	Variation/Performance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	**Excellent | Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good | Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning | Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent | Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent | Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good | Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning | Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent | Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
○	**Good | Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average | Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning | Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average | Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning | Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning | Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning | Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning | Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning | Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning | Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning | Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning |Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
↗				**Unsure | Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
↘				**Unsure | Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
○				**Unknown | Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

Levels of Assurance

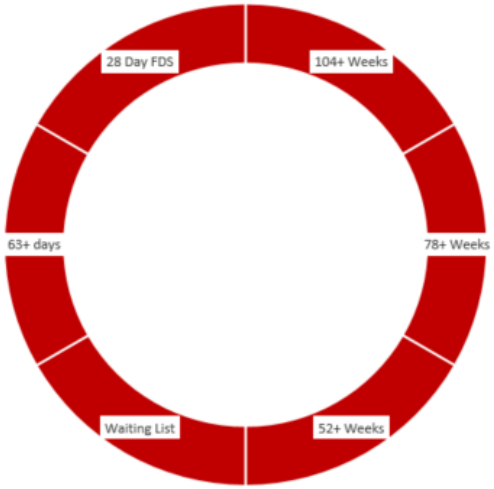
RAG Rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all the agreed actions, with clear evidence of the achievement of 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.

August 2022 | At A Glance

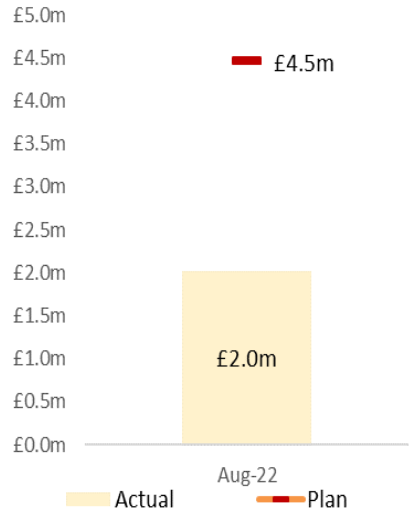
Our Annual Plan

Elective Activity

Elective Performance



YTD PEP Position



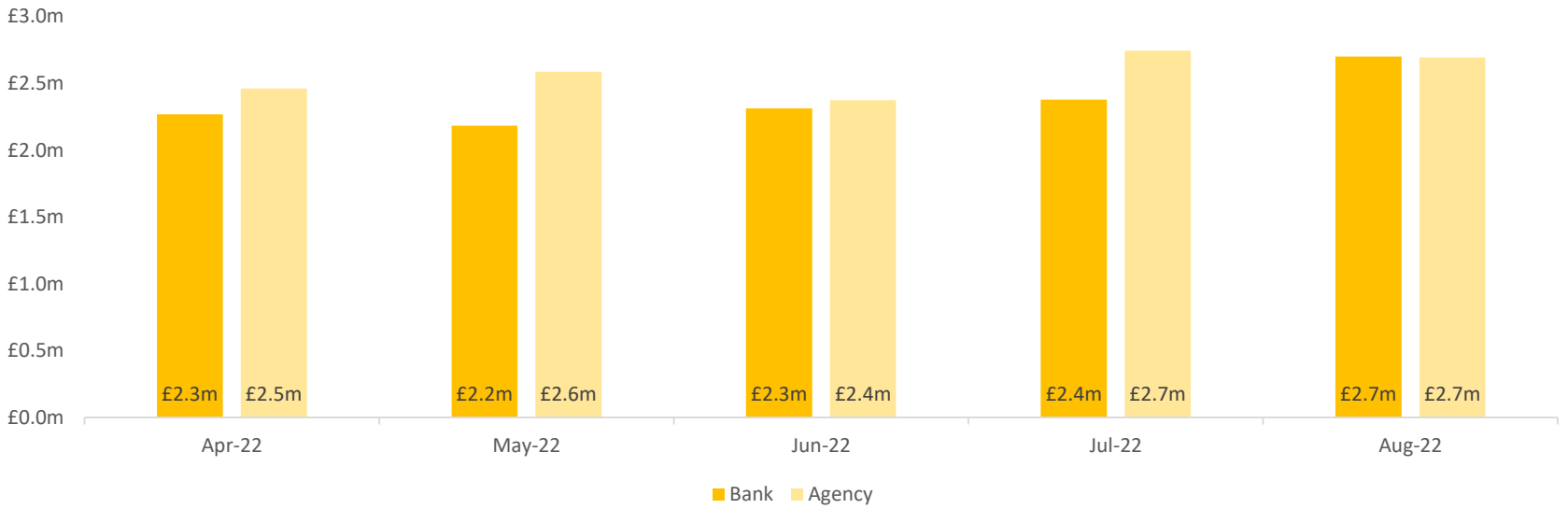
Our Emergency Departments

	Ambulances	60 Min Handover Delays	Walk-Ins	Breaches: 4 hours	Breaches: 12 hours
ED	3,885	1,281	9,905	6,223	254

	New Patients Seen	Patients Discharged Home		% of Take
SDEC *AEC and Surgical SDEC*	1,070	918	85.8%	43.6%

August 2022 | At A Glance

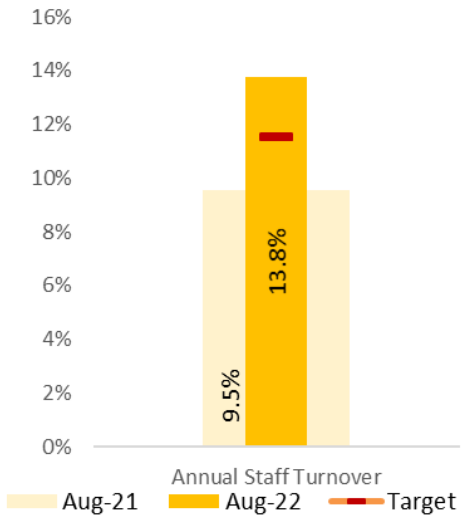
Our Locum / Agency Spend



Our Expenditure Run Rate

August 2022 | At A Glance

Our Staff Turnover



AUGUST 2022 IN NUMBERS

Worcestershire Acute Hospitals NHS Trust

9,905
Walk-in patients (A&E)

3,885
Patients arriving by ambulance

12,189
Inpatients

38,495
Face to Face outpatients

9,200
Telephone consultations

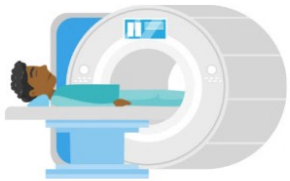
431
Babies

1,402
Elective operations

218
Trauma Operations

243
Emergency Operations

6.8
Average length of stay



17,752
Diagnostics

Putting Patients First 4ward

QUALITY AND SAFETY IN NUMBERS

August 2022

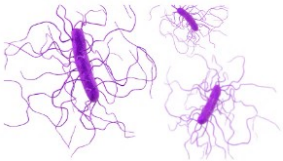
NHS Worcestershire Acute Hospitals NHS Trust

MRSA

0

ECOLI

2



CDIFF

7

MSSA

0

Hand Hygiene

Participation	**86.6**
Compliance	**99.8**

Sepsis

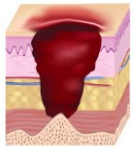
Screening Compliance	**94.1**
Sepsis 6 bundle compliance	**72.5**

ICE reports viewed

Radiology	**88.4**
Pathology	**94.8**

Falls per 1,000 bed days causing harm

0



Pressure Ulcers

All hospital acquired pressure ulcers	**22**
Serious incident pressure ulcers	**1**

Response Rate

A&E	**22.1**
Inpatients	**39.2**
Maternity	**1.9**
Outpatients	**11.1**

Recommended Rate

A&E	**86.96**
Inpatients	**97.9**
Maternity	**81.8**
Outpatients	**94.9**

HSMR 12 months rolling (March 22) **102.44**

Mortality Reviews completed </=30 days (Nov-20) **35.50**

Risks overdue review **194**

Risks with overdue actions **236**

Discharged before midday

15.1

Complaints Responses </=25 days

57.7

Total Medicine incidents reported **150**

Medicine incidents causing harm (%) **2.0**

Putting Patients First
4ward

WORKFORCE COMPOSITION IN NUMBERS

NHS
Worcestershire
Acute Hospitals
NHS Trust

August 2022

Employees

6,847

BAME employees

20%

Part-time workers

44%

Female

82%

Registered nurses

1,984 (29%)

Registered midwives

255 (4%)

HCAs, helpers and assistants

1347(20%)

Doctors

741(11%)

Other clinical and scientific staff

836 (12%)

