paper number | E2 |

## Introduction/Background

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

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

## Issues and options

With an approved future vision ("The Pyramid") and a number of key strategies or plans now approved or in development – including the Clinical Services Strategy, Digital Strategy, People and Culture Strategy, Quality Improvement Strategy and medium term financial plan – we have an opportunity to develop a Communications Strategy which sets out a clear vision for how a high quality communications service will actively promote and support the objectives of those other strategies – including 4ward

Our aims in developing the communications strategy have been to:

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

The current draft has been developed with input from the Trust Management Executive (TME) and People and Culture Committee and will inform the developments of a detailed annual plan for 2020/21 as well as system wide communications activities being developed with partners in our STP.

## Conclusion

The strategy sets out a broad set of priorities and principles which are aligned is developing in accordance with the agreed timeline.

Further input from key internal and external stakeholders will help to further develop and refine it prior to final approval

## Recommendations

## Appendices:

Communications and Engagement Strategy (version 5.0)

NHS
Worcestershire
Acute Hospitals
NHS Trust

# Communications Strategy

2019-22

# Contents

# Foreword/Welcome

**'Putting Patients First' is our Trust's clearly stated purpose, putting the people we care for at the peak of our strategic 'Pyramid.'**

Our Pyramid also has our 4ward behaviours at its heart, our vision and strategic objectives clearly set out and our plans for the future of our clinical services given due prominence.

All of these are underpinned by a number of enabling strategies, including this one.

The aim of this strategy is to transform the conversations we have every day about the care we provide for our patients, so that those conversations are better informed, more productive, positive, open, honest, transparent and engaging.

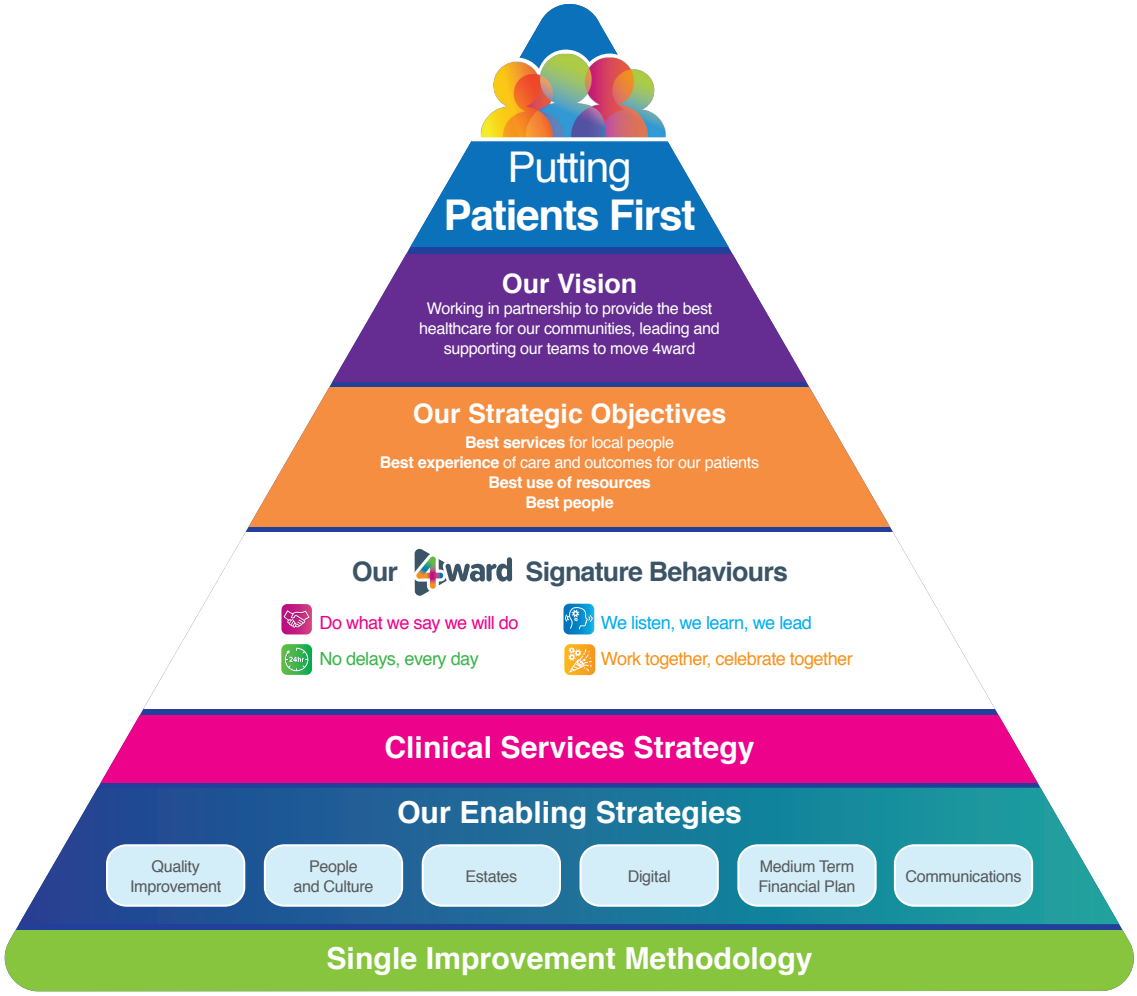
We want to build a conversation culture across our hospitals, so that we can harness the passion, commitment, insights and expertise of colleagues in every ward and department in delivering continuous improvement to the safety, quality and efficiency of our services.

And we want to expand those conversations across the communities we serve so that our patients, their carers, out partners, our regulators and everyone else whose lives are touched by the work we do has a chance to share their views, wishes and concerns about the future of those services.

