Worcestershire **NHS**
Acute Hospitals NHS Trust

There will be a meeting of the **Worcestershire Acute Hospitals NHS Trust Board** on
Wednesday 6 April 2016
at 09:30 in
Alexandra Hospital Board Room, Redditch

John Burbeck
Interim Chairman

Please take papers as read

AGENDA			
1	**Welcome and apologies for absence**	Interim Chairman	
2	**Patient Story**	Tarum Sharma, Consultant Ophthalmologist	
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest** *To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.*		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **2 March 2016** as a true and accurate record of discussions.*	Interim Chairman	**Enc A**
6	**Matters Arising**	Interim Chairman	**Enc B**
7	**Questions from the Public** *Questions relating to items on the agenda only should be provided in advance to the kimara.sharpe@nhs.net by 12 noon on Tuesday 5 April 2016.* **Please note change of email address**		
8	**Chairman's Update Report** *For information*	Chairman	**Enc C1**
9	**Chief Executive's Report** *For assurance*	Interim Chief Executive	**Enc C2**
STRATEGY **Board Assurance Framework 2665, 2904, 3140**			
10.1	**Annual plan** *For discussion and approval*	Director of Strategy, Planning and Improvement	**Enc D1**
QUALITY AND PATIENT SAFETY **Board Assurance Framework 2790, 2902, 3038, 2895**			
11.1	**Quality Governance Committee report** *For assurance*	Interim Chairman	**Enc E1**
11.2	**Patient Care Improvement Plan** *For approval*	Director of Strategy, Planning and Improvement	**Enc E2**

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	WORKFORCE Board Assurance Framework 2678, 2894, 2893		
12.1	**Workforce Assurance Group report** *For assurance*	Committee Chair	**Enc F1**
12.2	**Nursing and Midwifery Workforce** *For assurance*	Interim CNO	**Enc F2**
12.3	**Review of nursing establishment** *For approval*	Interim CNO	**Enc F3**
12.4	**Medical Workforce report** *For assurance*	Interim CMO *presented by Interim CNO*	**Enc F4**
12.5	**Staff survey/Staff Engagement** *For assurance*	Director of Communication	**Enc F5**
	FINANCE AND PERFORMANCE Board Assurance Framework 2888, 2668		
13.1	**Finance and Performance Committee** *For assurance*	Committee Chair	**Enc G1**
13.2	**Integrated Performance Report** *For assurance*	Director of Strategy, Planning and Improvement	**Enc G2**
13.3	**Financial Performance Report** *For assurance*	Interim Director of Finance	**Enc G3**
13.4	**Financial Plan 2016/17** *For approval*	Interim Director of Finance	**Enc G4**
	GOVERNANCE		
14.1	**Audit and Assurance Committee report** *For assurance*	Committee Chair	**Enc H1**
14.2	**Board Assurance Framework** *For approval*	Interim Chairman	**Enc H2**
14.3	**Declaration of Interests 2015/16** *For noting*	Company Secretary	**Enc H3**
15	**Any Other Business**		
	Date of Next Meeting The next public Trust Board meeting will be held on **Wednesday, 4 May 2016, Kidderminster Education Centre Kidderminster Hospital and Treatment Centre**		

Exclusion of the press and public

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

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Worcestershire **NHS**

Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON

WEDNESDAY 2 MARCH AT 09:30 HOURS

Present:

Chairman of the Trust:	Harry Turner	Chairman
Board members: (voting)	John Burbeck	Vice Chair and Non-Executive Director
	Mari Gay	Interim Chief Nursing Officer
	Rob Cooper	Interim Director of Finance
	Stephen Howarth	Non-Executive Director
	Rab McEwan	Interim Chief Operating Officer
	Andrew Sleigh	Non-Executive Director
	Chris Tidman	Interim Chief Executive
Board members: (non-voting)	Denise Harnin	Director of HR & Organisational Development
	Sarah Smith	Director of Strategy, Planning and Improvement
	Lynne Todd	Board Advisor
In attendance:	Paul Crawford	Patient Representative
	Tim Carter	Communications
	Kimara Sharpe	Company Secretary (minutes)
Public Gallery:	Press	1
	Public	6
Apologies:	Stewart Messer	Chief Operating Officer
	Mark Wake	Chief Medical Officer
	Marie-Noelle Orzel	Improvement Director
	Bryan McGinity	Non-Executive Director
	Bill Tunnicliffe	Associate Non-Executive Director
	Lisa Thomson	Director of Communications
	Andy Phillips	Interim Chief Medical Officer

215/15 **WELCOME**
The Chairman welcomed members of the press and public to the meeting. He thanked Kath Akhtar for her contribution to the Trust and wished her well in her retirement.

216/15 **PATIENT STORY**
The Chairman invited the Interim COO to give the patient story. The Interim COO stated that the story showed the value of allied health professionals in the care and rehabilitation of an elderly patient.

A very elderly gentleman with dementia had been admitted to the elective orthopaedic ward for a hip replacement. Two weeks prior to this admission he was admitted to a

nursing home for respite care. On arrival to the ward and following assessment by the consultant and the anaesthetist it became apparent that the gentleman was not medically fit for the planned surgery.

The family and the patient were very upset by this as they felt that once the hip replacement had been performed it would have been possible for the patient to be cared for at home once again, as they felt his decreased mobility was resulting in frustration which in turn was leading to the difficulties his wife was experiencing with the dementia symptoms.

The gentleman was assessed and treated by the physiotherapist and the occupational therapist on the ward and his mobility improved sufficiently for him to be discharged home in the care of his wife and family.

This admission proved to be for slightly longer than a straight forward hip replacement but ultimately resulted in a patient returning home rather than to the nursing home.

The Interim COO commented that far too many patients decline functionally on admission to hospital. There is a rate of decline of 10-29% in the reduction of a patient's ability to perform activities of daily living. This story shows that this is not always necessarily true and that such a trend can be reversed by the effective use of therapies.

The Interim CNO stated that the mortality of patients being admitted to nursing homes is high. She was keen to promote 'home first' and she was pleased with the outcome for this patient.

The Interim COO stated, in response to a question from Mr Howarth, that studies have shown that there is a 10-20% loss of function in the elderly in the two weeks prior to hospital admission which is then compounded by a further 7% loss in physical activity with an average length of stay of 5 days. There is a loss of 1% of muscle mass for every day of a hospital stay.

Mr Sleigh asked about the provision of facilities for people who were in need of rehabilitation but not necessarily acutely ill. He wondered whether the Trust ought to invest in alternative accommodation in order to free up acute beds. The Interim COO stated that the Trust's policy was 'home first'. The Interim CEO echoed this and stated that patient ought to be at home being cared for by sub-acute teams. Hospitals were not the best place for elderly non-acutely ill patients as confidence and ability is lost rapidly in a non-familiar environment. By staying at home with support arranged by the GP, patients respond better and are able to maintain independence longer.

Mrs Todd commented that community services should be involved with the frail elderly prior to a planned admission. The Interim COO agreed and stated that the health economy is committed to working together to improve the support for the 2% of the population who use 36% of NHS resources.

The Interim CEO reaffirmed that the frail elderly are key and core to the Sustainability and Transformation Plan (STP) vision. He stated that the public need to be aware of implication of a hospital stay on this cohort of patients and would be working with partners on this.

Resolved: that
The Board
- **Noted the content of the story**

217/15 **ANY OTHER BUSINESS**
No other items of business were raised.

218/15 **DECLARATIONS OF INTERESTS**
There were no additional declarations of interest.

219/15 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 3 FEBRUARY 2016**
Resolved: that
- **The Minutes of the public meeting held on 3 February 2016 be confirmed as a correct record and be signed**

219/15/1 **MATTERS ARISING/ACTION SCHEDULE**
The Company Secretary confirmed that actions relating to minute numbers 204/15/2 and 201/15/3 had been completed and all other actions were either complete or not yet due.

220/15 **QUESTIONS FROM MEMBERS OF THE PUBLIC**
220/15/1 **Question from HealthWatch:**
In light of the revised guidance recently issued by NHSE regarding NHS patient, visitor and staff car parking principles where concessions, including free or reduced charges or caps, should be available for the following groups:
- *Disabled people*
- *Frequent outpatient attenders*
- *Visitors with relatives who are gravely ill, or carers of such people*
- *Visitors to relatives who have an attended stay in hospital or carers or such people*
- *Carers of people in the above groups where appropriate*
- *Staff working shifts that mean public transport such be used*

Has the Trust implemented this – if it hasn't when does the Trust intend to do so?

The Interim CEO acknowledged that car parking was very important to all attendees to the hospital, whether patients, visitors or staff. He confirmed that the Trust had reviewed its car parking policy in the light of the guidance and concurred that the Trust adheres to most of the guidance except that which relates to free car parking for blue badge holders. He committed to reviewing the policy on an annual basis however charges for blue badge holders would remain for the foreseeable future. He reminded members that concessions were available for frequent attendees and staff were reminded to ensure that they raised awareness about this.

220/15/2 **Question from Mr B Griffiths:**
As the minutes show, at the last meeting my colleague Mr. McNally asked did "the Trust monitor, and make public, data about review appointments with clinics being delayed because of capacity problems. Has the Trust any concerns about the capacity of any particular clinic?" In reply the Interim COO said "that follow-up waiting lists and clinic capacity were monitored via the relevant directorates. There were internal follow-up waiting list reports including the target date for the follow up appointment. The data was not made public; there was no national requirement or expectation to report on follow-up waiting times and/or delayed follow ups. He added that there were particular issues currently in Dermatology, Gastroenterology and Respiratory Medicine which had the longest waiting times, but confirmed patients were being managed in time order and active recruitment was taking place to fill vacancies in all three

specialties, which were in regular contact with the affected patients".

Does the Trust not agree that this shows a disappointing lack of transparency with management information it already holds? We are aware of a patient in the Cardiology Clinic who was diagnosed June 2015, given a review date in 3 months and yet eight months later still has no idea when they will be seen because of "capacity problems." To avoid unnecessary stress to patients, and staff who have to handle telephone queries, would it not be possible for patients to be told at the outset that the review date is a clinical assessment only and then referring them to a real-time Trust website which explains by clinic the reasons for any delays and indicates in weeks the expected time by which appointment dates will be confirmed?

The Interim COO stated that patients are seen in clinical priority order. This changes on a daily basis. Disruption to appointments is more likely for those 3-6 months in advance as the demand at that time in the future will be unknown. He confirmed that the outpatient booking system is being reviewed. Finally he reminded those present that if patients were concerned that their condition had worsened whilst waiting for an appointment, they needed to be reviewed by their GP who could make the necessary arrangements for them to be seen earlier if clinically appropriate.

The Chairman stated that staff would be willing to meet with Mr Griffiths to talk through the issues if he so wished.

220/15/3   **Question from Mr B Griffiths:**
Does the Trust Chair not agree that to issue a Board Agenda paper on Monday afternoon for a meeting on Wednesday morning provides an unacceptably short period for members to prepare for and for the public to learn about what decisions are being taken in their name? If seven days is the conventional period for agenda papers to be circulated, will he therefore postpone this meeting for five days to ensure safe and sound decisions are taken?

The Chairman apologised for the lateness of the papers. However he was made aware of the situation on 25 February and made the decision to go ahead with the meeting. This was in accordance with the Trust's standing orders. He also stated that the Trust was in a minority of organisations who met monthly in public but he was committed to remaining open and transparent with Trust business.

220/15/4   **Question from Mr B Griffiths:**
The Board's last meeting noted "that the risk share agreement with the Commissioners had not materialised even though 3 high level meetings with the TDA and NHS England had taken place to resolve this and a number of other issues between the Trust and the CCGs. The outturn position has not been agreed commissioners as the final offer from commissioners falls short of the Trust's view, which could result in mediation/arbitration. The CCGs have since indicated their support in aiding the Trust to close down beds and thereby ensuring new costs, associated mainly with winter, do not enter the system."

What has been the cost so far to the Trust in seeking to resolve this issue?

The Interim DF stated that the Trust meets regularly with the CCGs on a number of issues. It was not possible to separate out the costs involved for this particular item.

221/15   **Chairman's Report**
The Chairman stated that he felt very privileged to be part of the Trust for the previous few years. It had been hugely rewarding because of the caring and compassionate

staff. He urged the Trust to continue to care for the staff as engaged cared for staff were more productive in giving high quality care.

In relation to reconfiguration, he was pleased that there was an agreed model of care but regretted the time taken to achieve this. He stated that the future was to work more closely together and to break down organisational barriers. He was positive about the role of the Health and WellBeing Board in taking forward the health agenda, but urged members to ensure that the two health providers were members of this Board.

Finally he thanked the Trust board for their leadership. He specifically thanked the Interim CEO.

He wished the Trust every success in going forward.

Resolved: that
The Board
- **Noted the verbal report.**

222/15   **Interim Chief Executive's Report**
The Interim Chief Executive presented the report circulated with the agenda (Enclosure C) and highlighted the main points. He outlined the process for the development of the Sustainability and Transformation Plan (STP). It was imperative to ensure that senior clinicians were involved in the process as they could influence the changes needed to deliver the Plan.

He thanked the staff involved in delivering the progress in reducing agency spend and reducing the number of cap breaches.

He was delighted that Monitor had nominated the Ophthalmology Department for a Value in Healthcare Award. He requested that Mr Sharma present to the Board the work that he has undertaken.

The Breast unit opened at the end of February. The initial feedback about the facility has been excellent.

He then turned to emergency care. He acknowledged that the activity had increased (blue light ambulances were up by 10% on last year) and confirmed that he was confident that despite the additional activity, that the service would improve with the additional use of ambulatory care and more structured ward rounds, which have been implemented elsewhere in the country. The ECIP work would support this.

Finally he reported that the staff survey was published in the last week. Given the turbulent year that staff had been through, it was perhaps not surprising that the results were disappointing. The Interim CEO gave his commitment that he and the executive team would improve staff engagement and an action plan would be bought back to the next meeting.

Mr Howarth stated that the development of the STP was a great opportunity. He queried what the on-going relationship with Wye Valley would be, in particular in relation to back office functions. The Interim CEO confirmed that the clinicians were reviewing how best to establish clinical pathways and there would also be a review of back office functions. He recognised the time that this would take – the most important issue was that any change would be clinically led.

Mrs Todd asked for an update on how the STP process was being managed. The

Interim CEO confirmed that the process was still under discussion and that an independent chair would oversee the process.

Mr Burbeck asked for more information about the end of life arrangements. The Interim CNO stated that the CCGs were looking to commission individual care packages from one organisation. St Richard's Hospice was involved in this work. She confirmed that the national work being undertaken within the Trust was separate to this work.

The Interim CEO confirmed to Mr Howarth that the he or the Interim COO were able to break the agency cap. He gave an example of the paediatric rota at the Alexandra Hospital which constantly operated above the cap as the only way at present of recruiting agency staff.