>55

Over age 55

19%

≤30

30 years and under

20%

Staff with less than 2 years service

29%

Staff with 20 years service or over

10%

Committee Assurance Reports

Trust Board

13th October 2022

Finance & Performance Committee Assurance Report: 28 & 30 September 2022

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Richard Oosterom – Associate Non-Executive Director	Rebecca O'Connor, Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**F&P BAF Risks**	7, 8, 13, 16, 18, 19, 20

Executive Summary

The Committee met virtually on 29 and 30 September and the following key points were raised

Item	Rationale for escalation	Action required by Trust Board
Three Year Plan	For approval	Recommended for approval
South Midlands Pathology Network SOC	For approval	Recommended for approval
TIF2 Short Form Business Case	For approval	Recommended for approval
Contract Approvals (x3)	Delegated limits	Recommended for approval

Finance & Performance Committee Assurance Report: 28 & 30 September 2022

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Richard Oosterom – Associate Non-Executive Director	Rebecca O'Connor, Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**F&P BAF Risks**	7, 8, 13, 16, 18, 19, 20

Executive Summary

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk (to which the paper relates)
Three Year Plan	Not Reported	N/A	3, 4, 9, 21
South Midlands Pathology Network SOC	Level 4	N/A	4, 13, 16, 18
Board Assurance Framework	Level 5	Maintained	7, 8, 13, 16, 18, 19, 20
Community Diagnostics Centre Business Case	Not Reported	N/A	
Integrated Performance Report	Level 4	Maintained	2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20
Finance Report: Income and Expenditure	Level 3	Maintained	7 and 8
Finance Report: Capital	Level 4	Maintained	7 and 8
Finance Report: Cash	Level 6	Maintained	7 and 8
PEP	Level 4	N/A	7, 10, 11, 16, 18 and 19
TIF 2	Not Reported	N/A	3, 4, 7, 8, 9, 11, 18
Robot	Level 5	N/A	3, 4, 8, 9, 10, 11, 16, 17, 18, 19, 21
Contract Awards (x2): Radiography and Royal Mail	Level 5	N/A	4, 8, 14, 11
Estates Update	Not Reported	N/A	

Finance and Performance Committee Assurance Report

Executive Summary

The Committee met virtually on 28 September and the following key points were raised :

Item	Discussion
External Meetings	A new standing agenda items was included and comprehensive updates were provided from members as to their activity and involvement within the system. The item was welcomed and longer time would be allocated to future discussions.
Three Year Plan	Committee noted the plan set out approach to delivery of the strategic pyramid and to reduce waste during 22-25. The plan is an outline and the strategic roadmap is under development. A event is proposed 9th November to look at future strategy and key risk areas. The plan has been developed in conjunction with ICB plan and long term priorities. **The plan was recommended for approval by the Board**
South Midlands Pathology Network SOC	The SOC proposes formation of a collaborative pathology network of 5 trusts with 3 partners. There are tight timescales due to NHSE funding with the LIMS having secured £14m from NHSE. A clinical senate board will be established. Committee noted the importance of the proposal and of alignment with the Trust's digital strategy, with which this is consistent. **The strategic outline case was recommended for approval by the Board**
Board Assurance Framework	The Committee specific report was noted and the key changes in risk score and assurance levels were noted. The risks aligned with the key focus areas of the Committee. **The BAF was approved as presented**
Community Diagnostics Centre Business Case	The Trust had a request for £4.7m though NHSEI and were invited by region to proceed this year. This was a retrospective approval of a bid made over the summer. It had capital funding approved nationally and revenue was being approved this week. **Committee received the retrospective bid**
Integrated Performance Report	The executive summary headlines were noted. In terms of elective performance position, the Trust was below plan for new outpatients however, more appointments have taken place this month, follow-ups continue to be over plan and PIFU is on track. Day case activity and inpatient were also below plan with diagnostics continuing to be challenged. There are a large number of cancer patients waiting over 63 day and 104 days, with urology most challenged tumour group, however 2WW was improving. 78 weeks RTT is reducing and there are improvements in orthodontics. Ambulance handover and urgent care pressures were discussed in detail and whilst has recently improved, is still very challenging. The north Bristol model is being rolled out to support this. **Assurance level 4 overall was agreed but the assurance level on cancer was reduced to 3**
TIF 2 Theatres Bid Update	Committee were advised the Trust had been invited to make a bid to increase elective capacity to reduce the waiting list backlog and the background to this was outlined. A proposal to deliver a modular unit for £15m by March 23 was discussed in detail. This required the Trust taking £1m at risk on fees to enable the design to be completed and the facility to progress in line with the availability of funding. Both the Divisions and ICB agreed the option offered enhanced capabilities against a backdrop of existing theatre estate in decline. The funding implications were discussed in detail and a letter of support with some caveats, from the system was noted. Committee agreed to establish a further Committee meeting to approve the bid ahead of its submission. This Committee meeting on 30th September, scrutinised and challenged the bid in detail, seeking assurances as to the funding and risks faced by the Trust, the bid having been earlier recommended by the Trust Management Executive. Following a comprehensive discussion, **Committee approved the bid for submission.**

Finance and Performance Committee Assurance Report

Executive Summary

The Committee met virtually on 28 and 30 September 2022 and the following key points were raised :

Item	Discussion
Finance Report M3:	The M3 position was actual deficit was £2.0m against a plan of £1.9m deficit, an adverse variance of £0.1m (5.3%). This brings the Year To Date M5 actual deficit to £8.8m against an plan of £8.6m deficit, an adverse variance of £0.2m (2.3%). Capital challenges remain in terms of timing. AMU and PDU funding was discussed. The position on ERF needs to be understood and bring a potential risk to the end of year position. Slippage on business cases was noted. The forecast to date is largely driven by underspend on business cases and developments, with an under performance on PEP. Month 6 is being reviewed with divisions and will explore any mitigating actions required as a result. **Assurance levels were approved at levels 3 I&E, 4 capital and 6 cash**
PEP	The cumulative PEP gap is increasing, currently standing at 46%. Current schemes have been reviewed and options are being progressed to take these forward. Committee was concerned as to the extent of the gap and the impact of operational pressures. Committee requested forecasts at the next meeting to understand the risks, opportunities, review of business cases and balance sheet work. A clear discussion on accountability and responsibility followed to ensure we have clarity of who is doing what, execution and monitoring. **Level 4 assurance was approved.**
Robot	Committee noted the late paper but was note discussed, this would be considered at the October Committee.
Estates	Committee received and welcomed a helpful presentation with the overview position regarding PFI challenges. A project team was in place. An annual plan for estates would be provided to the Committee in April.
Contract Award: Radiography	Committee considered the CAG and recommended approval by Trust Board.
Contract Award: - Royal Mail	Committee considered the CAG and recommended approval by Trust Board

Quality Governance Committee Assurance Report – 29 September 2022

Accountable Non-Executive Director	Presented By	Author
Dame Julie Moore – Non-Executive Director	Dame Julie Moore –Non-Executive Director	Rebecca O'Connor, Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**QGC BAF Risks**	2, 3, 4, 11, 17, 18, 19, 20

Executive Summary

The Committee met virtually on 29 September 2022 and the following were agreed as escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
Complaints & PALS Annual Report	Board approval required	Recommended for approval

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
Maternity Safety Report	Level 5	Maintained	2, 4, 9, 10
Quality & Safety Assurance Reviews/Deep dive	Level 5	N/A	4
Integrated Performance Report	Level 4	Maintained	2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20
Annual IP Programme	Not reported	N/A	
Harm Review	Level 6	N/A	18
VTE Q1 Report	Level 6	*N/A*	
Enabling Emergency Department Flow	Level 5	N/A	4, 18, 19, 20
Controlled Drugs Safe & Secure Handling Q1	Level 5	N/A	4
Research & Development Q1 Report	Level 5	N/A	
Maternity Engagement	Level 6	N/A	4, 10
Patient Experience & Carer Q1 report	Level 5	5 overall, Volunteering & Patient Engagement Level 6	2
Safeguarding Q1 Report	Level 6	N/A	
Complaints & PALS Annual Report	Level 6	N/A	
Board Assurance Framework	Level 5	N/A	2, 3, 4, 11, 17, 18, 19, 20

Quality Governance Committee Assurance Report – 29 September 2022

Executive Summary

The Committee met virtually on 29 September 2022 and the following key points were raised:

Item	Discussion
CNO/CMO escalations	Planning for robot surgery was underway and the team were keen to start surgery with the first patient expected next week.
Action log	The actions were reviewed and updates included within the agenda items.
Patient Story	A journey of a dementia cardiology patient will be shared where the patient was at the centre of every decision made.
Maternity Safety Report	12+6 bookings were discussed. Mortality is within national levels. No moderate incidents, SI's of HSIB's reported. Training has improved but medical staff compliance had decreased. 1 stillbirth was reported. A CQC visit was expected so the team were focused on updating RAIT actions. RAG status for CNST will not achieve 10/10. Evidence continued to be collated for Ockenden. A letter had been received from NHSE regarding milestones for the delivery of continuity of carer had been removed. There was a risk that there were a number of action plans in place. The Compliance and Assurance was in place and working one day per week currently and would create one complete action plan. **Level 5 assurance overall was approved**
Quality & Safety Assurance Reviews/Deep Dive	Following the heatwave, a review of all patients who were waiting in ambulances during that period were reviewed across both sites. There were no patient safety incidents reported, no safety incidents reported and no complaints received in relation to the matter. **Level 5 assurance overall was approved.**
Integrated Performance Report	Following the Finance & Performance Committee, there was reduced assurance to level 3 for cancer 62 day. 104 week waits has 12 patients waiting at the end of August. None of these patients are orthopaedic. 78 weeks and 52 week waits had reduced. Cancer performance remains challenged though there had been an improvement in 2 week waits. Cancer 62 day issues related largely to Urology and Colorectal. Plans were in place. **Level 4 assurance overall was approved**
Annual IP Programme	There was strong focus on alert organisms and c.diff was high on the priority list. A visit was expected by NHSIE in October and a peer review regarding c. diff was planned in October.
Harm Review	660 patients who had experienced ambulance handover delays were reviewed and no immediate harm was found, which provided assurance that the processes in place for patients waiting on ambulance were working. It was unknown if any harm occurred to the patient later which impacted upon length of stay or deconditioning. An ongoing area of focus was fractured neck of femur. An away day was planned in November to review the pathway and themes in complaints regarding delays in treatment. **Level 6 assurance overall was approved.**
VTE Q1 Report	Compliance with VTE assessment within 24 hours of admission has decreased. The decrease was likely due to a data issue on Badgernet and not an actual decrease. There was no hospital acquired thrombosis in this quarter. **Level 6 assurance overall was approved.**

Quality Governance Committee Assurance Report – 29 September 2022

Executive Summary

The Committee met virtually on 29 September 2022 and the following key points were raised:

Item	Discussion
Enabling Emergency Department Flow	Overall, the new model was working well. currently 36 patients were being moved over a 24 hour period. Plans were being finalised to increase the number of patients being moved. Surge beds in the community had been opened and there were wraparound services, though system working could be improved. **Level 5 assurance overall was approved.**
Controlled Drugs Safe & Secure Handling	100 incidents had been reported, mostly relating to documentation errors or errors with liquid drugs which were not accurately drawn up. There was 1 incident of patient harm reported during the period which was being investigated. **Level 5 assurance overall was approved.**
Research & Development Q1 Report	The Trust continued to perform well with recruitment in |R&D. Studies relating to Covid-19 had now stopped. The Clinical Director was stepping down but a secondment was being offered and R&D ambassadors would be recruited,
Maternity Engagement	The report was taken as read and no escalations were made
Patient Experience & Carer Q1 report	The report was taken as read and no escalations were made
Safeguarding Q1 Report	Committee noted an assurance level of 6. Sudden child deaths were also noted. Deprivation of liberty (DoLs) is being replaced but there is currently no start date.
Complaints & PALS Annual Report	The annual report was noted and was escalated to the Board for approval
Board Assurance Framework	The BAF risks reconciled with the discussions undertaken by Committee. The changes were noted, risks were approved and no further escalations made to the BAF

People & Culture Committee Assurance Report – 4 October 2022

Accountable Non-Executive Director	Presented By	Author
Dame Julie Moore – Non-Executive Director	Dame Julie Moore – Non-Executive Director	Rebecca O'Connor, Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	9, 10, 14, 15, 17

Executive Summary

The Committee met virtually on 4 October and the following were agreed as escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
WRES/WDES	Publication of Trust data for WRES/WDES/Gender Pay	Board approval to publish required
Responsible Officer Appraisal and Revalidation Annual Report	Board oversight of annual report and approval of the framework	Board approval

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
Integrated People & Culture Report	4		BAF 9/10/14/15
People & Culture Risk Register	Not Reported		Not Reported
WRES,WDES & Gender Pay Gap (GPG) Combined Report 2022	5		Not Reported
Responsible Officer Report	6		BAF 9
4Ward Improvement System Quarterly Update (July-September 2022)	Not Reported		Not Reported
Allied Health Professionals (AHP) Workforce Data Report	4		BAF 9
Nurse Staffing Report - August 2022	6		BAF 9
Midwifery Safe Staffing Report	4		BAF 9
Fit & Proper Person Test - Annual Audit	6		BAF 9
Board Assurance Framework (People & Culture)	5		BAF 9/10/14/15/17

People & Culture Committee Assurance Report – 4 October 2022

Executive Summary

The Committee met virtually on 4 October and the following key points were raised:

Item	Discussion
Staff Story	The Committee received a staff story telling the experiences of a Consultant Radiologist and the barriers they faced around flexible working. The impact on flexibility and limitations for example in respect of SPA activity, job plans and on the cultural development of the Trust were discussed.
Integrated People & Culture Report	Focus remains on recruitment and retention this quarter as a key risk. Summary of progress against the 7 people and culture priorities were noted. Leadership development is utilising the culture heatmap to target key areas and monitor impact. 284 staff recruited this quarter but staff turnover has increased. Focus on retention in getting the fundamentals in place for staff. Dignity and work and violence and aggression polices have been launched and are being implemented. Reporting has increased as a result. National recognition for family leave policy. Finance and wellbeing hub in place, with food vouchers available to staff. The national NHS staff survey is currently being undertaken. Non medical leadership and the role of Allied Health Professionals were discussed. The workforce plan has been refreshed which has identified a recruitment need of 551 wte by 31st March 2023.
WRES/WDES and Gender Pay Gap Report	Annual return noted for publication and the EDI plan incorporates the relevant indicators which is monitored via IDEA Committee. We have been successful with our innovation bid for £10k to support the work of our disability staff network. Actions are in place to address the areas for improvement identified in the report, but limited improvement has been made since last year. The increase in BAME staff in formal disciplinary processed was of concerned and will be reviewed at the Committee in more detail. Gender pay differences were noted as being related to legacy Clinical Excellence Awards.
Responsible Officer: Medical Appraisal and Revalidation	Annual requirement for the board that doctors are participating in revalidation and appraisal process and to flag any issues. 7 consultants are overdue an appraisal, all but one has had a delayed appraisal carried out. There is still work to do regarding linking appraisal to valuing individuals, the Trust's values and the Clinical Services Strategy. The Trust's lead Appraiser will be stepping down and this will be replaced by the Deputy CMO with a Head Appraiser.
4Ward Improvement System Update	The value stream activity was noted and the report was taken for assurance only.
AHP Workforce Data Report	The AHP workforce and vacancy challenges were discussed. AHP apprenticeships are under active discussion and the developments and challenges around this are being reviewed. International recruitment will be discussed and how this can be wrapped around for all staff groups will be taken forward.

People & Culture Committee Assurance Report – 4 October 2022

Executive Summary

The Committee met virtually on 4 October and the following key points were raised:

Item	Discussion
Staffing Report	**Nursing:** Level 6 assurance is offered with positive benchmarking. Sickness increased to 6% against a target of 5.5%. Covid is increasing. Turnover of Healthcare Support Workers and midwives is causing some issues. Bank rates are being reviewed to support shifts with gaps.. Committee requested a comparison of band 2-3 pay against other sectors. The aim being to increase substantive rates rather than using bank or agency. Early retirements and the impact of changes to the pension schemes were noted. **Midwifery:** Assurance level 4 is offered. Unusually busy August and red flag were noted but had reduced. Fill rates had increased as a result of the impact of incentives. Sickness and turnover is down. October reporting is promising. New starters joined a week ago. 5 community midwife posts has been offered. International recruitment bid has been submitted but the pipeline is immature. Change in behaviour regarding retirement where staff are not retiring and returning. **Obstetrics Staffing:** was discussed and a safe staffing tool is being developed by region. This is reported in the maternity safety report. Assurance levels were approved
Fit & Proper Persons Audit	The audit was noted.
Risk Register	The risks were noted and no further escalations made
Board Assurance Framework	The risks reconciled with the Committee's discussion and the risks were approved.

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Nurse staffing report –August 2022

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

Accountable Director	Paula Gardner, Chief Nursing Officer		
Presented by	Jackie Edwards, Deputy Chief Nurse	**Author /s**	Louise Pearson, Lead for N&M workforce

Alignment to the Trust's strategic objectives (x)							
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
TME	21/09/2022	Noted
People & Culture	04/10/2022	Noted

Recommendations	Trust Board are asked to note: • Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout August 2022 has been achieved. • August has seen an ongoing pressure on the need for temporary staffing specifically in the emergency department and Maternity due to short notice staff sickness. • August has seen an increase in the requirement for mental health specialist nurses increase significantly. • There were 27 insignificant or minor incidents reported. This is consistent with the past few months. • The health care assistant recruitment drive is ongoing, with the opening up following covid restrictions the recruitment centres have reopened. • A review of retention is being undertaken by HR. • Triangulation of data shows the bank and agency usage is reduced compared to the WTE in vacancy, sickness and maternity.