We will use this strategy to help us talk openly and honestly about the kind of organisation we aspire to be, the standards we set, and hold ourselves accountable to, the changes we need to make and the challenges we face.

We will proudly celebrate our successes and the progress we make on our improvement journey, but we will also say sorry when we make mistakes, share the lessons we learn from those mistakes and commit to continuously improving the care we provide, the working environment we nurture for colleagues and the contribution we make to the wider health and care system.

The delivery of this strategy will be led by our communications team, but it also offers opportunities for everyone who works in our hospitals, or is cared for by us, or works in partnership with us for, or has any kind if interest in helping to build a better future for the health and wellbeing of the people of Worcestershire and the surrounding counties.




*Our Strategic Pyramid*

# Executive Summary

**This strategy sets out our vision for the development, delivery, monitoring and evaluation of a cohesive, proactive and high quality programme of regular and ad hoc communications activities over the next three years.**

These activities will be aligned to, and supportive of, the aims and objectives of other key Trust strategies which are currently being delivered or in development.

At the heart of our strategy and plans is a simple question for the communications team, senior leaders and colleagues and partners to ask themselves: "Does this communications activity or output help us to achieve our purpose of ***Putting Patients First***?"

If the answer to that question is "yes" then we can be confident that we are doing the right thing, for the right reasons and having the right conversations about our services and our Trust, with the right people, at the right time, in the right way.

We know how much people care about the work we do, and we know that many of them have views and suggestions which will help us to seize the opportunities and rise to the challenges that the next few years will bring.

Effective two-way communication can make a huge contribution. If we get it right, we will see a number of important outcomes:

- **Improved staff morale and engagement**, making it easier for us to attract, and keep, colleagues with the skills and approach that we need to fulfil our purpose of "Putting Patients First."
- **Stronger clinical leadership** to deliver improved patient care, as our medical staff support and drive forward the delivery of our vision and strategic objectives and our Clinical Services Strategy.
- **More productive conversations with current and future patients** about how we can build services which best meet their needs and wishes, how they can have their say in how those services are planned, developed and delivered and how they can become active health citizens, better able to use services effectively and make positive choices about their health and healthcare.
- **A clearer vision for the future of our services** for our partners, to help them understand the contribution that we can make to the delivery of wider plans including the Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP) and the national NHS Long Term Plan.
- **A clear and compelling story for our regulators,** including NHS Improvement/NHS England and the Care Quality Commission (CQC) that sets out our plans for delivering sustainable long term improvements in quality, safety and efficiency.
- **A demonstrably improved reputation and profile for our hospitals, our services and our Trust** with all our key stakeholders, including elected representatives of our local communities and the media channels which help to shape perceptions of our Trust, built on a strategic programme of engagement.

The strategy covers a period of time which is likely to be one of significant opportunity, change and progress for our Trust and our local health and care economy.

This means that while we will strive to remain true to the principles set out in our strategy, regular reviews will be required to take stock of, and respond to, the changing operational, organisational and political health and care environment locally, regionally and nationally.

# Context

**Recent years have brought a new set of challenges for communications professionals working in the NHS.**

The rapid growth of social media, the commonplace use of smartphones and the drift towards an "always on" culture of communication have all further stretched the capacity and capability of NHS communicators working in what was an already high profile, politically sensitive and volatile environment.

The rise of citizen journalists, bloggers and other opinion formers operating outside the framework of 'traditional' media activity has added a further element of complexity but also new opportunities.

In addition, increasing familiarity with social media (and improved wifi access in our hospitals) has empowered patients, visitors, staff and volunteers to share their stories, in real time, on their experiences of being cared for or working in our hospitals, for better or worse.

At the same time, the NHS locally and nationally faces significant operational and financial challenges, driven by shifting demographics, innovative treatments, growing demand, recruitment and retention challenges and ongoing financial constraints.

In these circumstances, it is clear that the value and benefits of effective proactive communications management are greater than ever – as are the risks of misjudging what is needed or falling short of public expectations.

The opportunities this brings for communications teams are many and varied. The aim of this strategy is to ensure that we have a clear, shared vision for making the most of those opportunities, a clear plan for how we will go about it and a way of measuring how well we are doing.

It is also a way of providing assurance to our organisation that the resources allocated to communications are providing a good return on investment and making a positive contribution to our overall strategic aims and objectives for the benefit of our patients, carers, staff, partners and the community we care for.

# Strategic Overview – The Communications Connection

**The strategy has been developed by the communications team in collaboration with key internal and external stakeholders, taking into account examples of best practice from inside and outside the NHS.**

Our aim is to make sure that all our communications and engagement activity is aligned with, and actively promotes and supports our purpose, vision and strategic objectives set out in our Pyramid.

As part of our annual planning process to develop and monitor a detailed work plan, we will also take into account the improvement priorities set out in our Clinical Services Strategy and other enabling strategies.

As well as an ongoing focus on raising awareness and understanding of the **Pyramid** and our **Annual Planning** process with internal and external audiences, more specific examples of this 'communications connection' with organisational priorities are set out below.

Many of them overlap with or complement each other, but all will feature in our detailed workplan for 2020/21 and most are likely to continue beyond that period.

## Best Services for Local People

By effectively engaging patients, carers, partners and our staff in the development of our Clinical Services Strategy we will help to build a clear, shared vision for the future of health and care services in our county.

As we move to the implementation phase of the **Clinical Services Strategy**, our service users, staff, partners and other stakeholders will be offered opportunities to help shape the detailed service proposals to secure safe, high quality, sustainable services for the communities we serve.

We will also work in partnership with communications colleagues from partners in our local health and care system to ensure continuing public and patient participation in conversations around the aims and ambitions of the Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) and the local delivery of the national NHS Long Term Plan (LTP).