The Interim DF confirmed to Mr Howarth the process involved in relation to Lord Carter's review. The Finance and Performance Committee had received a paper which showed the Trust's reference costs as 103. The Trust is looking to engage with a partner to implement savings. The partner would be paid on the results of the savings generated. The Director of HR/OD confirmed that the Workforce Assurance Group was also reviewing aspects of the Lord Carter's review.

Resolved: that
The Board,
- **Noted the contents of the report**

223/15	**INTEGRATED PERFORMANCE REPORT**

223/15/1 **Integrated Performance Report**
The Director of Strategy, Planning and Improvement presented the report circulated with the agenda (Enclosure D1) and highlighted the main points. She reported compliance with the RTT 18 week incomplete target and 62 day treatment standard for cancer. The emergency access standard was not achieved, mainly due to very high occupancy (over 100%) in both hospitals. The two week wait for cancer referrals (breast and all) was also not achieved. She also reported that due to two significant equipment failures, the diagnostic 6 week waiting time was not achieved.

Mr Howarth asked how the RTT incomplete target had been met. The Interim COO stated that the Trust had now moved to a better reporting and tracking system which enabled divisions and directorate managers to directly manage the calling of patients. Waiting lists had also been validated.

The Interim COO confirmed to Mr Howarth that more elective surgery was being moved to the AGH site.

Mrs Todd expressed concern about the lack of achievement of the cancer two week wait, which had not been met since April 2015. The Interim COO acknowledged this but stated that the most important measure was ensuring that patients started their treatment within 62 days, which was happening. He reminded members that if patients chose not to accept one of the two appointments offered within the 2 week window, the Trust still had to record that as missing the target. He also stated that activity has increased by 17% which is partly due to the national campaigns about specific cancers.

Mrs Todd asked about the increase in staff turnover. The Director of OD and HR confirmed that she was undertaking further research to understand the increase. This was being monitored through the Workforce Assurance Group.

Mr Sleigh expressed his frustration about the lack of improvement in the numbers of patients medically fit for discharge. Mr Burbeck added his concern about the increased length of stay. The Interim COO confirmed that the length of stay was linked to the time of year and the number of patients admitted with respiratory illnesses. He referred to the discussion held earlier in the meeting about ensuring that patients went home as soon as possible. He was working with the third sector to ensure more support at home and South Worcestershire CCG was actively working with GPs for them to be able to manage more patients at home.

Mr Sleigh challenged again about joint working and suggested a series of joint programmes to ensure that the work progressed. The Interim CEO confirmed that the Strategic Resilience Group was overseeing the joint work and that the work outlined was part of the ECIP project. The Interim CEO also confirmed that many systems were reporting that a focus on internal improvements were as important as trying to reduce those patients who were medically fit for discharge. The Interim COO agreed to discuss this further at the Finance and Performance Committee.

Resolved: that
The Board:-
- **Received the Integrated Performance Report for December**
- **Supported 'home first'**
- **Expressed concern about the number of medically fit for discharge patients**
- **Noted the actions described in the report**

224/15	**PATIENT SAFETY & EXPERIENCE**

224/15/1 **Quality Governance Committee**

Mr Burbeck presented the report from the Quality Governance Committee (Enclosure E1) and highlighted the key points. He reported that the Committee had highlighted lack of progress on mortality reviews as an area of concern. The completion rate had decreased despite linking the process to appraisal and clinical excellence awards. He also raised a concern about the low completion rate of an electronic discharge summary. Finally he reported that the TACO-CS deep dive report had highlighted issues with patient identification. There was not a consistent approach to this throughout the Trust.

Mr Sleigh echoed his concern about the lack of progress on the mortality review process. The Interim COO, in the absence of the Interim CMO, stated that the numbers were expected to increase as this was a lag indicator and there was a significant focus on the area by senior clinicians. It was part of their professional standards. Mrs Todd reinforced that it was an individual clinician's responsibility.

Resolved: that
The Board
- **Noted the work being undertaken with Oxford University Hospitals NHS Trust in relation to the BAF**
- **Noted the poor performance in relation to hip fracture**
- **Noted the poor completion of the electronic discharge summary**
- **Noted the concern of the Committee in relation to the completion rate for primary mortality reviews**
- **Noted the concern in relation to complaints response times**
- **Noted the concerns in relation to the responsible clinician for people detained under the mental health act**
- **Noted the deep dive into the TACO/CS division**
- **Noted the report**

224/15/1   PATIENT CARE IMPROVEMENT PLAN

The Director of Strategy, Planning and Improvement gave a verbal report. She stated that the PCIP to date had been able to demonstrate significant progress with A&E (following the CQC unannounced visit); infection control (following the peer review) and junior doctor concerns (following the Health Education West Midlands visit).

She was now reviewing how to progress the PCIP, given the main challenges of urgent care and patient flow; mortality and cultural change. She would be developing an Improvement Board to replace the current Trust Management Committee. The first meeting of the Board would be on 9 March and following this meeting, she would bring further papers to the Trust Board.

The Interim CEO reminded members that the Trust attends the quality oversight review group which has recognised the significant improvements that the Trust has made over the last 12 months and that he was confident that an Improvement Board would further drive this work forward.

Mrs Todd supported the outlined approach. She asked how staff would be kept informed of the way forward. The Director of SI&P confirmed that a communications and engagement strategy would be developed to support the programmes.

The Company Secretary outlined the governance arrangements for the Improvement Board. It would be chaired by the Interim CEO and would report via his report to the Trust Board.

Resolved: that
The Board
- **Noted the verbal report**
- **Supported the development of the Improvement Board**
- **Requested that a communications and engagement plan be developed**

225/15   WORKFORCE

225/15/1   Nursing and Midwifery Workforce

The Interim CNO presented the nursing and midwifery workforce report (Enclosure F1) and highlighted the main points. The Interim CNO stated that the Trust met the current guidelines in respect of safer staffing but only because there was a heavy reliance on bank and agency staff. There had been a steady increase with qualified nurse turnover. As part of the review of nurse staffing, she was ensuring that the acuity of patients at individual ward level was being taken into account. A new role at band 4 of an associate nurse was being developed which would incorporate the role of ward administer and housekeeper and ensure that qualified nurses were released from some of their administrative roles. This role would be put in place over the next few months. She was working with the University to develop the role.

She confirmed to Mr Howarth that the funded establishment increase included a previously unfunded ward.

The Interim CEO asked what the Trust was doing to improve recruitment at AGH, in particular within surgery and medical assessment. The Interim CNO stated that the recent targeted recruitment events had been very successful – the main questions being asked were about career development, not about the future of the hospital. She was working with HR on opportunities for development. She went onto state that she would be keen to develop a nurse consultant-led ward at AGH for the frail elderly. She

felt that this would aid recruitment, showing what was possible for nurses to achieve.

She confirmed to Mr Howarth that the Workforce Assurance Group was reviewing the nurse establishment which included corporate nurse roles. This would be reported to the Trust Board at a future meeting.

Resolved that
The Board received and noted:-
- **The nursing and midwifery workforce metrics and associated action**
- **The safe staffing status**
- **The workforce review**
- **The state of preparedness for revalidation**

226/15	**STRATEGY**

226/15/1 **The Future of Acute Hospital Services in Worcestershire (FoASHW)**
The Interim Chief Executive presented the report circulated with the agenda (Enclosure G1). He stated that the stakeholder brief set out the process which was progressing. He reported on a stakeholder meeting held by NHS England and the Trust Development Authority which outlined the next steps. The Clinical Senate was considering its response to the latest questions and the formal NHS England assurance process would be completed in April/May which meant that public consultation would take place in the summer.

He stated that it was imperative that the Trust submitted the appropriate capital bids to support the model as proposed. It was also essential that the implemented model showed high quality safer care in a reduced financial envelope for the county.

Resolved that
The Board
- **Noted the Stakeholder Brief**
- **Noted the considerable progress being made with the Programme**

227/15	**FINANCE AND PERFORMANCE**

227/15/1 **Finance and Performance Committee Report**
Mr John Burbeck, Committee Chair, presented the report from the Finance and Performance Committee held on 26 February 2016 (Enclosure H1) and highlighted the main points. He stated that the divisions were challenged in the achievement of the £10m and this resulted in a high level of satisfaction and confidence in the progress towards its achievement. The Trust is working towards an end of year position of £59.9m deficit.

He went onto report that capital is very tight and cash flow remains a challenge. Members discussed the implications of Lord Carter's review and how value for money initiatives could be bought into the service delivered.

The Interim CEO confirmed that he was discussing with the Interim DF a change in the format of the Committee to ensure that there is more focus on future financial and activity performance.

Resolved that:-
The Board
- **Noted the revised forecast deficit to £59.9m.**
- **Received assurance that the £10m recurrent savings will be achieved**
- **Noted achievement against the performance targets in the face of continued**

emergency pressure and high bed occupancy and lack of flow.
- **Noted the progress in agency cap compliance.**
- **Noted the costing report update**

227/15/2 **Financial Performance Report**

The Interim Director of Finance presented the financial performance report (Enclosure H2) and highlighted the main points. He confirmed that the Trust was on schedule to save £10m. He was pleased with the grip that the divisions had displayed at the meeting in respect of finances. The end of year deficit had moved from £65.1m to £59.9m. The breakdown of the £59.9m was:
- pay and non pay savings - £1.6m
- additional healthcare income - £1.8m.
- other operating income – £1.75m
- Bad debt provision – £0.05m.

He was now in a position to move revenue to capital and would seek to capitalise other items. He was expecting an increase in pay savings at the end of the year for example in waiting list initiative payments. He had commissioned PWC to review the £10m savings to ensure that the money has been taken out recurrently.

Mr Sleigh observed that most of the remaining work was needed within the Medicine Division. Support was being given to ensure that this took place.

The Interim CEO asked the Interim DF for a forecast on the Trust's position for 2016/17. The interim DF stated that the key issue was the delivery of the cost improvement programme of at least £14m. He explained to Mr Sleigh that the Trust is currently at 103 for reference costs and his aim would to be at 103 or less in 12 months' time. This would need a saving of £14m or more.

Resolved that:-
The Board:-
- **Reaffirmed its commitment to rigorously pursuing its identified recovery actions in order to tackle the adverse financial position including:**
  - **Exploiting Clinical Decisions Unit (CDU) and Ambulatory Care**
  - **Compliance with new controls on non-pay restrictions**
  - **Locum expenditure being micro-managed**
  - **Increased targets and micro management of nursing agency**
  - **Further theatre productivity gains**
  - **Managing down Medically Fit for Discharge (MFFD)**
  - **Ensuring new costs do not enter the system**
- **Supported that the additional capacity at Worcestershire Royal Hospital (WRH) and the Alexandra Hospital needs to be contained to the agreed plans.**

228/15 **GOVERNANCE**

228/15/1 **Review of Board Assurance Risks**

The Chairman invited the interim Chief Nurse to outline the key aspects relating to the covering paper to the BAF risks. The Interim CNO outlined the changes that she was proposing to the BAF which included the merging of 4 risks and the inclusion of a new risk on performance. She confirmed that she had discussed the BAF with the buddying Trust who had suggested that the BAF and corporate risk register should be presented less frequently to the Trust Board. There was a general view that the proposed reporting frequency of quarterly was insufficient and the Interim CEO agreed to review the suggested timings at the executive management team.

Finally the Interim CNO stated that in future, the actions within the BAF will be shown in the PCIP.

The Chairman then led a discussion about the risks as outlined below:

Risk	Update
2665 – if we do not achieve wider service redesign in a timely way we will have inadequate numbers of clinical staff to deliver quality care	This was discussed under the FOASHW agenda item.
2668 – if plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support services	This was discussed under the F&P agenda item.
2678 – if we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels	• Successful recruitment event • Turnover up – work being undertaken on reasons for this • Internal nurse bank to be introduced. • Extensive work being undertaken with the University. • Trust-wide 'pulse surveys' being introduced • OD programme in development
2790 – As a result of high occupancy levels, patient care may be compromised and access targets missed	This was discussed under the IPR agenda item.
2888 – Deficit is worse than planned and threatens the Trust's long term financial sustainability	It was agreed that the future financial sustainability should be discussed
2891 – If the Trust does not learn from mortality reviews this knowledge will not be available to support improvements to patient care	This was discussed under the QGC agenda item.
3140 – If the Trust does not pro-actively manage its reputation, regional confidence and recruitment will be adversely affected	Agreed that communications would be agenda item for April meeting in respect of staff engagement
3038 – If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care	This was discussed under the QGC agenda item.
2894 – Failure to enhance leadership capability resulting in poor communication reduced team working and delays in resolving problems 2893 – Failure to engage and listen to staff leading to low morale, motivation and productivity	Targeted resource obtained for leadership development. Agreed to review risk rating as a result of the staff survey
2895 – if we do not adequately understand and learn from patient feedback we will be unable to deliver excellent patient experience	This was discussed under the QGC agenda item.
2902 - If the trust does not achieve safety targets, it will fail to improve clinical care and reduce avoidable harm to expected levels	This was discussed under the QGC agenda item.
2932 – Turnover of Trust Board members	This was discussed under the CEO

adversely affecting business continuity and impairing the ability to operate services	report agenda item.

Resolved that:-
The Board
- **Noted the changes to the BAF**
- **Reviewed the risk ratings, controls, assurance and mitigating actions and considered if these were reasonable**
- **Approved the risk updates**

DATE OF NEXT MEETING
The next Trust Board meeting will be held on Wednesday 6 April at 09:30 in the Alexandra Hospital Board Room, Redditch

Mr Burbeck thanked the Chairman for his work for the Trust over the last few years. He recalled that when he became chair in 2010, the Trust was very different. He had given very clear leadership and had instigated the PRIDE values within weeks of taking up office. He was also instrumental in the commissioning of the Oncology Unit and the refurbishment of the building for the new Breast Unit. Mr Burbeck reflected that the CQC report in 2011 gave significant criticism of some of the care delivered which was completely reversed in the most recent CQC report which reported the Trust as 'consistently Good' for care given.

He wished the Chairman the very best for the future.