Executive summary	This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during August 2022. Maternity staffing is provided as a separate report. Staffing of the wards/CCU's to provide the 'safest' staffing levels to meet the fluctuating needs of patients was achieved through August 2022. However, to note there has been a continued challenge due to the consistent pressure from patient demand and acuity through urgent care. This has impacted upon the needs for temporary staffing in areas such as urgent care.

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	There has been an increased demand for mental health trained nurses to support within the acute trust. There remains a reported concern of staff feeling tired and pressured in particular within urgent care and an ongoing focus on meeting the changing needs of the health and wellbeing for staff.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*BAF risk 9 -If we do not have a sustainable fit for purpose and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.*
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 | 6 x | 7 | N/A		
Financial Risk	There is a risk of increased spend on bank and agency given the vacancy position and short term sickness.		

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y	x	N			
Timescales to achieve next level of assurance						

Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing for August 2022

This assessment is in line with Health and Social care regulations:
Regulation 12: Safe Care and treatment
Regulation 17:Good Governance
Regulation 18: Safe Staffing

Issues and options

The provision of safe care and treatment
Staff support ongoing

A priority for the trust remains the health and wellbeing of staff as there remains the priorities of managing the ongoing demands from the acuity and dependency of the patients entering the hospitals and the increases in patient attendance through the urgent care pathway.

The provision of staff support continues to be a high priority for the teams. There is a Trust wide weekly meeting in place to assess progress with safest staffing and professional issues and to gain a professional update on health and wellbeing issues at ward/clinical level, led by the CNO/Deputy Chief Nurse. Twice daily trust staffing huddles are in place to ensure safest staffing across the trust.

Roll out of the Professional Nurse Advocate (PNA) training programme and PNA network is in place and restorative supervision offered for staff as required and areas for targeted support.

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Harms

There were 27 minor and insignificant patient harms reported for July 2022 over a variety of ward areas. No hot spot areas, with no patient related risks reported.

Good Governance

There daily staffing escalation calls to cover last minute sickness and the divisions work together to cover the staffing gaps with last resort escalation to off framework agencies. There remains an assurance weekend staffing meeting held each week with the CNO and the monthly NWAG meeting.
Triangulation of data is ongoing, with Whole time equivalent data now available for Maternity leave and sickness.

Safe Staffing

Nurse staffing 'fill rates' (reporting of which was mandated since June 2014)
"*This measure shows the overall average percentage of planned day and night hours for registered and unregistered care staff and midwifes in hospitals which are filled*". National rates are aimed at 95% across day and night RN and HCA fill
Mitigation in staff absences was supported with the use of temporary staffing and redeployment of staff where staff were able to do so.

Current Trust Position			What needs to happen to get us there	Current level of assurance
	Day % fill	Night % fill	The current domestic and international pipeline to be reviewed. The increase in RN fill is significant across the COVID areas and the need for additional staffing on these areas. The HCA fill rate on days and nights has increased slightly this month a trust wide advert is in place to fill all the HCA vacancies.	**5**
RN	92%	98%		
HCA	92%	105%		

DATA from Here is for July 2022

Vacancy trust target is 7%

The vacancy increase from 21/22- 22/23 is built upon the business cases and surgical reconfiguration that has been agreed and approved in year.

RN and RM vacancies ongoing recruitment to reduce vacancies both domestic and international. Rolling adverts for specialities have been ongoing. HCA recruitment continues following the recruitment drive with HEE and a centralised trust wide advert 22/23 International nurse

recruitment commenced in April 2022 for the next financial year with additional funds supported by NHSEI with supporting teaching for the Hereford and Worcester Health and Care Trust.

Current Trust Position WTE	Model Hospital data June 2022 Benchmarking	Current level of assurance
RN 216 WTE 10.9% RM 27 WTE 11.8% 112WTE HCA 11.46%	RN 12.3% RM not available HCA 11.1%	4

Staffing of the wards to provide safe staffing has been mitigated by the use of:

- Inpatient wards have deployed staff and employed use of bank and agency workers.
- Vacancies numbers has led to constraints on staffing and a need for bank or agency to keep staffing safe across all the Wards within safest levels.
- Urgent Care is currently carrying the majority of the RN vacancies.

Recruitment International nurse (IN) recruitment pipeline

Recruitment has already commenced with arrivals planned through from April 2022 to December 2022 totalling 80 with additional financial support from NHSEI.

Domestic nursing and midwifery pipeline

With the commencement of the grow our own campaign through the Best people programme, September will hopefully see new cohorts of Registered Nurse associates and Registered nurse degree apprentices.

Maternity

There is no trust target for maternity leave and no model hospital data to benchmark

Current Trust Position	Model Hospital data May 2022 Benchmarking	Current Level of Assurance
RN 68 WTE RM 8 WTE HCA 30 WTE	Not available	**4**

Bank and Agency Usage

Trust target is 7%-

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Current Trust Position WTE	Model Hospital data June 2022 Benchmarking	Current level of assurance

RN 293 WTE 10,2% RM 24 WTE HCA 183 WTE	RN 6.4% RM Not available HCA Not available	**5**

Sickness –

The Trust Target for Sickness is 4%, July sickness data 6.1%.

Current Trust Position	Model Hospital data May 2022 Benchmarking	Current Level of Assurance
RN 116 WTE 5.8% RM 17 WTE 7.9% HCA 93 WTE8.1%	RN 5.5% RM6.3% HCA 7.7%	**4**

Turnover

Trust target for turnover 11%. May RN 12.22%, RM 17.3%, HCA 16.95%

Introduction of Apprenticeships across all bands to encourage talent management and growing your own staff – Diploma level 3 – level 7 are available through the apprenticeship Levy.
Work being undertaken with NHSEI to develop a recruitment and retention action plan to support HCA recruitment. To have a pool of ready to start HCAs as vacancies arise.

Current Trust Position	Model Hospital data March 2022 Benchmarking	Current level of Assurance
RN Turnover 11.59% RM Turnover 16.4% HCA Turnover 17.15%	RN Turnover 13.1% RM Turnover 13.8% HCA Turnover 18%	**3**

Recommendations

Trust Board are asked to note:

- Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout August 2022 has been achieved.
- August has seen an ongoing pressure on the need for temporary staffing specifically in the emergency department and Maternity due to short notice staff sickness.
- August has seen an increase in the requirement for mental health specialist nurses increase significantly.
- There were 27 insignificant or minor incidents reported. This is consistent with the past few months.
- The health care assistant recruitment drive is ongoing, with the opening up following covid restrictions the recruitment centres have reopened.
- A review of retention is being undertaken by HR.
  Triangulation of data shows the bank and agency usage is reduced compared to the WTE in vacancy, sickness and maternity.

NHS
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Midwifery Safe Staffing Report

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

Accountable Director	Paula Gardner, Chief Nursing Officer		
Presented by	Justine Jeffery, Director of Midwifery	**Author /s**	Justine Jeffery, Director of Midwifery

Alignment to the Trust's strategic objectives (x)							
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
Maternity Governance	August 2022	
TME	21/09/2022	Noted
People & Culture Committee	4 October 2022	Noted

Recommendations	The Trust Board is asked to note how safe midwifery staffing is monitored and actions taken to mitigate any shortfalls.

Executive summary	This report provides a breakdown of the monitoring of maternity staffing in August 2022. A monthly report is provided to Board outlining how safe staffing in maternity is monitored to provide assurance. Safe midwifery staffing is monitored monthly by the following actions: • Completion of the Birthrate plus acuity tools • Monitoring the midwife to birth ratio • Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • Unify data • Daily staff safety huddle • SitRep report & bed meetings • COVID SitRep (re - introduced during COVID 19 wave 2) • Sickness absence and turnover rates • Recruitment/Vacancy Rate • Monthly report to Board There were 422 babies born in August. The escalation policy was enacted to reallocate staff internally as required however the community and continuity teams were also required to support the team throughout August. It has not been possible to achieve minimum safe staffing levels on all shifts.

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	The supernumerary status of the shift leader was not maintained in August and there were 2 reports when 1:1 care could not be supported. There is ongoing support required to embed the acuity app into the ward areas. There were nine no/insignificant harm staffing incidents and ten medication incidents reported on Datix Sickness absence rates remain higher than the Trusts target but have decreased to 7.02% across all areas. COVID absence rates were lower in August. The directorate continue to work with the HR team to manage sickness absence timely and have 3 areas for focus. The rolling turnover rate decreased to 16.48%. The current vacancy rate remains at 10% and is expected to reduce to 5% following the arrival of 14 WTE midwives in September/October. Further recruitment events are planned The suggested level of assurance for August is 4. This reduction is due to the increased vacancy rate despite positive recruitment in Q1. Delays in care were noted but no reported harm although it is recognised that this impacts negatively on women's experience. There has been an increase in red flag reporting. A higher level of assurance will be offered when there is a sustained decrease in sickness, a reduction in turnover and vacancy rates.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*9-If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting poor patient and staff experience and premiu staffing costs.*

Assurance Level (x)	0		1		2		3		4	x	5		6		7		N/A		
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																		

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**3 months**					

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Introduction/Background

The Directorate is required to provide a monthly report to Board outlining how safe midwifery staffing in maternity is monitored to provide assurance.

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tools
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unify data
- Daily staff safety huddle
- SitRep report & bed meetings
- COVID SitRep (re - introduced during COVID 19 wave 2)
- Sickness absence and turnover rates
- Recruitment/Vacancy Rate
- Monthly report to Board

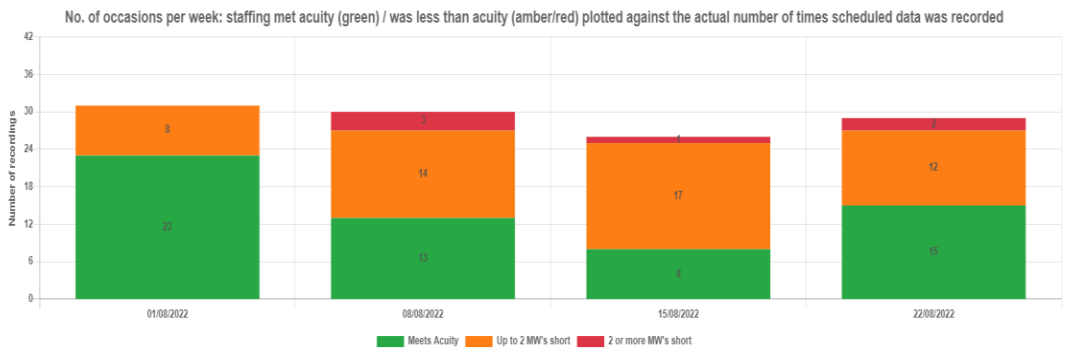
In addition to the above actions a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits. The next complete full Birthrate plus audit is currently being undertaken. A draft report has been received and a workforce paper will be submitted to Board in August 2022.

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 69 % of the expected intervals which is a little lower than last month. The diagram below demonstrates when staffing was met or did not meet the acuity. This indicator is recorded prior to any actions taken. Despite a number of mitigations, the minimum safe staffing levels were not maintained on all shifts throughout August; where this was not achieved mitigations were put in place to maintain safety and the escalation policy was used accordingly in response to activity and professional judgment.



From the information available the acuity was met in 51% (an increase from previous month) of the time and recorded at 49% when the acuity was not met prior to any actions taken.

The mitigations taken are presented in the diagram below and demonstrate the frequency of when staff are reallocated from other areas of the inpatient service (61% to mitigate the risk. This is a significant increase on the previous month. Also to note a decrease when staff are unable to take their allocated breaks (12%) and there were no reports of staff staying beyond their shift.

It is reported that the on call midwives and/or the continuity teams were required to support the inpatient service on 6 occasions however this is underreported and also ward managers and specialist midwives were deployed to support the clinical areas.

Number & % of Management Actions Taken

From 01/08/2022 to 31/08/2022

MA1	Redeploy staff internally	35	61%
MA2	Redeploy staff from community	6	11%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	7	12%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	4	7%
MA9	Utilise on call midwife	2	4%
MA10	Escalate to Manager on call	3	5%
MA11	Maternity Unit on Divert	0	0%
	Total	57	

Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'

All of the NICE recommended red flags can be reported within the new acuity app and are presented below.

The labour ward coordinator was not supernumerary 100% of the time; it was reported that there were 6 events across the month (20 in July, 10 in June, 3 in May) when this was

not maintained. This is a concerning rise in red flags and the matron is currently in discussion with the team to ensure that the reporting is correct and if so how to ensure management actions are taken to avoid this occurring in the future.
There were two reports when 1:1 care in labour was not provided. Delays in the IOL pathway continued during August and there was a small reduction in the number of other delayed clinical activity with no report of associated harm.

Number & % of Red Flags Recorded

From 01/08/2022 to 31/08/2022

RF1	Delayed or cancelled time critical activity	2	14%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	2	14%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	1	7%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	1	7%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	2	14%
RF10	Delivery Suite Co-ordinator is not supernumerary	6	43%
	Total	14	

Antenatal & Postnatal Wards

The data remains incomplete for the antenatal and postnatal ward. Based on this rate of completion the data is not reliable and therefore cannot be included in the report. Previously agreed actions have seen no improvement – further work required.

Staffing incidents

There were nine staffing incidents reported in August via Datix and no harm was recorded. There continues to be a noticeable decrease in reported staffing incidents as these are now captured in the acuity tool. The following incidents were reported:

1. Sickness impacting on ANC staffing
2. Unavailable medical staff (2)
3. Escalation causing delays in care the following day
4. Cancellation of elective CS
5. Referral to WRH from AGH as insufficient staff available to complete assessment.
6. Inappropriate skill mix on AN or PN ward (2)

It is noted that any reduction in available staff results in increased stress and anxiety for the team and the staff have continued to report reduced job satisfaction and concern about staffing levels, burnout and staff health and well – being.

Staff drop in events have continued throughout August to offer support to staff and to update staff on the current challenges in maternity services. Attendance low due to holidays.

Medication Incidents

There were ten medication incidents in August:

- Inappropriate storage of medication
- Stock unavailability
- Dose limit exceeded (4)
- No entry in CD book
- Missing TTOs from pharmacy – returned following day to collect
- Uncharted medication

Unify Data

The fill rates (actual) presented in the table below reflect the position of all inpatient ward areas. The rates reported demonstrate a further improvement in fill rates for registered midwives and maternity support workers in the majority of the inpatient areas.

	Day RM %	Day HCA %	Night RM %	Night HCA %
Continuity of Carer	100	-	-	-
Community Midwifery	65	-	-	-
Antenatal Ward	88	68	92	61
Delivery Suite	82	59	90	91
Postnatal Ward	81	76	92	77
Meadow Birth Centre	68	65	66	49

Monitoring the midwife to birth ratio

The ratio in August was 1:24 (in post) and 1:22 (funded). This is higher than the agreed midwife to birth ratio as outlined in Birthrate Plus Audit, 2022 (1:24).

Daily staff safety huddle

Daily staffing huddles are completed each morning within the maternity department. This huddle is attended by the multi professional team and includes the unit bleep holder, Midwife in charge and the consultant on call for that day. If there are any staffing concerns

the unit bleep holder will arrange additional huddles that are attended by the Director of Midwifery. There were no additional huddles required in August.

The maternity Unit Bleep Holder and the on call manger continue to join the Trust site meeting twice per day. This has facilitated escalation of any concerns and a greater understanding of the pressures within maternity services. The maternity team have also gained an insight into the challenges currently faced across our hospital services.

Maternity SitRep

The maternity team SitRep continues to be completed 3 times per day. The report is submitted to the capacity hub, directorate and divisional leads and is also shared with the Chief Nurse and her deputies. Maternity staffing is also discussed at the Chief Operating Officers daily meeting.

The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. Further work on the Sitrep is ongoing and the pilot of the regional Sitrep continues.

COVID SitRep/Huddle (re-introduced during COVID 19 Wave 2)

The directorates continue to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing. The meetings are now held weekly. The national COVID SitRep continues to be completed each fortnight and there has been cause to report that safe staffing levels have not been maintained (without mitigation) throughout August.

Vacancy

There remain 24 unfilled midwifery posts – vacancy rate of 10%. 14WTE posts have been offered and the majority of these staff will start in September.

Sickness

Sickness absence rates were reported at 7.02% in month- a further reduction from the previous month.

The following actions remain in place:

- Monthly oversight of sickness management by the Divisional team with HR support
- Focus review of sickness management for 3 departments – Delivery Suite and AGH & WRH ANC.
- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- Signposting staff to Trust wellbeing offer and commencement of wellbeing conversations.
- Daily walk rounds by members/member of the DMT.
- Close working with the HR team to manage sickness promptly.
- Health and wellbeing work stream actions

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Turnover

The rolling turnover remains below the Trust target at 16.48%.