The meeting closed at 12:05 hours

Signed _____   **Date** _____
        John Burbeck, Acting Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT 6 APRIL 2016

RAG Rating Key:

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

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
02-03-16	CEO report	222/15	Mr Sharma to present to the Trust board	KS	April 2016		On the agenda. Mr Sharma is presenting the patient story for April	
02-03-16	CEO report	222/15	Staff survey – action plan	DH	April 2016		On agenda	
02-03-16	IPR	223/15/1	Discuss medically fit for discharge at F&P	RM	April 2016		Transferred to F&P. Also see PCIP	
02-03-16	BAF	228/15/1	Discuss future financial sustainability	CT/RC	April 2016		Transferred to F&P for initial discussion	
02-03-16	BAF	228/15/1	Communications to be an agenda item in April	LT	April 2016		On agenda – staff engagement (staff survey item)	
03-02-16	Financial Performance Report	14/16/2	Re. adverse variance on non-pay. The Interim DF agreed to email Mr McGinity with an analysis of this transaction.	RC	Mar 2016		This has been discussed at F&P. Closed	
03-02-16	CIH report	11/16/3	The Interim CNO agreed to notify Mr Burbeck by email regarding the 2 outstanding matters to be completed (page 4 of the report).	MG	Mar 2016		Completed	

03-02-16	PCIP	11/16/2	PCIP to include a tab for women and children services showing actions at the local level.	SS	Mar 2016		PCIP being revised.	
9-9-15	BAF risk	117/15/1	Review OD strategy at a future board development session	DH	March 2016		Completed.	
9-9-15	CEO report	116/15	Baseline assessment and audit for seven days services	RM	Mar 2016	May 2016	Executive Team developing a proposal on 7-day services for discussion at the May Board meeting. The Interim COO agreed to circulate the baseline audit undertaken which set out the services already being provided 7 days a week.	
03-02-16	PCIP	11/16/2	Director of HR will look into improved methods for capturing exit information at source and capturing centrally	DH	Apr 2016			

Date of meeting: **6 April 2016** **Enc C1**

Report to Trust Board

Title	Chairman's Report
Sponsoring Director	**John Burbeck, Interim Chairman**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is recommended to: • Note and approve the proposed changes to the chairs and membership of the committees • Note the appointment of Bryan McGinity as Vice-Chair.
Previously considered by	Not applicable

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	√
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	√

Related Board Assurance Framework Entries	None.
Legal Implications or Regulatory requirements	None
Glossary	

Key Messages
This report provides a proposed update to the NED responsibilities.

Title of report	Interim Chairman's Report
Name of director	John Burbeck

REPORT TO TRUST BOARD – 6 APRIL 2016

1 Background

This report outlines the proposed governance changes to the Trust Board, with effect from April 2016.

2 Proposed changes

The Trust Board subcommittees are chaired by non-executive directors. I am proposing a series of changes to strengthen the challenge and rigour of the committees.

3 Proposed changes to the chairs and membership of the Board Committees

I am proposing the following changes to the Board subcommittees:

Committee	Proposed change
Audit and Assurance	Bryan McGinity to chair Members: Andrew Sleigh and Stephen Howarth
F&P	Andrew Sleigh to Chair Members: Bryan McGinity and John Burbeck
Strategy and Transformation	Andrew Sleigh to chair (new committee) with Stephen Howarth as a member

The changes outlined are shown in summary form overleaf.

I am delighted that Lynne Todd has agreed to carry on as the Board Advisor for Quality and Women and Children until September 2016.

4 Vice Chair

I have appointed Bryan McGinity to acting vice-chair until a new chair is appointed.

5 Recommendations

The Board is recommended to:
- Note and approve the proposed changes to the chairs and membership of the committees
- Note the appointment of Bryan McGinity as Vice-Chair.

John Burbeck
Interim Chairman

Title of report	Interim Chairman's Report
Name of director	John Burbeck

Worcestershire **NHS**
Acute Hospitals NHS Trust

NON EXECUTIVE DIRECTOR & EXECUTIVE DIRECTOR COMMITTEE ALLOCATION

COMMITTEE	NON-EXECUTIVE DIRECTOR	EXECUTIVE LEAD	SUPPORT	FREQUENCY
Audit and Assurance Committee	**Bryan McGinity, Chair** Andrew Sleigh, Vice-Chairman Stephen Howarth	Rob Cooper (Interim)	Company Sec	7 x year
Charitable Funds Committee	**Andrew Sleigh**, **Chair** Bryan McGinity Chris Tidman (Interim) Mari Gay **or** Andy Phillips (Interim)	Rob Cooper (Interim)	Company Sec	2 x year
Remuneration Committee	**John Burbeck, Chair** Stephen Howarth Andrew Sleigh	Denise Harnin	Company Sec	When required
Quality Governance Committee	**Bill Tunnicliffe – Chair** John Burbeck Stephen Howarth Chris Tidman (Interim) Mari Gay (Interim) Andy Phillips (Interim) Rab McEwan (Interim) Steve Graystone Company Secretary	Mari Gay (Interim)	Company Sec	Monthly
Finance and Performance Committee	**Andrew Sleigh, Chair** John Burbeck Bryan McGinity Chris Tidman (Interim) Rob Cooper (Interim) Rab McEwan (Interim) Mari Gay (Interim)	Rob Cooper (Interim)	PA to Director Resources	Monthly
Workforce Assurance Group	**John Burbeck, Chair** Denise Harnin	Denise Harnin	PA to Director of HR/OD	Monthly

Title of report	Interim Chairman's Report
Name of director	John Burbeck

COMMITTEE	NON-EXECUTIVE DIRECTOR	EXECUTIVE LEAD	SUPPORT	FREQUENCY
	Mari Gay (Interim) Sarah Smith			
Strategy and Transformation Committee	**Andrew Sleigh, Chair** Andrew Sleigh Andy Phillips (Interim) Chris Tidman (Interim) Sarah Smith	Sarah Smith	PMO	TBC

Title of report	Interim Chairman's Report
Name of director	John Burbeck

Worcestershire **NHS**
Acute Hospitals NHS Trust

Title of report	Interim Chairman's Report
Name of director	John Burbeck

Report to Trust Board

Title	**Interim Chief Executive's Report**
Sponsoring Director	**Chris Tidman, Interim Chief Executive**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is asked to • Receive the assurance contained within the report • Note the terms of reference for the Improvement Board.
Previously considered by	Not applicable

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	√
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	√

Related Board Assurance Framework Entries	None.
Legal Implications or Regulatory requirements	None
Glossary	Sustainability and transformation plan (STP)

Key Messages

This report is provided to inform the Board on issues relating to the activity of the Trust and national policy that the Board needs to be aware of but which do not themselves warrant a full Board paper.

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

REPORT TO PUBLIC TRUST BOARD – 6 APRIL 2016

1   Situation
This report aims to brief Board members on various issues.

2   Background
The Chief Executive's report is provided to inform the Board on issues relating to the activity of the Trust and national policy that the Board needs to be aware of but which do not themselves warrant a full Board paper.

3   Improvement Board
I have reviewed the functioning of the Trust Management Committee. In order for the Trust to concentrate on the key improvement areas, I have put in place an Improvement Board which will meet eight times a year. TMC will continue quarterly. I am also meeting with the key senior leaders weekly to ensure that the Trust is clinically driven in its priorities.

The Improvement Board is accountable to the Executive Management Team and will report to the Trust Board via my report. The Terms of Reference for the board are shown in the appendix for information.

4   Progress on reducing Agency Spending
We continue to reduce our reliance on agency staff through our targeted action plan to improve recruitment substantively and to our bank. The agency caps have been helpful in reducing rates of pay although we continue to use agency in a number of higher risk areas at present to ensure safe staffing levels.

5   Building on the best
Worcestershire Acute Hospitals NHS Trust has been named as one a group of ten acute hospital trusts who have been selected to take part in the 'Building on the best' programme, which will support improvements in quality and experience of palliative and end of life care across the UK.

Building on the best will develop new areas of focus for improving end of life care. These will include making information more accessible to patients and their families, to enable more shared decision making; taking the opportunities offered by outpatient appointments to discuss advance and anticipatory care planning; improving the handover of information and records as people move between hospital (acute) and out of hospital (secondary care); and improving pain and symptom management.

The programme will run for two and a half years after which there will be a thorough evaluation and lessons learned will be used to contribute to improvement work on palliative and end of life care in acute hospitals across the country.

I recently visited the newly opened End of Life room on ward 12 at the Alex, which is an exemplar of what can be achieved locally by motivated staff with a clear vision.

6   Planned changes to emergency pathways and patient flow
The Medicine division continues to work on 'breaking the cycle' of patients being admitted in order for them to be assessed. In collaboration with Emergency Care Improvement Programme (ECIP) team the division is developing models of

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

assessment for admission; this will improve patient experience and flow through the hospital and the wider healthcare system including admission avoidance, timely discharges, best practice ward rounds (SAFER care bundle) and site capacity management.

Initiatives in place include:

Ambulatory Emergency Care (AEC)
Ambulatory Emergency Care (AEC) to promote the treatment of patients in an ambulatory care setting leading to enhanced patient experience including admission avoidance. AEC will be operational 9 am to 5 pm Monday to Friday.

Older Persons Liaison Service (OPAL)
The multidisciplinary OPAL service is located within the Emergency Department at WRH. This team will promote ambulatory care pathways for frail elderly patients aiming to promote independence and prevent avoidable hospital inpatient admissions.

Multidisciplinary Accelerated Discharge Event (MADE)
The third MADE initiative took place during the weekend of 18 – 21 March. This involved targeted collaborative working with the wider health economy partners on maximising discharges out of hospital settings to most appropriate care environment including patient's home.

Continued pressures on our Emergency Department
Pressure on our Emergency Departments has continued into March, with blue light ambulance conveyances up by 10% on last year. In particular the Easter Bank Holiday weekend was the busiest Friday, Saturday and Sunday on record for A&E attendances. To complement our internal work, the SRG will also be reviewing the capacity in place to try to alleviate these pressures.

7   Worcestershire Breast Unit
The formal launch of the Worcestershire Breast Unit took place on 22 March. This was covered by a range of media including local papers, radio and TV. The tweets about the Unit were viewed by 4300 people and the Facebook posts reached over 2000 people. The post by BBC Midlands Today on their Facebook page had nearly 13,000 views.

8   Future of Acute Hospital Services in Worcestershire
At the Programme Board on 17 March, the timeline was confirmed for proceeding to consultation. Firstly the West Midlands Clinical Senate have agreed three dates for site visits to the trust which are Monday 21 April, Tuesday 3 May and Monday 16 May after which we can expect their final report at the end of May. It is then intended that the NHS England assurance process commences and, subject to a satisfactory level of assurance, it is currently planned that public consultation will commence at the beginning of September 2016. The programme board recognised the fragility of some of the affected services and will continue to monitor the risk mitigation through the Quality and Sustainability Subgroup.

9   Junior Doctors – Strike Action
It is regrettable that further industrial action has been announced which will inevitably mean that many patients will see their care disrupted. Contingency plans remain in

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

place although the proposed withdrawal of emergency cover on 28-29 April will require some additional measures to be implemented.

10   Improvement Board (9-3-16)
10.1   Urgent Care/patient flow
The Director of Operations (Medicine) presented the project plan for this work stream. The project structure was agreed. A detailed discussion was held in relation to the proposed metrics and an additional metric of 'home by lunchtime/discharge lounge by 10am. Concern was expressed about the lack of roll out of the SAFER bundle and actions were agreed to revitalise this.

The medical rota to cover ambulatory care has been developed and will be operational from 14 March. Ambulatory care will be based on Mulberry and the Trust expects to stop 20-30% of admissions. Mulberry is an outpatient area and will consist of chairs not beds or trolleys. An internal communications strategy is planned.

The Trust is putting in place a geriatrician at the front door of A&E to support the assessment of elderly frail people with the aim of avoiding admission.

Finally there was a meeting on the 24 March to better incorporate the development of the Patient Flow Centre into the Trust's processes with the aim of streamlining the discharge pathways.

10.2   Mortality
The Improvement Board will drive the operational execution of the actions needed to reduce mortality. QGC will still need to provide the assurance to the Trust Board about the progress of reducing mortality.

There are four work streams - reviews, sepsis management, fractured neck of femur (time to theatre) and NEWS (establishing best practice in the management of the deteriorating patient). Leads are currently being sought for sepsis management and NEWS.

Metrics for monitoring the success of this work stream were agreed. Extra management support for the work stream was also agreed.

10.3   Organisational Development and Staff Engagement
This work stream combines the CQC actions and the actions needed arising from the Good Governance Institute. There are seven project areas:

 Effective leaders: A strategy is being developed to ensure that we support the development of leaders.
Training: There will be a review of all training programmes including commissioning the band 4 assistant practitioner role and ensuring the physician associate role is embedded within the Trust.
Culture: This incorporates the Big Conversation and the embedding of PRIDE values.
Engagement and Communication: Internal Chat back survey programme which will survey all staff on a regular basis will commence in April 2016. Listening into Action will roll out shortly.
Clear HR policies: This is in relation to raising concerns including an updated Dignity at Work Policy and revision of the induction programme.

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

Workforce plans: This includes reasons for leaving the Trust as well as the development of new roles (band 4 and physician associates)

Patient safety and service improvement culture: Induction has been reviewed and resources have been secured for the roll out of Human Factor training.

10.4 Operational updates

Emergency surgery: surgical rotas are now developed

Vascular and Surgery HDU: The project team has now been set up and have met. Work is on-going in response to the CQC report and a baseline audit is underway in respect of numbers of level 1 and level 2 patients.

Outpatients: Project team has met and the lead is the deputy COO. The team will look at booking processes and room allocation as well as referral management. It was agreed that key to transforming outpatients is the culture within outpatients and this will be considered.

Diagnostics: Robust checking mechanisms are can now be evidenced within radiology. New appointments have been made to ensure better leadership within the area.

Maternity: This project team was set up in reaction to the CQC report. Most of the actions within the PCIP are now business as usual. Further metrics are now being developed.

Governance and safety: Good progress has been made within all areas. An action in respect of learning will be included on the action plan. This is managed though QGC.

10.5 CQC Inspection

The Trust will coordinate a mock inspection in mid-May. Additionally there will be two mini inspections of A&E and women and children. The quality review visit process has been revamped and inspections have recommenced. Quality champions have been formalised and further work is being undertaken.

10.6 GP led Intermediate Care service

The Trust is working closely with Wyre Forest CCG over the redesign of the GP led Intermediate Care service with the aim of creating a community based alternative to the current GP ward. This is the right thing to do although it is clear from stakeholder feedback that the patients and carers will wish to be involved in the new service. We expect to see proposals by the end of May.

11 National Update
11.1 Review of deaths

All deaths to be independently reviewed from 2018 and a new "Healthcare Safety Investigation Branch" will operate from April this year.

11.2 NHS England announces new action to cut stillbirths

NHS England has published new guidance to reduce stillbirths in England. The new guidance, called Saving Babies' Lives Care Bundle is part of a drive to halve the rate of stillbirths from 4.7 per thousand to 2.3 per thousand by 2030, potentially avoiding the tragedy of stillbirth for more than 1500 families every year.

12 Recommendation

The Board is asked to
- Receive the assurance contained within the report
- Note the terms of reference for the Improvement Board.

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

Worcestershire NHS

Acute Hospitals NHS Trust

Terms of Reference

Improvement Board

Version: 1.0

Terms of Reference approved by: Improvement Board

Date approved: 9-3-16

Author: **Company Secretary**

Responsible directorate: CEO

Review date: September 2016

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Terms of Reference

1. Introduction

This Committee will act as a subcommittee of the Trust Executive Management Team and is set up to develop, action and monitor the Trust's Improvement Plan as well as provide oversight to the preparation for the repeat CQC visit in 2016.