Actions throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed meeting twice per day
- Non - clinical staff redeployed to clinical rota as required
- Agency staff block booked to support across summer months
- Sitrep report completed three times per day
- Daily COO meeting
- Maintained focus on managing sickness absence effectively.
- Further training and oversight by ward managers to improve completion rates of the acuity app agreed.
- Further recruitment event planned for October for midwives.
- Weekly 'drop - in' sessions led by the DoM continued in month.
- Additional drop in sessions with CNO & DoM

Conclusion

The activity was high in August (422 births) and there was an increase in the % of time that acuity was met on delivery suite. To maintain safety staff were deployed to areas with the highest acuity; minimum safe staffing levels were not achieved on all shifts and the escalation policy was utilised alongside professional judgment to maintain safety.

Agency midwives and non-clinical midwives have provided additional support to all areas of the service when required. Deployment of all non-clinical staff was requested to maintain safe staffing and support required from the community and continuity teams.

There were reported delays in care, occasions when 1:1 care was not provided and a decrease in the times the shift leader was not supernummary was noted.

Sickness absence rates have decreased and now been reported at 7.2%. It is noted this remains above the Trust target; ongoing actions are in place to support ward managers and matrons to manage sickness effectively.

The rolling turnover rate is at 16.48% and the vacancy rate is now 10%. Fourteen new starters will commence in September/October.

The reduction in available staff on each shift in the inpatient area continues to impact on the health and wellbeing of the team; support is available from the visible leadership team, PMAs and local line managers.

The suggested level of assurance for August is 4. This reduction is due to the increased vacancy rate despite positive recruitment in Q1. There has been an increase in red flag reporting.

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Delays in care were noted but no reported harm although it is recognised that this impacts negatively on women's experience. A higher level of assurance will be offered when there is a sustained decrease in sickness, a reduction in turnover and a reduction in vacancy rates.
Recommendations
The Trust Board is asked to note how safe midwifery staffing is monitored and actions taken to mitigate any shortfalls.
Appendices

Worcestershire Acute Hospitals NHS Trust

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Responsible Officer Report 2021/22

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

Accountable Director	Dr Christine Blanshard, Chief Medical Officer		
Presented by	Dr Christine Blanshard, Chief Medical Officer	**Author /s**	Kira Beasley, Business Manager

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

Report previously reviewed by		
Committee/Group	Date	Outcome
People & Culture	4 October 2022	Noted

Recommendations	The Trust Board are asked to approve the Responsible Officer's Report 2021/22 for submission to NHS England and be assured that appropriate measures and oversight are in place for Medical Appraisal and Revalidation.

Executive summary	The appraisal year runs from 1 April to 31 March annually and many appraisals were delayed over the past appraisal year due to the impact of the pandemic. As at 4th August 2022 there are currently 31 overdue appraisals. There are a total of 24 agreed exceptions, and therefore only **7** Drs who did not have an appraisal during the 2021/2022 appraisal year who were not an agreed exception. The funding for the existing has 58 approved appraisers has been moved centrally to deliver long term equity, no additional funding has been agreed; however, the costs associated with recruitment of medics needs to include this to ensure adequate appraisers are available. We currently have a ratio of 7 appraisees to each appraiser (this is within the required 5-8 ratio). The Appraisal lead is providing appropriate training and networking events.

Risk			
Which key red risks does this report address?	*9 (workforce)*	**What BAF risk does this report address?**	*9 (workforce)*
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 | 6 X | 7 | N/A		
Financial Risk	*None*		

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Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	13 October 2022
Paper number	Enc I

Introduction/Background

The appraisal year runs from 1 April to 31 March annually and many appraisals were delayed over the past appraisal year due to the impact of the pandemic.

As at 4th August 2022 there are currently 31 overdue appraisals. Of these:

- 1 Dr on Sabbatical
- 2 Drs on Long term sickness absence for the majority of the appraisal period
- 1 Dr returned from long term sickness absence and her due date was then adjusted to outside of 2021/2022 appraisal year
- 2 Drs on Maternity/adoption leave
- 1 Dr postponement request was approved and new due date was then outside of 2021/2022 appraisal year
- 17 Drs joined during the 2021/2022 appraisal year having not had a previous appraisal (new to the NHS) and their appraisal due date fell into the following appraisal year

This would make 24 agreed exceptions, and therefore only **7** Drs who did not have an appraisal during the 2021/2022 appraisal year who were not an agreed exception.

The funding for the existing has 58 approved appraisers has been moved centrally to deliver long term equity, no additional funding has been agreed; however, the costs associated with recruitment of medics needs to include this to ensure adequate appraisers are available. We currently have a ratio of 7 appraisees to each appraiser (this is within the required 5-8 ratio). The Appraisal lead is providing appropriate training and networking events.

Issues and options / Actions

There have been significant issues within the Job Planning and Appraisal & Revalidation function; this has been due to sickness, staff turnover and annual leave; this has caused delays in the responsible officer function of the Trust.

In order to provide a clearer oversight and management role of these functions, it is suggested that Job Planning Officer and the Appraisal and Revalidation Teams should realign to the Chief Medical Office. Discussions with the affected parties and teams will occur once this has been agreed.

Recommendations

The Trust Board are asked to approve the Responsible Officer's Report 2021/22 for submission to NHS England and be assured that appropriate measures and oversight are in place for Medical Appraisal and Revalidation.

Conclusion

Although the service has experienced some turbulence over the past 12 months due to the fragility of the teams; processes and procedures have been continued to ensure appropriate action is taken where required.

Appendices

1. Trust Approved Appraiser List
2. Submission document for Quality Assurance Framework

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: New Responsible Officer commenced in post in October 2021 Action for next year: Ensure Deputy Responsible officers have received appropriate training.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: N/A Comments: There have been issues with the resilience of the Appraisal and Revalidation team due to sickness / staff turnover. Action for next year: Ensure the Appraisal and Revalidation Team are closer aligned with the Job Planning Officer for efficient cover and reassign the teams to the Chief Medical Officers Team.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A Comments: Due to the resilience issues of the team there have been some delays in maintaining an accurate record. Action for next year: Ensure the Appraisal and Revalidation Team are closer aligned with the Job Planning Officer for efficient cover and reassign the teams to the Chief Medical Officers Team.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A Comments: Policies were last reviewed at MMC on 27/04/2022 Action for next year: N/A

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year N/A Comments: Action for next year: Explore with partner organisations if this would be possible.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A Comments: Locum doctors whose appraisal is due during their placement with us are supported to undertake their appraisal and provided with any relevant information. Where appropriate, feedback on the doctors performance is provided to the relevant responsible officer. Action for next year: N/A

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1] Action from last year: N/A Comments: Clinical Governance information is provided to doctors on request. Action for next year: Develop a system that allows a doctor's clinical manager to sign off whether any incidents or complaints needs to be implemented.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A Comments: Yes; there is a process for reminding doctors when their appraisal is due; escalation to the appraisal lead and responsible officer where appropriate. Action for next year:

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A Comments: Policies in place and reviewed annually Action for next year: N/A

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Move the budget for Medical Appraisers to the Chief Medical Officers team Comments: More appraisers are required due to retirement, sickness and staff turnover, however we fall in line with the 5-8 appraisees per appraiser (7) Action for next year: Work with the Appraisal Lead to ensure an adequate number of Medical appraisers are trained.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Comments: Appraisers are required to attend a minimum of 1 Appraiser Network events per year hosted by the Medical Appraisal Lead. These events provide a forum for networking and discuss any issues or challenges.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

There were no Appraiser Networks in 2021, instead Mr Pereira met with each appraiser individually for a QA review

Action for next year: Ensure there are networking events for Appraisers in 2022/2023

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N/A Comments: Action for next year: Further development of our quality assurance process and ensure there is a regular report to Trust Management Executive Committee.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	455
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	424
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	31
Total number of agreed exceptions	24

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Drs whose submission date fell between 01 April 2021 and 31 March 2022	150
Of these, recommendations before the revalidation submission date deadline	148
Positive recommendations to revalidate	131
Requests to defer revalidation	19

Number of deferrals due Doctor is subject to an ongoing process	2
Number of deferrals due to Insufficient evidence for a recommendation to revalidate	17
Number of those deferred due to insufficient evidence subsequently successfully revalidated	12

Action for next year: Ensure all recommendations are made in a timely manner

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

Comments: These are not always discussed with the doctor prior to the recommendation being made

Action for next year: Ensure that where appropriate these conversations occur.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A

Comments: Clinical governance processes are in place and are supported by clinical governance teams in each division.

Action for next year: N/A

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

Comments: We have a policy for managing performance and conduct within the Trust and is in line with Maintaining Higher Professional Standards.

Action for next year: Improve processes for sharing lower level concerns with the doctor's appraiser.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

Comments: The trust currently uses the MHPS policy. There is a process in place for responding to concerns but this is not formally documented.