2. Membership

Chief Executive
Chief Medical Officer
Chief Nurse
Deputy Chief Nurse
Director of Strategy, Planning and Improvement
Director of HR and OD
Director of Communication
Chief Operating Officer
Improvement Director
Divisional Medical Director (Medicine Division)
Divisional Director of Operations (Medicine Division)
Divisional Medical Director (W&C) (or nominated representative)
Divisional Medical Director (TACO-CS) (or nominated representative)
Divisional Medical Director (Surgery) (or nominated representative)
AMD – Patient Safety and Quality
Associate Director – Training
Director of Asset Management, IT and Estates

In attendance:
- Company Secretary
- Head of Transformation
- Head of Information

Membership will be kept under review and if necessary other members will be co-opted according to the Improvement Plan agenda.

Papers will be received by the Director of Finance.

3   Arrangements for the conduct of business

3.1   Chairing the meetings

The CEO will chair the meetings. In the absence of the CEO, the Chair will be the Director of Strategy, Planning and Improvement.

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

3.2   Quorum
The Group will be quorate when 5 members are present, including one clinician.

3.3   Frequency of meetings
The Committee will meet eight times a year.

3.4   Frequency of attendance by members
Members are expected to attend each meeting, unless there are exceptional circumstances.

3.5   Declaration of interests
If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the subject consideration has been completed. All declarations of interest will be minuted.

3.6   Urgent matters arising between meetings
If there is a need for an emergency meeting, the Chair will call one in liaison with the clinicians.

3.7   Secretariat support
Secretarial support will be through the CE secretariat and a summary of the discussions will be presented to Trust Board via the CEO report.

4   Authority
The Committee is authorised by the Trust Board.

5   Purpose and Functions
5.1   Purpose
The purpose of the Board is to develop, monitor and action the Trust's Improvement Plan. The Board will also oversee the preparation for the CQC repeat visit in 2016.

5.2   Duties
In discharging the purpose above, the specific duties of the PRB are as follows:
- Receive the following Improvement plans monthly
    - Urgent Care/Patient Flow
    - Avoidable mortality
    - OD and staff engagement
- Agree future actions in relation to the above Plans
- Receive an update on the following improvement plans monthly via the COO:
    - Emergency surgery
    - HDU
    - Outpatients
    - Diagnostics

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

- Receive an update on the following improvement plans monthly via the CNO
    - Governance and Safety
    - Maternity
- Plan and implement a programme to oversee the CQC visit planned for the Autumn of 2016
- Develop and implement appropriate communication strategies (internal and external) to support the work streams.

6.   Relationships and reporting
6.1   The Committee is accountable to the Trust EMT and will report to Trust Board via the CEO report.

7   Review of the Terms of Reference
These Terms of Reference will be reviewed in September 2016.

KS/SS/ToR IP final
March 2016

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

Worcestershire **NHS**
Acute Hospitals NHS Trust

6 April 2016   **Enclosure D1**

Report to Trust Board in Public

Title	Trust Operational Plan 2016/17
Sponsoring Director	Sarah Smith, Director of Planning and Development
Author	Sarah Smith, Director of Planning and Development
Action Required	The Board is asked to approve the final draft of the Trust operational plan for 2016/17, subject to further minor changes in advance of the April 11th submission to NHS Improvement.
Previously considered by	

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	√
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	√

Related Board Assurance Framework Entries	The operational plan is informed by and underpins the Board Assurance Framework and delivery against the Trust strategic objectives.
Legal Implications or Regulatory requirements	
Glossary	

Key Messages

1. The Trust operational plan 2016/17 has been developed in response to joint planning guidance issued NHS England and the then Trust Development Authority (now NHS Improvement) in December 2015.

2. A one year operational plan is required from NHS organisations in April 2016, in line with the development of a 5 year Sustainability and Transformation Plan (STP) for the local area in July 2016. The STP planning footprint for Worcestershire Acute Hospitals NHS Trust is Herefordshire and Worcestershire.

3. The Worcestershire Acute Hospitals NHS Trust 2016/17 Operational Plan has been developed following feedback from an earlier draft submission in February 2016

Title of report	Trust Operational Plan 2016/17
Name of director	Sarah Smith

and a confirm and challenge meeting with the TDA in March 2016.

4. The Trust operational plan is the route through which the Trust will access the 2016/17 £1.8bn national sustainability fund. The Trust has been allocated £13.1m from the fund should the necessary conditions be met and this is assumed in the operational plan although confirmation has yet to be received.

5. The Trust operational plan is presented to the Board for approval pending further minor changes to the workforce information following finalisation of the detail in the financial savings plans.

Title of report	Trust Operational Plan 2016/17
Name of director	Sarah Smith

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – APRIL 2016

1.   Situation

The Trust is required to develop an operational plan for 2016/17 for submission to NHS Improvement on April 11th 2016.

2.   Background

Joint planning guidance was issued by NHS England and the then Trust Development Authority (now NHS Improvement) in December 2015.

All NHS non-foundation acute Trusts are required to submit one year operational plans for 2016/17 including plans for activity, quality, workforce and finance that support the emerging 5 year Sustainability and Transformation Plan (STP) for their local area. The STP planning footprint for Worcestershire Acute Hospitals NHS Trust is Herefordshire and Worcestershire.

The 5 year STP is the vehicle for unlocking access to transformation funds in future years and, in year one, the Trust operational plan and in particular the financial plan and the key performance trajectories is the route through which the Trust will access the 2016/17 £1.8bn national sustainability fund. The Trust has been allocated £13.1m from the fund should the necessary conditions be met and this is assumed in the operational plan although confirmation has yet to be received.

The first draft 2016/17 operational plan was submitted as required on February 8th 2016 and the final plan has been developed incorporating feedback from the draft plan submission and from the operational plan confirm and challenge meeting held with the TDA on March 4th 2016.

Alongside the financial and quality challenges the Trust is experiencing, workforce was highlighted as a risk for the organisation in terms of both the levels of agency expenditure and the development of a sustainable workforce through improved recruitment, retention and skill mix.

The Trust faced significant challenges in 2015/16 and has identified the following priorities for 2016/17:

1. **Delivering better performance and flow**, by supporting the Medicine Division to;
   – to create a sustainable countywide strategy
   – to deliver ambulatory care to avoid admission
   – to reduce the number of stranded patients

2. **Improving safety** by;
   – learning from incidents and harm reviews in a 'no blame' culture
   – reconfiguring fragile services

Title of report	Trust Operational Plan 2016/17
Name of director	Sarah Smith

- – reducing overcrowding and occupancy levels
- – making data transparent to expose variability

3. **Investing in our staff** to;
   - – find solutions through teamwork
   - – develop new roles, improve recruitment and retention and to reduce reliance on agency staff
   - – become our ambassadors and to promote our organisation

4. **Stabilise our finances** by;
   - – delivering priorities 1 - 3
- – managing to budget and delivering better value for money

3.   Assessment

The Trust operational plan is presented to the Board for approval pending further minor changes to the workforce information following finalisation of the detail in the financial savings plans.

4.   Recommendation

The Board is asked to approve the final draft of the Trust operational plan for 2016/17, subject to further minor changes in advance of the April 11th submission to NHS Improvement.

Sarah Smith
Director of Planning and Development

Title of report	Trust Operational Plan 2016/17
Name of director	Sarah Smith

Worcestershire Acute Hospitals NHS Trust

Operational Plan 2016/17

Introduction

The document sets out the operational plan for 2016/17 for Worcestershire Acute Hospitals NHS Trust.

2015/16 was a very challenging year for the Trust, with at the start of the year, unannounced visits to the Trust's emergency departments (ED) by the Care Quality Commission (CQC) following concerns about safety and performance due to overcrowding.

Early in the year, the Trust also experienced a considerable change in personnel at Board level, and it is noteworthy that significant operational stability was restored rapidly.

The Trust enters 2016/17 with a major challenge around its financial position. Primarily this is a result of on-going issues with patient flow and bed occupancy and the need to open and staff additional non-elective bed capacity, leading in turn to a reliance on premium rate temporary staffing. This also impacts negatively on the delivery of the elective programme and on income levels. The Trust's financial position is also adversely affected by the delay in reaching agreement on the reconfiguration of acute services in Worcestershire and the centralisation of key acute services at the main emergency centre at Worcestershire Royal Hospital (WRH). Towards the end of 2015/16 this came closer to resolution however the Trust continues to double – run the majority of services at its acute sites.

The Trust has some quality improvement challenges. In July 2015, the Trust received its announced visit from the Care Quality Commission (CQC) Chief Inspector of Hospitals team. Following the inspection itself, the Trust started to tackle the main issues fed back directly from the inspection team; in particular in respect of governance systems within the Trust's Maternity services. The inspection report was published in December 2015 and the Trust was placed in special measures after receiving an inadequate rating overall, due to inadequate ratings in the well-led and safety domains. These domain ratings were driven by the CQC's assessment of Women's and Children's services at both WRH and the Alexandra General Hospital (AGH) Redditch and specific concerns relating to Medicine at WRH and Surgery at AGH (there is recognised need to centralise all emergency general surgery at WRH). A Patient Care Improvement Plan (PCIP) has been developed to drive the sustained improvements the Trust needs to make to improve the care it provides and to leave the special measures regime.

Engagement of staff from ward to Board is fundamental to improving the quality and safety of care across all Trust sites. It is testament to staff that despite the challenges the Trust has faced; the CQC found the staff approach to caring for patients to be good and in some cases outstanding, and the Trust must build on this going forward, especially in light of the disappointing results for the Trust from the recently published 2015/16 National Staff Survey.

The key Trust priorities for 2016/17 are:

1. **Delivering better performance and flow**, by supporting the Medicine Division to;
   – to create a sustainable countywide strategy
   – to deliver ambulatory care to avoid admission
   – to reduce the number of stranded patients

2. **Improving safety** by;
   – learning from incidents and harm reviews in a 'no blame' culture
   – reconfiguring fragile services
   – reducing overcrowding and occupancy levels
   – making data transparent to expose variability

3. **Investing in our staff** to;
   – find solutions through teamwork
   – develop new roles, improve recruitment and retention and to reduce reliance on agency staff
   – become our ambassadors and to promote our organisation

4. **Stabilise our finances** by;
   – delivering priorities 1 - 3
   – managing to budget and delivering better value for money

The Operational Plan for 2016/17 is set out under the following headings:

1. Activity planning
2. Quality planning
3. Workforce planning
4. Financial planning
5. Sustainability and Transformation Plan

1. Activity Planning

1.1 Demand and capacity planning

1.1.1 Emergency care

Lack of appropriate capacity (both physical capacity and early senior decision-making capacity) is an on-going and major limiting factor for the Trust in achieving its goals; impacting on finance and on the quality of care.

Throughout 2015/16, the Trust has experienced significant levels of stranded patients (defined as any patient, regardless of age, who has been in a 'therapeutic/assessment bed' for 7 days or more). In this respect, from figure one it can be seen that in March 2016, the Trust is an outlier.

Figure One – Trusts in the Emergency Care Improvement Programme, levels of non – elective stranded patients (w/e 27/03/16).

Weekly proportion of beds occupied by Emergency Stranded patients (Not available at Site level)
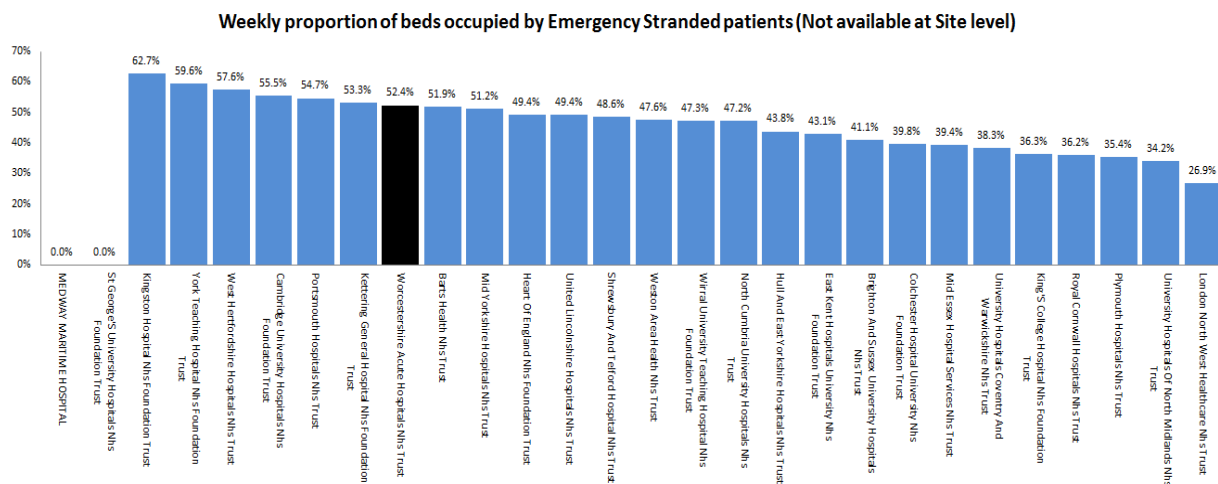
In the 2015/16 operational plan, the System Resilience Group (SRG) agreed £1m funding for sub-acute capacity, which translates into one additional ward for six months. In reality, as a result of the high levels of bed occupancy and bed days associated with poor patient flow, the Trust has utilised additional capacity throughout the year with at its peak, three additional wards open and multiple medical patients outlying on surgical wards, which has in turn impacted on the delivery of the planned elective programme.

Over the past two years, the Trust has seen some increases in emergency demand. There was a step change in the yearly average ambulance attendances between 2013/14 and 2014/15 and between 2014/15 and 2015/16. Walk in attendances showed a similar pattern but the increases were greater in terms of ambulances

Worcestershire as a health and social care economy is part of the Emergency Care Improvement Programme (ECIP) and from Q4 2015/16 onwards has been receiving support with the implementation of the SAFER patient flow bundle, review of the system-led patient flow centre and the development of more ambulatory emergency care including frailty assessment. High levels of bed occupancy in itself leads to delays and inefficiencies as patients are often not able to access the right bed first time.

In light of the ECIP concordat, the Trust will work intensively with partners to address the issues with patient flow and to develop a trajectory for a reduction in the number of stranded patients at the Trust. This work is embedded in the Patient Care Improvement Plan and this must be delivered early in 2016/17. The Trust will reframe budgets in the second half of the year to reflect any realignment of capacity.

Through the 2016/17 contract negotiations, the Trust will seek to ensure funded capacity to manage emergency surge pressures and will develop surge workforce plans aligned with this.

In addition to these immediate capacity problems, the Trust has worked with partners in health and social care to develop an agreed longer term bed model for the county based on a shared set of demand assumptions. This model has identified under a range of planning

scenarios, an underlying shortfall in the number of acute beds at the Worcestershire Royal Hospital site.

A parallel model based on the same set of planning assumptions has been used to model the further impact on the WRH site from the centralisation of obstetrics and neonatal services, emergency general surgery and inpatient paediatrics under the acute services reconfiguration programme. A business case is being prepared for approval in 2016/17 for additional capacity at WRH in line with this joint commissioner/provider clinical strategy.

1.1.2 Elective care

In the 2015/16 operational plan, the Trust modelled at a high level, the bed, theatre and outpatient capacity required to deliver the activity plan (including the use of the independent sector). In addition, with the agreement of commissioners, Trust divisions and directorates used the NHS IMAS tool to estimate the RTT capacity in admitted and non-admitted elective care to meet planned demand including the backlog to be cleared to sustainably deliver national, and locally agreed, waiting time standards. These plans however were impacted on by the in-year capacity problems described above and by a significant increase in referrals from GPs in some non–admitted care pathways such as Dermatology and Oral Surgery, with Oral Surgery also facing pressure on the admitted care pathway.

The 2016/17 work programme will identify an initial tranche of key specialties for an urgent assessment of capacity and demand to maximise efficiency and to ensure the sustainability of services. This will include Dermatology where the Trust currently loses the vast majority of the income in contract penalties due to a significant mismatch between capacity and demand. Further work will be undertaken around zero - basing these targeted specialties through the first half of 2016/17. Importantly, this should support an on-going reduction in the level of ad-hoc additional activity sessions that incur additional costs for the Trust and may inconvenience patients due to short notice of attendance.

The activity plan for 2016/17 otherwise remains demand focussed however, in keeping with the national drive to base activity plans on available capacity, the Trust is establishing a work programme to more robustly embed capacity planning. A number of finance and planning staff attended the regional demand and capacity workshop in January 2016 and a rolling training programme will be established to ensure all specialties have consistent tools to be able to undertake demand and capacity planning as "business as usual".

1.2 Planning assumptions and activity plan

The Trust is working on an 'open book' basis with commissioners, and has an agreed a baseline for 2016/17 based on 2015/16 forecast outturn, and a growth factor of 2% to be applied.

There is no indication from commissioners around any top-slice other than CQUIN and limited detail on any commissioning policies and QIPP schemes they may wish to apply.

Initial high level activity assumptions are as in Table One below.

Table One – 2016/17 activity based on 2015/16 outturn plus 2% growth

	AGH	KTC	WRH	Other	Total
Day case	15,862	20,764	28,783	1,400	66,808
Elective Inpatient	4,590	766	4,226	0	9,582
Non Elective Inpatient	19,252	39	30,528	0	49,820
Maternity Inpatient	[2,244]	0	5,320	0	7,564
Outpatient exc Maternity	110,353	95,588	225,124	20,036	451,101
Maternity Outpatient	12,706	10,842	19,342	1,794	44,684
A&E Attendances inc MIU	51,540	27,256	66,567	35,211	180,574

Previously, due to capacity constraints, the Trust has contracted with the independent sector, primarily around endoscopy activity however this will be reviewed in 2016/17 in line with a demand and capacity review and any opportunities from acute service reconfiguration.

1.3 Delivery of operational performance standards

The Trust is committed to delivering strong operational performance and ensuring safe, high quality, efficient services, which provide a good experience for the patient and their families.

Emergency demand and the increased acuity of patients, the lack of available capacity and flow within the Trust and within the health and social care system, have been significant challenges in 2015/16 and have been major limiting factors for the Trust achieving optimal operating performance and quality of care.

Nonetheless, through improved internal management processes the Trust in Q3 2015/16 met the national RTT incomplete pathway standard and made some inroads into the backlog of long waiters. The 62 – day cancer waiting time standard was also met in December 2015 and January 2016. In Q3 2015/16, the emergency access standard (EAS) was above 90% for the first time in over 12 months. Performance in these key measures declined in February and March 2016 due to significant capacity constraints.

To support delivery of the elective programme, the Trust has moved a significant tranche of elective orthopaedic work off the WRH site to AGH and has plans to also transfer inpatient breast services and some elective gynaecology services to the Redditch site. The transfer of emergency surgery from AGH to WRH in 2016/17 (alongside the acute services reconfiguration programme), will be supported by the development of an ambulatory surgical care model at AGH to reduce further the reliance on bed capacity.

The Trust continues to work in partnership with stakeholders in the System Resilience Group, and has participated in reviews of urgent and emergency patient pathways and patient flow from both ECIST and ECIP. This work is key to unblocking flow out of the emergency department (ED), which impacts on the timely assessment and treatment of patients in ED, and the achievement of the 4 hour emergency access standard.

In addition to the above, through the 2016/17 contract negotiations, the Trust will seek to ensure funded capacity to manage emergency surge pressures to reduce the impact on the core elective programme.

The Trust will seek to address the specific capacity challenges in some key elective pathways through demand and capacity modelling and where indicated, the management of demand through referral caps or other such approaches.

The Trust has a number of key performance standards which in line with planning guidance require accelerated action during 2016/17 as set out below:

Performance standard	Trajectory
Emergency Access Standard (EAS) – target - at least 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival in A&E	- Q1 2016/17 90.00% - Q2 2016/17 92.00% - Q3 2016/17 91.00% - Q4 2016/17 90.00%
RTT Incomplete - target 92% treated within 18 weeks	- Q1 2016/17 91.07% - Q2 2016/17 91.66% - Q3 2016/17 92.00% - Q4 2016/17 92.00%
Compliance with maximum 62 day wait for first definitive treatment for cancer – target 85% of patients referred as urgent by their GP	- Q1 2016/17 82.10% - Q2 2016/17 84.40% - Q3 2016/17 85.00% - Q4 2016/17 85.00%
Diagnostic waiting times – target no more than 1% of patients waiting 6 weeks or more for diagnostic tests	- Q1 2016/17 1.17% - Q2 2016/17 1.00% - Q3 2016/17 1.00% - Q4 2016/17 1.00%

These trajectories are based on a range of assumptions including improvements in patient flow and the management of demand as described above.

The above areas of performance are reported monthly to the Finance & Performance Committee, where plans are reviewed.

2. Quality Planning

2.1 Approach to quality improvement

2.1.1 Methodology

Towards the end of 2014/15 the Trust received unannounced visits from the Care Quality Commission (CQC) at the two ED departments at WRH and AGH. This followed concerns raised around the quality and safety of care in these departments, due to unprecedented levels of pressure on service capacity over the winter period. A number of immediate improvements were made and plans were developed to address in the short to medium term, the issue of delays and overcrowding, especially in the ED at WRH.

The Trust also underwent its planned inspection by the Chief Inspector of Hospitals and team in July 2015. The Trust received its inspection report in December 2015 and, as a result of receiving a rating of inadequate in two out of the five inspection domains, was placed in special measures. These ratings were driven by the assessment of Women's and Children's services at both WRH and AGH, in addition to specific concerns relating to Medicine at WRH and the sustainability of Surgery at AGH

CQC Inspection Rating	Safe	Effective	Caring	Responsive	Well-led
Worcestershire Royal Hospital	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate
Alexandra General Hospital	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate
Kidderminster Treatment Centre	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Evesham Community Hospital	Good	Good	Good	Good	Good
Trust Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate

Following the informal feedback at the end of the CIH inspection week in July, the Trust developed a follow – up action plan based on the improvement requirements communicated at that stage. In particular there was an executive focus on governance systems and processes in the Trust's maternity services. Of the 33 actions in the CIH immediate follow – up action plan 31 had been completed by the time of the Quality Summit in November 2015.

Following publication of the final CQC CIH report in December 2015, the Trust developed fully a patient care improvement plan (PCIP) setting out the priority improvement goals and 'must do' actions to meet the CQC fundamental quality standards for NHS organisations.

Within the PCIP there are three priority improvement plans relating to urgent care & patient flow, reducing mortality and organisational development & staff engagement. There are also a set of divisional level operational improvement plans and a set of governance improvement plans. These include plans around governance and safety, women and children's services, outpatients, high dependency care in surgery and emergency surgery centralisation. Delivery of these plans is governed through an Executive Improvement Board that meets monthly (see figure two).

Through the Improvement Director, the TDA (now NHS Improvement) is supporting the Trust and the PCIP leads, to ensure that the PCIP is robust, live and sufficiently improvement focussed. Recently the PCIP has been refreshed to ensure that the improvement plans are built 'bottom up' and that project plans are developed in granular detail including key milestones and 30/60/90 day improvement actions. Reporting is based on key project metrics to provide evidence of sustained improvement

<u>Figure Two – Patient Care Improvement Plan</u>

Executive Improvement Board

Trust Improvement Plan

**Urgent Care and Patient Flow
Avoidable Mortality
Organisation Development / Staff Engagement**

Operational Improvement Plans		Governance Improvement Plans	
Outpatient Strategy	**HDU Review Emergency Surgery Reconfiguration**	**Women and Children's Improvement Plan**	**Governance and Safety Action Plan**
TACO/CSS Division	**Surgery Division**	**W&C Division**	**All Divisions**

In addition to the development of the PCIP, the Trust has secured 'buddying' arrangements with other hospital Trusts. For example, the Trust has engaged with Birmingham Women's Hospital to secure support from its former Medical Director in delivering the early and significant improvements in maternity services at the Trust. The Trust is now developing a buddy contract with Birmingham Women's and Birmingham Children's NHS FT's around reviewing its current improvement plan and extending this to ensure that the Trust is following best practice across its maternity, neonatal and paediatric services. There has already been an external governance review in maternity and the Trust has also engaged with Oxford University Hospitals NHS Foundation Trust to provide support for the development of Trust - wide governance arrangements and processes.

The Trust recognises that in terms of the CQC well – led framework, as well as strengthening our governance and assurance processes there is a significant amount of work to do to engage staff in the vision and priorities for the Trust and to develop the leadership at all levels within the Trust for a culture of improvement, quality and safety. To this end, the Trust has already employed the recognised Medical Engagement Survey (MES) and is receiving support around other aspects of its organisational development framework. In April 2016 the Trust will launch Listening into Action (LiA) to develop the capacity and capability to improve across all the spans and layers of the organisation. These

developments are being led by the Chief Executive with the full engagement of the Trust Board and the Executive Team.

The Trust anticipates that it will be re inspected within 12 - 18 months of the original inspection date and is making preparations through the Improvement Board, the Trust Quality Champions and mock inspections.

The Trust has an established Quality Strategy that includes the improvement methodologies that the Trust has adopted. A range of methods for improvement are applied to information arising from sources including:

- Root cause analysis (RCA) investigations for incidents and complaints
- Clinical Audit
- Patient and carer feedback
- Invited peer reviews
- Self-assessment and external validation of compliance with standards
- Internal and external reports
- Analysis and triangulation of quality data to determine the relationships between them and to allow targeted action to address the root cause

The ability to measure quality is key to improvement and the Trust has developed and utilises a range of indicators and a dashboard presentation to show performance. As part of the PCIP governance and safety action plan, there has been prompt action and the Trust has reviewed and improved reporting systems and information flows to ensure floor to Board reporting on the key quality performance indicators. Through weekly operational governance meetings, the Trust has improved systems for recording and learning when things go wrong.

The development of the PCIP has exposed a general lack of awareness around the key principles of improvement planning and PCIP leads at the Trust have received training and have on-going coaching support for project planning to ensure that they have the necessary tools to deliver sustained improvement in performance.

The Trust employs a range of other improvement methods including:
- Continuously learn and improve culture set by the Board
- Values - based recruitment
- An improvement model based on LEAN and the Institute of Healthcare Improvement's Plan-Do-Study-Act cycle.

The Trust has developed a rolling programme of Human Factors training that started with the TACO Division that embraced the training in support of delivering consistently high levels of compliance with the WHO Surgery Checklist. Human factors training will be rolled out across the whole organisation in 2016/17.

2.2 <u>Seven day services</u>

The Trust has a strong focus on avoidable mortality through the PCIP and this will extend to participation in 2016/17 in the publication of avoidable mortality rates by individual Trust. There is a work stream within the Reducing Mortality PCIP that is focussing on the roll out of the National Early Warning Score (NEWS) to all clinical areas.

There are already some enhanced and innovative services in place to maintain patient flow seven days a week, including diagnostic support services extending into the evenings and at

weekends, the weekend pharmacy service and the nationally recognised pharmacist in A&E initiative.

The Trust has recently commenced a Consultant – led ambulatory emergency care service and a frailty assessment service that supports comprehensive 'front door' geriatric assessment by Consultant Geriatricians and a therapies-led older people's assessment and liaison service (OPAL) in the ED. Although over-reliant on temporary locum staff at present, the Trust has introduced more senior review capacity into the EDs at peak times including early evenings and weekends.

In line with the commitment to achieving seven day services, the Trust has convened a Medical Workforce Assurance Group and is developing a progressive medical workforce plan and reviewing all of its Consultant job plans. The Trust has experienced chronic recruitment difficulties in some key clinical specialities in particular in Medicine. There is an emergency vision for the countywide acute medical service that is key to unlocking some of this. Supporting the Medicine division to develop this vision and a sustainable countywide strategy is one of the four priority areas of focus for the Trust in 2016/17. In addition, Trust consultants have agreed to develop at the start of 2016/17 a set of professional standards in relation to patient care that includes the current achievable standard and the aspirational standard for time to first consultant review and the implementation of criteria-led discharge.

As a result of running dual rotas in some specialities across Trust sites, the Trust has anticipated the developing shortage of specialty junior doctors and is developing an innovative hospital at night model to provide medical team cross - cover and greater use of non-medical roles including physician associates and advanced nurse practitioners to support the other hospital teams at night and at weekends.

The Trust is working with a neighbouring Trust to scope the potential for a joint radiology rota to release radiologist capacity to consolidate delivery of a 24/7 interventional radiology service.

2.3 <u>Quality Governance</u>

The named executive for quality is the Chief Nursing Officer who also manages the governance and safety team.

The Trust's overarching governance structure comprises audit & assurance, quality governance, finance and performance.

At the heart of quality governance is the Quality Governance Committee, chaired by a non-executive director which, on behalf of the Trust Board, monitors and assures the three dimensions of quality: patient safety (including mortality surveillance), patient outcomes (audit and effectiveness) and patient experience, each of which in turn has an associated management committee chaired by an Executive Director. This enables a strong Board focus on all aspects of quality and is the framework through which the Trust's quality priorities are monitored.

Following the CQC CIH visit the Trust has acknowledged the need to improve floor to Board assurance and has introduced a new performance framework supporting information flows and performance management systems and processes (including routes for escalation) at ward/department, division and board sub - committee level. This is being supported by the

Trust organisation development plan which is focussed on creating a performance, safety and improvement culture at all levels across the Trust including the Trust Board.

The Trust Board receives regular reports on all aspects of quality through the monthly integrated performance report and dashboard and the monthly report from the Quality Governance Committee.