Action for next year: Develop a policy and document the process for responding to concerns.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: N/A

Comments: No- this is not currently in place

Action for next year: Develop a policy and document the process for responding to concerns.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Comments: Appraisal and Revalidation Team support the completion of MPIT forms on behalf of the Responsible Officer to transfer information. If urgent the RO will telephone other RO. Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Comments: Action for next year: Develop a policy and document the process for responding to concerns, including guidance.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Comments: Doctors in Training and both permanent and fixed term non-training Trust doctors are cleared for employment in line with the NHS Employment Check Standards, including the checking of GMC licence to practice and qualifications. This is also assessed through shortlisting and interview by a panel of experienced and trained consultants supplied by the specialty department. Short-term doctors (bank and agency) are recruited via NHSP who subscribe to the same standards of employment checks, and who seek approval of CVs from divisions prior to booking workers. Action for next year: N/A

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report: N/A**
- **Actions still outstanding: N/A**
- **Current Issues: I**ssues with the resilience of the Appraisal and Revalidation team due to sickness / staff turnover.
- **New Actions:**

  i) Develop a policy and document the process for responding to concerns.

  ii) Improve processes for sharing lower level concerns with the doctor's appraiser.

  iii) Further development of our quality assurance process and ensure there is a regular report to Trust Management Executive Committee.

  iv) Develop a system that allows a doctor's clinical manager to sign off whether any incidents or complaints needs to be implemented.

  v) Ensure Deputy Responsible officers have received appropriate training.

  vi) Ensure the Appraisal and Revalidation Team are closer aligned with the Job Planning Officer for efficient cover and reassign the teams to the Chief Medical Officers Team

Overall conclusion:

The light tough approach during the pandemic was welcomed by doctors and the ongoing issues with COVID remain to have an impact on our services. The Trust are moving back towards more rigorous appraisal process and therefore reviewing our underpinning policies and clinical governance process.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	13 October 2022
Paper number	Enc J

Board Assurance Framework

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

Accountable Director	Rebecca O'Connor, Company Secretary		
Presented by	Rebecca O'Connor, Company Secretary	**Author /s**	Rebecca O'Connor, Company Secretary

Alignment to the Trust's strategic objectives (x)							
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	21 September 2022	Noted
Quality Governance	29 September 2022	Noted
Finance and Performance	28 September 2022	Noted
People and Culture	4 October 2022	Noted

Recommendations	To review and approve the Board Assurance Framework on a confirm or challenge basis

Executive summary	This report sets out the full Board Assurance Framework (BAF) following a process of review by Executives and during the September Committee cycle. • The full BAF (at the current point of review) is enclosed within the reading room • There have been two changes in BAF score since the last high level summary to Trust Board in June 2022. • BAF 8 risk score increased from 12 to 16 and BAF 17 risk score has decreased from 16 to 12 • There have been three changes in level of assurance; • BAF 9 has reduced from level 5 to level 4; BAF 14 and BAF 15 have both increased from level 5 to level 6 • Supporting detail and control measures for risks have been reviewed and updated. BAF risks 18, 19, 20 will be subject to a further focussed review To address a recommendation made by external audit, the target risk score is now duplicated within the BAF summary document, whereas this was previously within the full BAF.

Risk

NHS
Worcestershire Acute Hospitals NHS Trust

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Which key red risks does this report address?		**What BAF risk does this report address?**	*All BAF risks as outlined in this report.*

Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A		
Financial Risk	*If the Trust does not have a robust BAF and system of monitoring in place there is the risk that the strategic objectives will not be achieved, which could have regulatory, reputation and financial implications and could impact on the quality of care that is provided. Individual risks and associated controls and or mitigating actions may have financial implications.*																		

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	X	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N		As per report	
If no has the action plan been revised/ enhanced	Y		N		As per report	
Timescales to achieve next level of assurance	As outlined for each risk					

Introduction/Background

The Trust Board is responsible for identifying and monitoring the risks to the achievement of the Trust's strategic objectives. This is achieved through the development of a BAF, which is monitored by the Trust Board and its Committees for areas of their authority.

The Audit and Assurance Committee also has oversight of the BAF to inform the annual programme of internal audit activity and to allow the Committee to discharge its duties in terms of providing assurance around the robustness of the overall system of internal control, of which the BAF is an integral component. Strategic risks on the BAF are those which are of such importance, that failure to control the same, may cause the Trust to fail to deliver its strategic objectives.

This report provides assurance as to the management of strategic risks which are presented on a confirm or challenge basis.

Issues and options

BAF Summary

A summary of the risk position is as follows:

	Number	**Comment**
New Risks opened	0	
Risks Closed	0	
Risks Escalating	+2	BAF 8 – risk score increased from 12 to 16 given current challenging capacity BAF 19 – UEC system working has increased from 16 to 20 as a result of ongoing UEC pressures
Risks De-escalating	-	
Total risks identified	17	

Level of assurance changes	2 decrease 2 increase	BAF 8 - level of assurance has reduced from level 4 to level 3 given current challenging capacity BAF 9 – level of assurance reduced from level 5 to level 4 due to a deterioration in staff turnover and vacancy rates negatively impacting on premium staffing costs BAF 14 – level of assurance increased from level 5 to level 6 assurance given positive benchmarking. BAF 15 – level of assurance increased from level 5 to level 6 assurance following improvements in My Manager section of staff survey

A summary of the Trust's risk exposure is below. This shows that whilst the mitigations put in place are slightly reducing the overall risk exposure, this remains very high.

	Extreme	High	Moderate	Low
Current risk score	9	8	-	-
Initial risk score	11	6		

BAF Updates

BAF risks have been reviewed and updated, the following changes have been endorsed by Committees as follows:

- **Risks Opened/Closed:**

None

- **Risk Escalating/ De-escalating:**

BAF 8 risk score increased from 12 to 16 given current challenging capacity.

BAF 17 risk score has decreased from 16 to 12 based on progress made in embedding understanding of change throughout layers of the organisation

- **Risk Narrative Updates**

Reviews of all risks have taken place and updates made to all current BAF risks in respect of the actions, controls and mitigations. The latest full BAF is enclosed in the reading room and the high level summary is appended.

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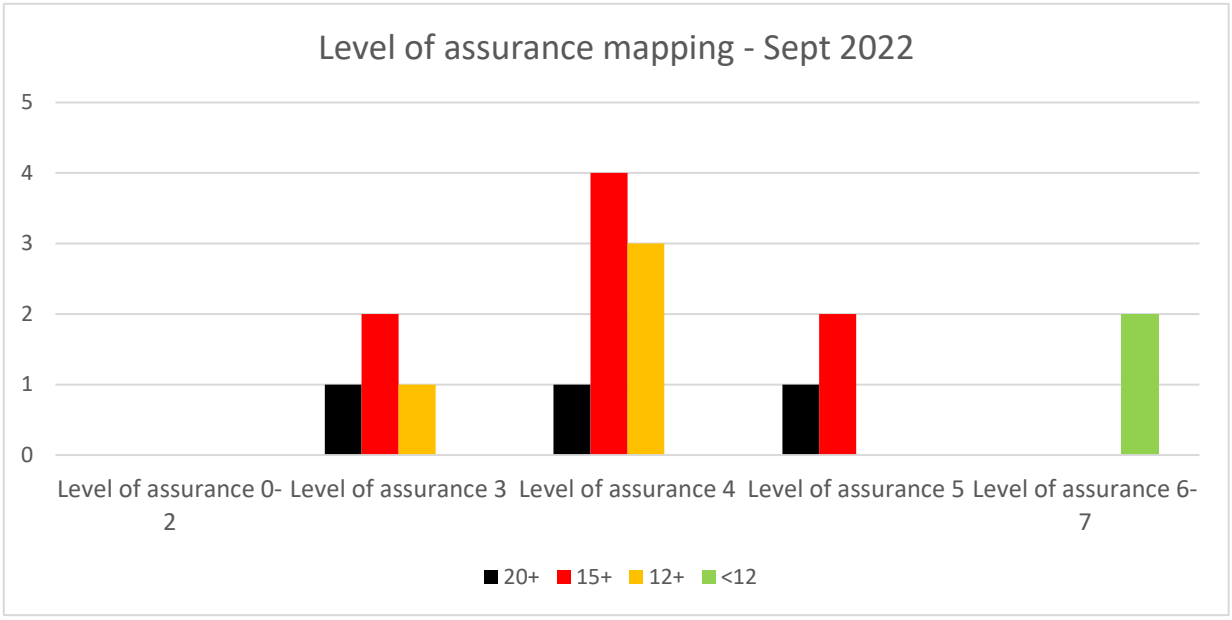
Level of Assurance

The level of assurance is mapped as follows. The graph shows the number of risks and their risk score mapped against the level of assurance; the majority of risks (8) having a level 4 assurance. Of the 17 risks, 13 provide level 4 assurance or above.