As part of the PCIP, and with support from the buddy trust, the Trust is undertaking a major review of its governance structures, systems and processes and has successfully recruited to a new post of associate director to lead this work and to continue to develop and improve Trust quality governance.

2.4 <u>Triangulation of indicators</u>

The Trust has recently reviewed its Board sub-committee structures and arrangements and alongside this the Trust balanced scorecard performance dashboard has been reviewed, with ownership of key performance indicators aligned to the overarching governance framework. There is cross representation from both executive directors and non-executive directors across the quality, workforce and performance board subcommittees and the opportunity to challenge across the respective agenda and performance issues.

The Trust Board receives a summary balanced scored every month that identifies the key performance metrics relating to quality, operational performance and efficiency, workforce and finance and these are derived from national standards, local contractual requirements and Trust priorities. Alongside this the Trust Board receives reports from each of the board sub-committees namely, performance and finance, quality and workforce. The Trust Board receives a separate report on the issues relating to the Nursing and Midwifery workforce which is the largest workforce within the Trust.

Through the Future of Acute Hospital Services in Worcestershire (FoAHSW) Quality and Sustainability Group, the Trust and partners have been monitoring and acting upon workforce indicators and clinical risks in services that have significant workforce sustainability issues, due to national shortages and recruitment problems at the AGH. This led to the emergency centralisation of maternity and neonatal services at WRH in November 2015 and prior to that a number of emergency surgery pathways were put in place to ensure that high risk cases were transferred to WRH

2.5 <u>Quality priorities</u>

The quality priorities for Worcestershire Acute Hospitals NHS Trust in 2016/17 are driven by the PCIP:

- The primary improvement priority is the need to improve patient safety through optimising patient flow and developing effective systems for early senior review

- The Trust has already established as a priority, the need to ensure that we are learning from incidents and other harm reviews (including mortality reviews) and identifying and addressing the causes of avoidable harm to patients in our care; including pre-emptively through the adoption of early warning tools and best practice care bundles.

- The third priority is to develop a greater quality and safety culture across the organisation through engagement, training and staff development from ward to Board,

The top three risks to quality start with the issues with workforce and the over reliance on temporary staff, and the ability of the Trust to recruit a substantive clinical workforce of the right calibre and capacity. To mitigate this we are looking reduce the reliance on temporary staffing by proceeding with our reconfiguration plans and thereby cementing and clarifying the future for teams and for individual hospital sites and by developing a vision and strategy for countywide working in Medicine. We are also working closely with the University of Worcester to support the development of new roles such as the Band 4 Nurse Associate, the Physician Associate as well as developing innovative recruitment practices and workforce development plans.

The Trust also faces a significant financial challenge and needs to stabilise its financial position and improve its productivity and efficiency without impacting on quality and safety of patient care. To this end we have undertaken a comprehensive benchmarking exercise with external support to drive productivity improvements across key points of delivery in line with peer Trust and best in class which should impact positively on patient care.

The third risk is around the capacity and capability of staff to meet the challenging Trust improvement agenda and we have secured the resources for rapidly delivering an organisation development plan to equip staff with the skills and tools to meet this challenge.

2.6 'Sign up to Safety'

We have established our 'sign up to safety' plan using the driver diagram below. We have identified that in terms of the primary drivers, Nos. 1, 2 and 3 are comprehensively covered within the PCIP however we need to create an additional action plan to address deficiencies identified in respect of 4. *Documentation is complete and fit for purpose*, and this action is in train.

Sign up To Safety Driver Diagram

Version 2.0 SJG 17/11/15
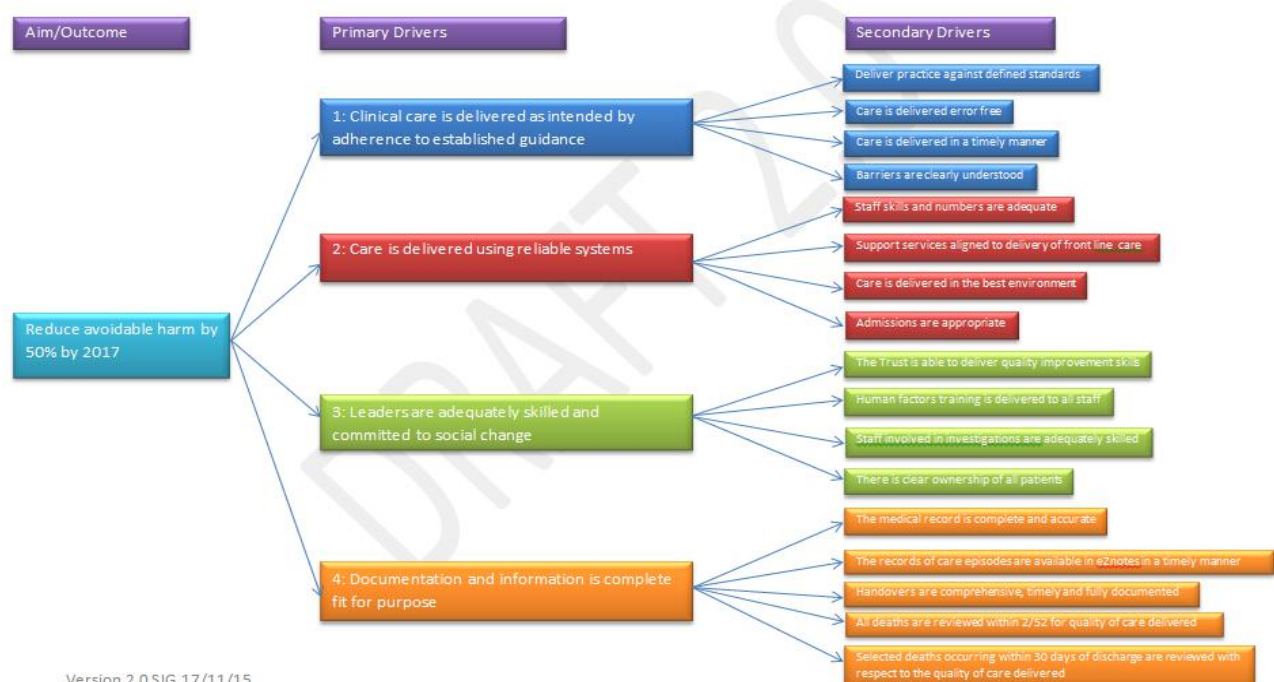
2.7 Quality impact assessment

The Trust has a dedicated Internal QIPP Programme Management Office (PMO) that co-ordinates the internal QIPP planning, reporting and performance management process using an internal project management framework. This includes a Quality Impact Assessment (QIA) for all schemes which requires approval by the Chief Nursing Officer, Chief Medical Officer and Associate Director of Patient Quality and Safety, before the scheme can proceed. Those schemes likely to impact patient safety, patient experience or clinical effectiveness are subject to regular review during the project life cycle. The Finance and Performance Committee receives a quarterly report around QIA from the Chief Nursing Officer as well as an overview of QIA through the monthly QIPP report.

The Trust QIA policy and process is based on the Monitor guidance which can be described as follows:

1. Identify CIP Scheme
- The majority of CIPs should be based on changes to current processes, rather than top-slicing current budgets
- Where possible ,CIPs should be expecetd to have a neutral or positive impact on quality as well as reducing costs
- At a minimum, CIPS should not put registration at risk by bringing quality below essential common standards

2. Assess potential impact on Quality and Cost
- CIPs should be categorised by potential impact on quality
- CIPs with significant potential impact on quality covering safety, clinical outcomes and patient experience.
- All CIPS should be subject to a detailed assessment of their financial impact, in line with current practice

3. Approve Plans
- Clinicians understand and accept CIPs and approved plans have appropriate clinical ownership (e.g. relevant clinical director)
- Board assurance is required that CIPs have been assessed for quality (potentially via direct approval for highest potential impact CIPs)
- There must be appropriate mechanism in place for capturing front-line staff concerns

4. Assess actual impact on quality
- All CIPs should be subject to an ongoing assessment of their impact on quality;post roll-out:
- Identify key measures of quality covering safety, clinical outcomes and patient experience
- Monitor each measure before and after implementation
- take action as necessary to mitigate any negative impact on quality

3. Workforce Planning

3.1 Approach to workforce planning

3.1.1 Methodology

The workforce high level plan for 2016/17 has been developed alongside the service and financial plans and in line with the significant savings schemes which are driven primarily by the need to reduce dramatically the Trust requirement for and expenditure on temporary and agency staff.

As part of its financial recovery plan for 2016/17 the Trust has targeted a £10m recurrent full year reduction from temporary workforce costs with plans already in place to deliver £9.6m of this. The Trust is planning further savings of £14.3m in 2016/17 of which a further £9.5m

is expected to be from pay cost reduction (in most part agency costs and some reduction in additional ad hoc activity payments).

The Trust divisions have outlined their 1, 3 and 5 year strategic service development plans that include priorities linked to service sustainability. The Trust acknowledges the need to work towards a workforce plan that is governed by assumptions around future demand for acute hospital care and through the sustainability and transformation planning process is working with partners in health and social care to develop this.

Additional posts required for agreed service developments have been included in the workforce plan and the key developments commencing 2016/17 or carried over from 2015/16 and requiring workforce change are:

- Emergency Department expansion at WRH - an additional 11.1WTE staff
- Development of a Theatres Admission Unit at WRH - an additional 5.41 WTE staff
- Introduction of 9-12 WTE new Physician Associate posts
- A new Consultant Rheumatologist post
- A new Consultant Urologist post and 0.5 WTE secretarial support
- Bowel Scope Screening programme Phase 3 – an additional 5.0 WTE staff
- Ophthalmology Nurse Practitioner and specialty doctor an additional 2 WTE staff

These service developments have been included based on agreed business cases with a net cost of £0.2m. With regard to the financial position these business cases will be reviewed again by the Executive Team prior to final approval to recruit.

3.2 Workforce redesign

Through the development of dashboards and the nursing and midwifery and medical workforce planning groups, the Trust has a much greater understanding of the workforce profiles and recruitment and retention hotspots, and nursing and midwifery and medical workforce plans are being expedited.

During 2015/16, the Trust has engaged much more proactively with the local university around new roles such as the Physician Associate role and the Associate Nurse role to support more traditional medical and nursing models. For example, in light of the growing pressure on junior doctor specialty training post allocations, the Trust is looking to take 9-12 Physician Associates if possible from the cohort at the University of Worcester that are due to complete their training in 2016/17. The Trust Chief Medical Officer is working with colleagues in primary and community care to develop a joint 'internship' whereby PAs can gain experience in acute primary and community care in a generalist role rather than specialise immediately after their training and this fits with both the developing models of care under the NHSE Five Year Forward View and the RCP Future Hospital Model.

The Trust has significant challenges and a range of unfilled consultant and junior doctor posts in Medicine which we will be looking to address during 2016/17 through the development of a medical workforce recruitment plan and our countywide vision for the delivery of acute and specialty medicine.

The Trust has launched a nursing and midwifery review that is looking in three phases at roles, responsibilities and staffing models at all levels of the nursing workforce. This includes a focus on initiatives such as 'time to care' and in some areas, in advance of the formal

review, wards have been allocated more administrative staff time to release staff to provide more direct patient contact.

Frailty has been identified as a growing issue for health partners across Worcestershire and the Trust has developed a proposal through redesign, to introduce a therapies-led Older People's Assessment and Liaison Service (OPAL) in the ED to ensure that older people whose acute needs are not best met by admission to hospital are supported to be able to return home.

As a result of the acute service reconfiguration plans and the sustainability and transformation plan, the Trust will be playing a more significant role alongside primary care, the ambulance service and specialist nurses in the delivery of urgent care, integrated with the hospital emergency departments.

3.3 <u>Governance</u>

Workforce is a key risk and therefore a key priority for the Trust and the Trust Board has formed a Workforce Assurance Group as a Board sub-committee with a non–executive Chair. The committee meets monthly and subsequently reports to the Trust Board.

The committee receives reports from various working groups and regularly reviews a key set of workforce metrics and strategies. This committee will be responsible for the sign-off of the 2016/17 workforce plan.

As well the reports from the individual sub-committees, the Trust Board receives a balanced scorecard performance dashboard each month that combines key quality and safety performance metrics with workforce and financial performance indicators.

Each Trust cost improvement scheme undergoes a quality impact assessment by the Chief Nursing Officer, Chief Medical Officer and Associate Medical Director for Patient Safety. Whilst individual schemes are reviewed, we also collate and examine the wider workforce planning assumptions and determine the implications of these for safe staffing and the workforce plan.

The Trust, in line with the national direction of travel, needs to dramatically reduce the requirement for and expenditure on temporary and agency staff and this is the main area of focus for the Trust savings plan in 2016/17. The delivery of this programme of work of governed by the Finance and Performance Committee.

3.4 <u>Agency staffing</u>

The Trust run rate has deteriorated significantly over the past 12 months, largely as a consequence of high levels of agency and temporary staffing expenditure to staff surge capacity (which has been deployed throughout the year), and to fill areas where there are chronic issues with vacancy rates due to national shortages in the specialist workforce or posts that are hard to fill due to uncertainty over the future configuration of acute services in Worcestershire. It is in the Trust's best interests from both a patient care and financial perspective to reduce this reliance on temporary and ad hoc staffing.

The Trust had started to tackle this issue prior to the introduction of the national drive to cap agency payments and enforce framework agreements. This includes a focus on strategies that support a reduction in unfunded surge capacity.

As is the case in the majority of acute hospital Trusts, the Trust is experiencing recruitment difficulties in key medical specialties and the situation in Worcestershire is exacerbated by the uncertainty surrounding the plans for the reconfiguration of acute services which is now in the final stages of approval. Now that this is progressing, over the next 2-3 years, the Trust will look to address a significant element of its recruitment issues and increase the resilience of the substantive consultant workforce.

In 2015/16, Health Education West Midlands workforce plan predicted a shortfall of 1,200 nurses over 2 years. Whilst historically nurse recruitment has not been an issue for the Trust, significant difficulties and hot spots have emerged over the past 12 –18 months. The Trust has sought to reduce the reliance on temporary nurse staffing by streamlining appointment processes and by substantiating student nurses as they progress towards the end of their training. The Trust has also joined the wider Birmingham cluster around agency staffing in order to reduce agency rates paid and minimise cap breaches. The Trust has held a number of successful large scale recruitment events / assessment centres for both qualified and unqualified nursing staff at both acute hospital sites. In other specific hotspot areas such as theatres, the Trust has developed an innovative recruitment and retention strategy including an internal bank to maximise the availability and flexibility of our own trained staff. The Trust is also in the process of developing an internal general Staff Bank which should in time reduce the reliance on agency - sourced ad hoc staffing.

The Trust has reviewed a significant number of clinical and non-clinical agency posts to assess compliance with the national capped rates as well as to assess the absolute need for the post and the added value of the post holder. Where a post remains essential and there is no extant recruitment plan, then every effort is being made to move staff onto cap rates and any new agency roles are reviewed on a case by case basis. To reinforce controls, the role of medical locum co-ordinator is being centralised within the Human Resources function. Ultimately any problems with compliance should be restricted to critical specialty medical posts such as in ED and paediatrics and specialist nursing roles such as in ED.

The Trust is assuring all these plans through the QIA process

3.5 Proposed workforce changes from current service and financial plans

Trust Staff (WTE)	As at	As at
Bank	147.34	214.47
Agency staff (including, Agency, Contract and	311.03	170.55
Total temporary staff	**458.37**	**385.02**
Total Non-Medical: Clinical Staff	3,856.23	3,918.32
Total Non-Medical: Non-Clinical Staff	581.13	579.53
Total Medical and Dental Staff	600.98	615.98
Total substantive staff	**5,038.34**	**5,113.83**
Total staff	**5,496.71**	**5,498.85**

Notes:
- Up until April 11th 2016, these workforce figures are subject to change as the final detail of the 2016/17 financial plan is worked through

- The impact from Commissioner QIPP plans is currently unknown as no detailed schemes have been put forward at the time of writing.

4. Financial planning

A key driver of the Trust's financial deficit position is the premium costs from agency and temporary staffing expenditure that is in turn driven by:

(a) recruitment difficulties arising from the prolonged lack of certainty over the future configuration of acute services across the Trust's two main hospital sites, and;

(b) additional capacity the Trust has had to find throughout 2015/16, to manage the high levels of bed occupancy and bed days lost to patients who do not need to be in hospital, either because their care could have been delivered more appropriately in an ambulatory setting, or because their acute episode of care has completed.

In addition to our financial recovery plan, these factors are also key drivers of the Trust's quality and workforce priorities for 2016/17 and as described above, our operating plan for 2016/17 is focussed on driving out these costs, capacity constraints and inefficiencies, to restore a more optimal operating model for the organisation in terms of quality, patient safety and financial run rate. The high levels of stranded patients have also impacted performance and elective activity resulting in reduced income levels.

4.1 Financial forecasts and modelling

The financial plan for 2016/17 has been developed using the following key assumptions:

- 2016/17 expenditure baseline reflects Q4 2015/16 forecast outturn run rate adjusted for:
  - non recurrent items
  - agreed service changes
  - Trust CIP & financial recovery plans

- Inflation has been based on tariff and planning guidance and contained within the assumptions made to date.

- Reserves and contingencies have been held for a general 0.5% contingency, income risk around contract agreement and a reduction in deanery posts.

- Growth has been assumed at 2%, with a higher rate for drugs. This has been assumed at no margin.

- CIP targets will be deducted from budgets

- No impact of winter costs above those planned for 2015/16 are included within the position.

- Service developments have been included based on agreed business cases with a net cost of £0.2m. With regard to the financial position these business cases will be reviewed again by the Executive Team.

- No in year impact of Commissioner QIPPs have been included in plans. The Trust is working with Commissioners on a shared QIPP programme for 2016/17. The key work streams and leads have been identified and project plans are being developed. As this work progresses we will assess the potential in year impact of these on the Trust.

Table 3 below shows the impact of the assumptions in arriving at the 2016/17 planned deficit of £38.3m in a scenario where the Trust receives £13.1m from the National 2016/17 Sustainability and Transformation Fund. At the time of writing, a firm decision on this was awaited.

Table Three – 2016/17 Financial Plan

2016/17 Financial Position	£m	£m
FOT		(59.9)
Reprovide 15/16	(1.3)	
Impact of Q4 Run Rate	(5.6)	
		(66.8)
NR Income 14/15 outstanding issues	2.0	
NR Income 15/16 adjustment & contract risk	1.0	
		(63.8)
Service developments (net)	(0.2)	
		(64.0)
Tariff Increase	4.8	
Cost Pressures and inflation	(13.8)	
		(73.1)
0.5% contingency	(2.2)	
Deanery Contingency	(0.5)	
		(75.7)
£14.3m CIP	14.3	
£10m FRP	10.0	
Total Without S&T Fund		**(51.4)**
S&T Fund	13.1	
Total With S&T Fund		**(38.3)**

Notes:

- No provision has been made for an activity cohort to address the RTT backlog due to affordability issues for CCGs in relation to the baseline activity plan

4.2 Efficiency savings for 2016/17

4.2.1 Financial recovery plan (FRP)

In Q3 2015/16 to stabilise the Trust's financial position, the Trust Board set the operational divisions a target to take out of budgets recurrently, £10m (full year recurrent impact) of additional /premium staffing expenditure that had materialised since the start of the financial.

In 2016/17, the operational teams have been tasked with identifying further savings from this programme. This is in addition to the 2.5% CIP of £11.4m. This will result in the Trust achieving £14.3m savings which is over double the CIP required as part of 2016/17 Tariff rules. The current pay/non-pay split is as follows:

2016/17 savings programme	£m
Pay	9.5
Non – pay	4.8
Total	14.3

4.2.2 Procurement

Currently, the £14.3m CIP includes £2.0m of contract renegotiation and procurement savings. The Trust Procurement Team Strategy is already aligned with the anticipated Lord Carter report into provider efficiency:

- Trust Chairman nominated as the board director to oversee the local procurement transformation plan.
- Spend analytics and electronic catalogue systems have been implemented.
- Inventory management systems and other back office saving opportunities are being explored.
- Department strategy aligned to the NHS Standards of Procurement

The team is also exploring the benefits of joining a procurement shared service collaboration outside of Birmingham.

4.2.3 Agency rules

The Trust has developed comprehensive information and analytical systems to support the reduction in agency expenditure, in line with the introduction of national ceilings, price caps and mandatory framework agreements. The Trust has a significant challenge in respect of use of agency and temporary staffing and is incrementally working through the issues in line with the national timetable. The agency expenditure cap for the Trust is £22.94m and the agency expenditure is planned to reduce to £14.08m in 2016/17.

4.2.4 Other QIPP/CIP

In addition to the planned procurement and agency expenditure reduction, to achieve the £14.3m CIP, savings will need to come from the other areas identified in the 'Drivers of the Deficit' work undertaken by the Trust in 2015/16. These areas include:

- Workforce plans to be able to recruit to staffing vacancies, particularly in medical and nursing posts. Clear recruitment trajectories for both nursing and medical post will form the financial analysis of the expected savings, noting the lead times required for differing staff groups.
- Improvement of flow within the system. This will require all partners in the health economy to improve process and reduce the level of stranded patients.
- Elective productivity improvements linked to Lord Carter's national review and the diagnostic work undertaken at the Trust during 2015/16.

4.2.5 Sustainability and Transformation Plan

All organisations in Herefordshire and Worcestershire are working together as part of the National Sustainability and Transformation Programme (STP), and Trust representatives are involved in key work streams to develop and deliver the plan.

The Trust is taking a lead in terms of scoping the opportunity from the Sustainability and Transformation Plan for service and infrastructure rationalisation across the Herefordshire and Worcestershire acute hospital trusts, including some key clinical services and back office and support functions

In light of the STP joint working, the Trust and Worcestershire CCGs are endeavouring to develop an alternative contract model for 2016/17. This, if agreed, would see a contract value set with a very tight cap and collar arrangement in place, to minimise financial risk for all parties. The model relies upon the parties working jointly on shared QIPP schemes to significantly reduce demand for services by the end of 2016/17, allowing the Worcestershire health economy as a whole to reduce its cost base.

A Partnership Agreement is in place which sets out the key heads of terms between the respective organisations. It does not however replace the need for a traditional NHS Standard Contract to be in place and work is on-going to develop and agree all of the required schedules for the main contract. If we are unsuccessful in negotiating a mutually agreed position on this alternative model then we would need to revert to a traditional PbR contract.

4.3 Cash position

Throughout 2015/16 the Trust has required significant levels of working capital in order to meet its financial commitments. The Trust has received cash support of £61.9m to cover the £59.9m forecast deficit, loan principal repayments, the capital element of the unitary payment and the working capital movement. The cash support has been received through interim revenue support facility loans and revolving working capital loans.

The total cash requirement for 2016/17 is £52.9m based on:

- Planned deficit £38.3m
- 15/16 cash shortfall £7.5m
- Loan principal repayments £5.1m
- Capital element of the unitary payment £2.0m

The cash support application process for April 2016 requires submissions by 30th March however the application process for future months beyond April is still under discussion centrally.

4.4 Capital planning

In order to ensure that the Trust can maintain its estate, IT and equipment to required standards, the capital planning strategy will continue to be to use depreciation as the sinking fund for asset renewal and replacement.

The strategy for financing new investments will continue to be to borrow but only where there is a clear return on investment. The DH through the TDA has been made aware of the circa £19m capital requirement for phase one of the acute services reconfiguration business case, which will provide up to 80 additional beds on the WRH site plus car parking and meet the requirement to invest in endoscopy and elective women's care at the Alexandra General Hospital site at Redditch. The cost will be split across the next 2 financial years.

The capital expenditure plan for 2015/16 has been closely monitored and approved at Capital Prioritisation Group. (CPG) The plan for 15/16 resulted in deferring ICT schemes to

ensure essential backlog maintenance work could be undertaken; this in turn will put pressure on the resources available for new schemes in 2016/17. The expectation is that the Trust's internally generated resource will be principally committed to essential works and equipment replacement.

Bids for equipment replacements were requested from the Divisions, linked to their divisional priorities for 2016/17. All Divisional bids for ICT and Property & Works were jointly submitted with the Divisions and capital work stream leads and again linked to the divisional priorities. Any schemes that have been deferred from 15/16 that are still deemed to be a priority will be the first call on the capital plan for 16/17.

The draft capital plan for 16/17 shows an over commitment against the plan by £1.1m, however this may change once depreciation is finalised. The over commitment will be managed through slippage and regular reviews of the position with the work stream leads and finance to ensure the Trust meets its CRL. There is no contingency built into the capital programme.

Before the final plans are submitted, the Trust will be reviewing the affordability of the capital programme in light of the overall financial position and recovery plan and the sources of funding.

The key points to note from the draft capital plan set out in the table below are:

- The only agreed capital loan within the draft plan for 16/17 relates to the Emergency Department (ED) at WRH, estimated to be £1.386m.

- Almost £7m of the capital programme is subject to successful loan applications. If the business cases and loans are not agreed then these schemes cannot proceed. The risk associated with backlog maintenance will need to be kept under review.

- The draft plan includes £3m for the anticipated capital loan in 16/17 to support the implementation of the acute service reconfiguration (ASR) programme. The total capital requirement for implementation of ASR over a three year period is circa £35m.

- Further schemes are being reviewed to include invest to save schemes with a potential for at least a 1 to 1 return including the closure of Aconbury East and A Block at KTC and the expansion of car parking on the WRH site. These are estimated at £1.2m in 16/17 funded via further capital loans subject to business cases.

- The draft plan also includes an estimated £2.8m for a distressed capital loan application for Property and Works (P&W) backlog maintenance, subject to a business case being presented. P&W schemes in 16/17 relate only to essential backlog maintenance and statutory/mandatory works. This is to enable the Trust to prioritise the essential maintenance works required countywide. The schemes have been reviewed further to phase the plans over a 3 year programme.

- It is proposed that the WRH Theatre Admissions Unit (TAU) is supported from the capital programme in 16/17, at an estimated cost of £170k. Further clinical developments and schemes amounting to circa £6m are not included in the capital

programme. These will be reviewed by Executive Team and will need to be funded through further loan applications if deemed to be necessary.

- Receipts from the Sale of Land at Redditch have been included at an estimated Net Book Value of £325k which was deferred from 15/16. There is potential to release further surplus land for sale which is being reviewed by the Director of Asset Management and ICT but not included above as yet.

- Equipment replacement is planned to be £700k. It is assumed that equipment will be leased where better value for money can be achieved.

- The Information and Communications Technology (ICT) plan is estimated at £2.5m which includes the expenditure to finalise the data centre scheme (£1.8m). There is an opportunity for a further bid for some digital roadmap funding, which the Director of Asset Management and ICT is reviewing.

The outline capital plan is included below:

Capital Plan	2016/17 Plan £000's	16/17 Proposed Schemes £000's	16/17 Variance to Plan £000's
Funding			
Depreciation	8,165		
Capital Loan ED	1,386		
Anticipated Capital Loan - ASR	3,000		
Anticipated Capital Loan - Invest to Save	1,200		
Distressed Capital Bid - Backlog Maintenance	2,756		
CRL	**16,507**		
Capital Loan Principal Repayments	(2,756)		
Total Available Capital Funding	**13,751**		
Expenditure			
ED Expansion	1,386	1,386	0
TAU	170	170	0
Anticipated Capital loan - ASR	3,000	3,000	0
Sub Total Developments	**4,556**	**4,556**	**0**
Property & Works	2,364	2,503	(139)
Anticipated Capital Loan - Invest to Save	1,200	1,200	0
Distressed Capital Bid - Backlog Maintenance	2,756	2,756	0
Sub Total P&W	**6,320**	**6,459**	**(139)**
Equipment	700	700	0
Sub Total Equipment	**700**	**700**	**0**
ICT	700	1,661	(961)
Data Centre	1,800	1,800	0
Sub Total ICT	**2,500**	**3,461**	**(961)**
Total Expenditure	**14,076**	**15,176**	**(1,100)**
Alex Land Disposals	(325)	(325)	0
Sub Total Donations/Receipts	**(325)**	**(325)**	**0**
Total Net Expenditure	**13,751**	**14,851**	**(1,100)**

5. Link to the emerging 'Sustainability and Transformation Plan (STP)

The planning footprint for the local STP is Herefordshire and Worcestershire.

At the start of this year's planning round in January 2016, the Trust invited Worcestershire CCG representatives to share their emerging strategies for future sustainability at Trust planning forums. These are broadly in line with Trust priorities around frailty pathways (including Dementia), ambulatory care, the community services interface at the front and back door of the hospital and demand/capacity for elective care pathways.

As a first step towards the development of the STP, the Trust is working with commissioner colleagues to identify how joint QIPP approaches may be developed in relation to the 2016/17 operational plan to start to mobilise some of these work programmes and to take out system cost.

There is also a significant opportunity to work with partners across Worcestershire and Herefordshire to explore the opportunity for service and infrastructure rationalisation including some key clinical services, back office and support functions. The Trust is taking a lead in terms of scoping this opportunity across the Herefordshire and Worcestershire acute hospital trusts.

A range of work streams have convened to support the development and delivery of the Herefordshire and Worcestershire STP and Trust representatives are involved at all levels of the planning programme.

In line with the NHS England Five Year Forward View, STP work streams include assessment of the 5 - year finance and efficiency gap, and the care and quality gap.

The work that the Trust has already undertaken to recover its financial position in 2015/16 along with the 2016/17 savings/recovery plan, joint QIPP proposals and the acute reconfiguration programme will help move the Trust and the health economy towards improved financial sustainability - although there is much more to be achieved.