Tracking of assurance levels demonstrates the improvement made in assurance of the BAF risks, this is shown by movement to the right of the graph.



The change in levels of assurance can be tracked in the following table which will be added to throughout the year:

	Dec 21	Feb 22	May 22	Sept 22	Change from last Board report
Level of assurance 0-2	-	-	-	-	-
Level of assurance 3	4	3	4	4	-
Level of assurance 4	10	10	8	8	-
Level of assurance 5	3	5	5	3	-2
Level of assurance 6-7	-	-		2	+2

Mapping of Strategic Risks Against Strategic Objectives

The table below shows a mapping of the Trust's strategic objectives and goals against the risks identified in the assurance framework. All strategic objectives and goals are covered by a range of risks.

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		BAF 2	BAF 3	BAF 4	BAF 7	BAF 8	BAF 9	BAF 10	BAF 11	BAF 13	BAF 14	BAF 15	BAF 16	BAF 17	BAF 18	BAF 19	BAF 20	BAF 21
Strategic Objective	Best services for local people	X							X	X			X	X	X			X
	Best experience of care & outcomes for our patients		X	X					X							X	X	
	Best use of resources				X	X			X									
	Best people						x	x	X		X	X		X				
Goal	Goal – strategy	X							X	X		X	X	X	X			X
	Goal – quality		X	X					X							X	X	
	Goal - finance				X	X			X									
	Goal – workforce and culture						X	X	x		X	X						

- **Risk Exposure**

The Trust's risk exposure is increasing from the last report and in general over the medium term. This is due to a number of factors including the ongoing impact of urgent and emergency care pressures, restoration and recovery, the significant capital programme and underlying deficit.

Mitigating activity, controls and assurance are identified for all risks and detailed within the reading room. The intention being the mitigations in place demonstrate a reduction in risk exposure from the initial to residual risk scores. However, there are times where despite there being control measures in place, these are not yet sufficiently effective, nor embedded to enable a reduction in the current risk score. It is not within the Trust's risk appetite to accept risks with no control measures in place.

- **Risk Appetite**

The Trust's risk appetite is not necessarily static, but all risks are expected to have controls and mitigations in place, which aim to reduce the risk exposure to a tolerable level.

The Trust Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. Committees review the BAF and can makes recommendations to the Trust Board regarding the adequacy of the outlined mitigations and control measures. If the Trust Board is unwilling to accept the level of risk to which it is currently exposed, it is invited to consider further mitigating actions or challenge those already identified.

Conclusion

The Trust has a Board Assurance Framework in place which is operational and effective. The Trust's risk exposure is static from the last report and mitigating actions are as outlined in this report.

Recommendations

To review and approve the Board Assurance Framework on a confirm or challenge basis

Worcestershire Acute Hospitals NHS Trust

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Appendices
High level BAF risk summary Full BAF within the reading room

BOARD ASSURANCE FRAMEWORK
SEPTEMBER 2022

Risk Number	Theme	Risk Description	Exec Lead	Responsible Committee	Current Risk Score			Change	Previous Risk Score	Initial Risk Score	Target Risk Score	Risk appetite	Level of Assurance	Change
					Likelihood	Consequence	Risk Score							
Sort	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*		*Sort*	*Sort*	*Sort*
18	Activity	If we are unable to increase elective activity, remove long waits and reduce waiting list size in a timely and cost effective manner, then patient outcomes will suffer, patient care will be compromised and/or costs will increase	COO	QGC/F&P	4	5	20	→	20	25	8	Low	5	→
7	Finance	If we fail to address the drivers of the underlying deficit and fail to respond effectively to the new financial regime (post COVID-19), then we will not achieve financial sustainability (as measured through achievement of the structural level of deficit [to be fully determined]) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	Chief Finance Officer	F&P	5	4	20	→	20	15	12	Low	3	→
19	System working	If we do not have effective system wide working to enhance patient flow and to ensure patients are managed in the most appropriate environment, then we will not be able to manage the level of urgent care activity and patient experience for patients who are clinically ready for discharge, but have not been, will suffer	COO	QGC/F&P	5	4	20	↑	16	16	8	Low	4	→
8	Infrastructure	If we are not able to secure financing then we will not be able, to address critical infrastructure risks as well as maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	Chief Finance Officer	F&P	4	4	16	↑	12	15	12	Moderate	3	↓
13	Cyber	If we do not have assurance on the technology estate lifecycle maintenance and asset management then we could be open to a cybersecurity attack or technology failure resulting in possible loss of service.	Chief Digital Officer	F&P	4	4	16	→	16	20	10	Low	3	→
16	Digital	If we do not make best use of technology and information to support the delivery of patient care and supporting services, then the Trust will not be able to deliver the best possible patient care in the most efficient and effective way	Chief Digital Officer	F&P	4	4	16	→	16	20	15	Low	5	→
20	Urgent care	If we do not ensure that all actions are in place to enable discharge at the point of being ready for clinical discharge then we will adversely impact patient experience and inhibit flow	COO	QGC/F&P	4	4	16	→	16	16	8	Low	4	→
3	Clinical Services	If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	CMO/Dir of S&P	QGC	4	4	16	→	16	15	5	Low	4	→
17	Engagement with staff	If we fail to effectively involve our staff and learn lessons from the management of change and redesign / transformation of services, then it will adversely affect the success of the implementation of our Clinical Services Strategy resulting in missed opportunity to fully capitalise on the benefits of change and adversely impact staff engagement, morale and performance	COO/Dir P&C	QGC/P&C	4	4	16	→	16	12	8	Low	5	→
11	Reputation	If we have a poor reputation this will result in loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care.	Director of C&E	QGC	4	4	16	→	16	12	8	Moderate	4	→
9	Workforce	If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting in poor patient and staff experience and premium staffing costs.	Director of People & Culture	P&C/Trust Board	3	5	15	→	15	15	9	Moderate	4	↓
2	Engagement with patients, public and partners	If we fail to effectively engage and involve our patients, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	Director of C&E/CNO	QGC	3	4	12	→	12	12	3	Moderate	4	→
4	Quality	If we do not have in place robust systems and processes to ensure improvement of quality and safety and to meet the national patient safety strategy, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	CMO/CMO	QGC	3	4	12	→	12	20	8	Low	4	→
21	ICS	If the Trust fails to capitalise on the benefits of integrated care at Place, System or intra System level then this will result in missed opportunities to improve quality of care, patient experience, efficiency or financial sustainability	Director of Strategy	Trust Board	3	4	12	→	12	16	8	Low	3	→
15	Leadership	If we do not have a comprehensive leadership model and plan in place then we may not have the right leadership capability and capacity to deliver our strategic objectives and priorities	Director of People & Culture	Trust Board	3	4	12	→	12	12	8	Moderate	4	→
10	Culture	If we fail to sustain the positive change in organisational culture, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.	Director of People & Culture	People and Culture/Trust Board	2	5	10	→	10	15	6	Moderate	6	↑
14	Health and Wellbeing	If we do not have the capacity and capacity to implement, or staff do not access, health and wellbeing support then we may be unable to maintain safe staffing levels due to higher rates of absence and staff turnover	Director of People & Culture	P&C	2	5	10	→	10	15	10	Moderate	6	↑

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	13 October 2022
Paper number	Enc K

Audit and Assurance Committee Report

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

Accountable Director	Colin Horwath, Audit and Assurance Committee Chair		
Presented by	Colin Horwath, Committee Chair	**Author /s**	Rebecca O'Connor, Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Board is requested to: 1. Note the report for assurance

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meeting held on 13 September 2022. The following key points are escalated to the Board's attention: **1. Value for Money Audit** Committee received the final Audit Report and this has been published with the Annual Report and Accounts. One key recommendation and six improvement recommendations were made and progress against the same will be reviewed by the Committee. **2. Internal Audit Reports** Committee received a progress update against three areas of facilities timesheets, financial governance (significant assurance) and leavers (limited). A detailed update was provided by Executives on progress made regarding leavers since the audit had taken place. Follow up of the recommendations arising will be monitored by Committee **3. Data Quality, Counter Fraud, Health & Safety and Freedom to Speak Up** Committee received assurances regarding progress and developments in these areas **4. HFMA Financial Sustainability** Committee received the progress report which set out the Trust's approach to completing the self-assessment and how the actions arising would be embedded and used to support ongoing improvement.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	13 October 2022
Paper number	Enc K

	5. Committee Effectiveness Review Committee reviewed the effectiveness of the Remuneration Committee

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*All – Committee's work cross cuts all underpinning BAF risks*

Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A	
Financial Risk	*None directly arising as a result of this report*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						