In terms of work identify and to address the care quality gap, the Trust has developed a comprehensive patient care improvement plan in response to being placed in the Trust special measures regime. This plan will deliver some significant quality improvements for the Trust which will contribute to closing the care quality gap in Worcestershire now and into the future.

Sarah Smith
Director of Planning and Development
April 2016

Report to Trust Board

Title	**Quality Governance Committee – report to Trust Board**
Sponsoring Director	**Dr Bill Tunnicliffe, Associate Non-Executive Director, Chair** *(presented by John Burbeck)*
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is requested to: • Receive the assurance in respect of the consideration of the four BAF risks allocated to the Committee • Receive assurance with respect to the actions being taken to increase the number of VTE assessments • Receive the final summary reports into the two never events, one concerning insulin dosage and one wrong implant • Note the root causes and learning from the two never events • Note the mortality report and that the data are being reviewed • Receive the assurance in relation to the surgery division deep dive in particular assurance in relation to the management of fractured neck of femur • Note the February exception reports for medicine, TACO-CS and women and children • Receive assurance in relation to the management and progress of the Governance and Safety Improvement Plan • Note the report
Previously considered by	Not applicable

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	√
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	
Develop and sustain our business	√

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience 2902 If the Trust does not successfully improve clinical care, we will fail to reduce avoidable harm to expected levels 3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care
Legal Implications or Regulatory requirements	This report covers some statutory issues such as CQC or accreditation visits.

Key Messages

This paper provides the Board with the key achievements, issues, and risks discussed at the Quality Governance Committee on 17 March 2016

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Worcestershire **NHS**
Acute Hospitals NHS Trust

REPORT TO TRUST BOARD – 6 APRIL 2016

1. Situation

This report provides the Board with key quality issues and risks discussed at the QGC's meeting held on 17 March 2016.

2. Background

This report provides the Board with assurance on matters related to patient safety and quality. The QGC reviews reports from its sub-committees, quality performance data, and risks to meeting strategic quality objectives. In this way it provides assurance in the areas outlined below and identifies risks and areas of concern for the Board's attention. Where appropriate, the Committee also considers county-wide issues.

3. Assessment

3.1 Risk

The Committee considered the four BAF risks for which the Committee has responsibility:

Risk 2790 As a result of high occupancy levels, patient care may be compromised: The Committee received verbal reassurance given at the meeting and from next month the Committee will receive regular reports in relation to the Emergency Care Improvement Programme which will ensure that assurance can be given.

Risk 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience: Assurance was provided against this risk at the last meeting.

Risk 2902 If the Trust does not successfully improve clinical care, we will fail to reduce avoidable harm to expected levels: The Committee discussed mortality in detail (see item below).

Risk 3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care: The Improvement Plan for Governance and Safety was reviewed and approved.

3.2 Quality Account and Corrective Action Statements

The Committee received a report from the Interim CNO. She gave assurance in respect of the number of incidents open for more than 60 days and the Committee were pleased with the progress with the Complaints response target.

The Committee were assured with the action being taken to improve the VTE risk assessment with the Interim CMO leading a campaign throughout the Trust. Concern was expressed over the performance with the CQUIN audits for acute kidney injury and sepsis. A plan for raising awareness with staff was outlined which included a 30 minute session with front line staff. It was acknowledged that the Trust should improve its position on sepsis to have a positive impact on patients and HSMR.

3.3 Future of Acute Hospital Services – quality risks

The Committee received the metrics. The Committee was assured with the

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

actions being taken in respect of night staff in general surgery at AGH.

3.4 Operational Governance group incorporating Safe Patient Group

Assurance was given in respect of the actions being taken to ensure daily checking of resus trolleys. The Committee heard that video blogs are being considered to enhance learning from incidents. The ward dashboards (first report due at QGC in April) would show consolidated learning from issues.

3.5 Final reports into two Never Events

The Committee received the final reports from two never events that occurred at the end of the last calendar year. The first one was an overdose of insulin. The patient suffered minimal harm. The root cause was the lack of training of the trained nurse who administered the insulin. It was agreed that this was a rare situation. The Workforce Advisory Group monitors the numbers of nurses completing the preceptorship training.

The second never event was the implantation of a wrong prosthesis. No harm was done to the patient. This event coincided with planned orthopaedic surgery being centralised on the AGH site. The root cause was the unfamiliarity of the system used at AGH for the storage of prostheses. This has now been rectified. It was agreed that the wider learning for the Trust was in respect of merging services and the Divisional Medical Director for Surgery will do a communication on this.

3.6 Mortality

The Committee remains concerned about the mortality review process and a further review of the data was requested. SHMI and HSMR remain raised. The Trust recognises that more work needs to be undertaken county wide in respect of the HSMR. There was concern that the GP ward at Kidderminster maybe artificially raising the SHMI. The AMD – Patient Safety and Quality was reviewing the working of the unit and also the use of the unit as a palliative care unit.

The Committee were assured that the figure of 18% of completed mortality reviews which was reported to the Trust Board in March was inaccurate due to the lag time of the receipt of completed reviews. The Committee has requested a review of the way these data are presented and to present to figures, those reviews completed within 2 weeks and the overall completion rate.

Mortality reviews have also been requested into GI haemorrhage, other circulatory disease, chronic ulcer of the skin and pulmonary heart disease although no progress was reported. These areas were showing as hot spots on the heat map.

The Committee was concerned that the report showed only one secondary review had taken place and therefore no learning had taken place. A report was requested for the next meeting.

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

3.7 Quality Exception Reports

The Surgery Division presented their deep dive. Whilst it was evident that considerable work was being undertaken with respect to the closing of historical incidents, the Committee was keen to understand how the Division ensured learning and a change of behaviour. The Division described the various mechanisms and agreed that the ward dashboards would show this in the future. The Division agreed to present to the Committee an example of learning from incidents at the next deep dive presentation.

Learning was also the focus of the next item discussed, inquests. The Division gave a good example of learning in respect of blood tests and also agreed to expand this section in the next deep dive report.

The Trust's approach to ensuring mandatory training was undertaken included the prevention of consultants applying for Consultant Excellent Awards unless they are up to date. Revalidation will also be delayed if mandatory training is not completed.

The Clinical Lead for Trauma and Orthopaedics was present to discuss the time to theatre for patients needing a fractured neck of femur treated. The operational challenge was described (this has now been eliminated – the timing of the routine theatre maintenance). As an unintended consequence of moving planned orthopaedic surgery there has been a lack of surgeons at WRH to undertake emergency operations.

The Committee were pleased with the improvement in this metric which placed the Trust in the mid range of peers. The Committee requested a trajectory to meet the overall target.

The deep dive provided the Committee gave assurance in respect of complaints management, mandatory training and the managing of patients with a fractured neck of femur. However further assurance was requested in respect of clinical audit participation, NICE compliance, stranded patients and risk mitigation. This assurance will be provided at the next deep dive report.

The other divisions presented exception reports:
TACO-CS: Microbiology and histopathology have successfully retained their CPA accreditation. A focus has been made on patient identification and the checking of name badges as a result of learning from incidents.
Medicine: There has been a focus on completing mortality reviews and reviewing historical incidents.
Women and Children: The lack of dedicated gynae beds will form a focus in the deep dive due in April. The Division is buddying with Birmingham Children's Hospital and the Children's Board has agreed to prioritise improvements to children's facilities in A&E, out patients and theatres.

3.8 Governance and Safety Improvement Plan

The Committee received assurance in respect of actions within this improvement plan. Challenging targets are being set with in relation to pressure ulcers and falls. There is also a focus on training investigators to

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

ensure the quality of investigations improves. The Trust is finding the buddying arrangement with Oxford Hospitals NHS Trust a positive experience. This buddying arrangement was set up after the receipt of the CQC report.

4   Recommendation

The Board is requested to:

- Receive the assurance in respect of the consideration of the four BAF risks allocated to the Committee
- Receive assurance with respect to the actions being taken to increase the number of VTE assessments
- Receive the final summary reports into the two never events, one concerning insulin dosage and one wrong implant
- Note the root causes and learning from the two never events
- Note the mortality report and that the data are being reviewed
- Receive the assurance in relation to the surgery division deep dive in particular assurance in relation to the management of fractured neck of femur
- Note the February exception reports for medicine, TACO-CS and women and children
- Receive assurance in relation to the management and progress of the Governance and Safety Improvement Plan
- Note the report

Dr Bill Tunnicliffe
Chair – Quality Governance Committee

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Worcestershire **NHS**
Acute Hospitals NHS Trust

6 April 2016 **Enclosure E2**

Report to Trust Board in Public

Title	Patient Care Improvement Plan (PCIP)
Sponsoring Director	Sarah Smith, Director of Planning and Development
Author	Sarah Smith, Director of Planning and Development
Action Required	The Board is asked to receive the Patient Care Improvement Plan (PCIP) for assurance and to consider the next steps in respect of the (PCIP) to ensure progression.
Previously considered by	Improvement Board

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	
Develop and sustain our business	

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2902 If the Trust does not successfully improve clinical care we will fail to reduce avoidable harm to expected levels 2893 Failure to engage and listen to staff leading to low morale, motivation and productivity 2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels. 2894 Failure to enhance leadership capability resulting in poor communication, reduced team working and delays in resolving problems
Legal Implications or Regulatory requirements	
Glossary	

Key Messages
The Patient Care Improvement Plan (PCIP) is the key to the delivery of the Trust Improvement objectives, and to meeting the requirements of the regulators, and it needs to support the delivery of measurable and sustained improvement

Title of report	Integrated Performance Report
Name of director	Sarah Smith

The Trust's initial approach to the PCIP has delivered improvement in some key areas such as Maternity however a review has demonstrated the need for a refresh to develop effective programmes to support sustained and measurable improvement in some priority areas such as urgent care and patient flow, mortality reduction and organisational development/ staff engagement.

In addition, in order to meet its obligations as a trust in special measures, a public facing CQC monitoring plan and dashboard has been developed that specifically tracks progress against the CQC 'Must do' and 'Should do' actions. The March 2016 CQC Monitoring Plan will be published and will be available to Trust Board members after the April Board meeting.

Title of report	Integrated Performance Report
Name of director	Sarah Smith

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PCIP – APRIL 2016

1.   **Situation**
This paper describes the need for review and the actions supporting the further development of the Patient Care Improvement Plan (PCIP) - in particular to improve the PCIP as a delivery mechanism for the Trust's top priority improvement programmes and to strengthen the governance arrangements.

2.   **Background**
The PCIP was developed principally to address the concerns and issues identified following the unannounced and announced visits to the Trust in 2015 by the Care Quality Commission (CQC) Chief Inspector of Hospitals (CIH) team.

Immediately following the visits in March and July 2015, the Trust developed action plans in relation to safety and performance concerns in the Trust Emergency Departments (ED) (in particular the Worcestershire Royal Hospital ED), and in relation to the governance systems supporting the delivery of Maternity services at the Trust, and these were incorporated into the PCIP along with other areas of improvement subsequently identified by the Trust.

Following publication of the final CQC CIH report in December 2015, the PCIP was broadened to include the 'Must do' actions and priority 'Should do' actions set out in the report.

3.   **Assessment**
The initial approach to the PCIP has delivered improvements in some key areas such as in Maternity but has not proved to be an entirely effective vehicle for delivery of the Trust top priority improvement programmes namely; urgent care and patient flow, mortality reduction and organisational development/staff engagement.

Lessons learnt include the fact that ownership and in depth understanding of the issues are key to successful delivery and the Trust needs to ensure that improvements are measurable and sustained. For these reasons the PCIP is being rebuilt 'bottom up' with granular project plans that address the fundamental issues and drivers that in turn support measurable improvement.

Fundamentally, the PCIP drives delivery of the CQC Must do and Should do actions however, in order to meet its obligations as a trust in special measures, the Trust should be able to track these clearly and publish a progress report monthly on the NHS Choices and the Trust's own website.

A CQC Monitoring Plan and dashboard has thus been developed that is public facing and tracks progress against the CQC 'Must do' and 'Should do' actions.

Title of report	Integrated Performance Report
Name of director	Sarah Smith

4.   Recommendation
The Board is asked to receive the Patient Care Improvement Plan (PCIP) for assurance and to consider the next steps in respect of the (PCIP) to ensure progression.

The March 2016 CQC Monitoring Plan has been developed that will be published and will be available to Trust Board members after the April Board meeting.

Sarah Smith
Director of Planning and Development

Title of report	Integrated Performance Report
Name of director	Sarah Smith

Enc E2

Patient Care Improvement Plan

March 2016

Where we started

Patient Care Improvement Plan (PCIP)
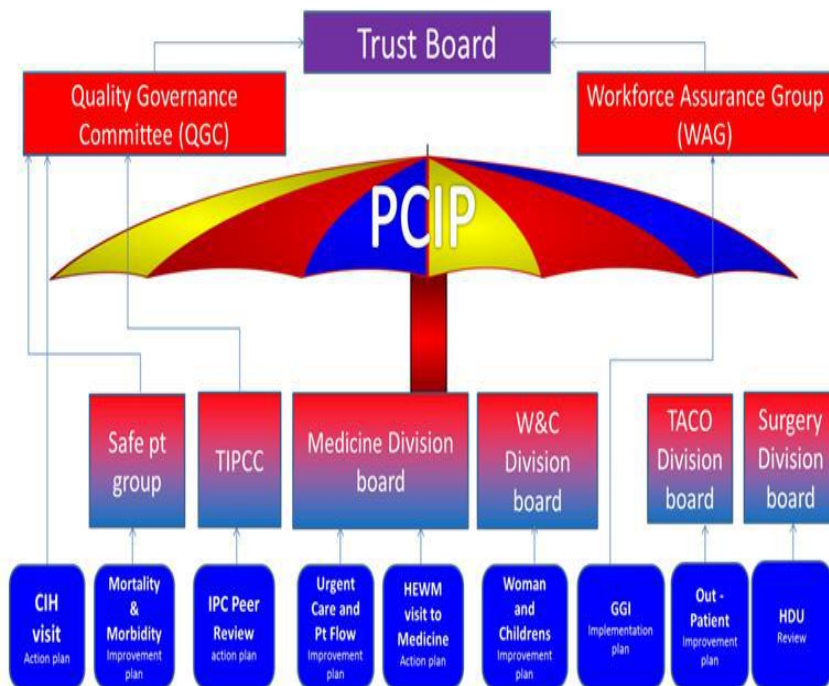
Lessons learnt:-

- Initial 'top down' plan lacked traction, and progress at project level has been variable

  – Good divisional ownership and traction in W&C has set the stage

  – Ownership is key - from SRO to project lead

  – Need time and coaching support to build the fundamental improvement skills across the organisation

  – Although the PCIP underpins our whole improvement journey, organisationally, we also need visibility of the actions arising directly from CIH visit

  – This PCIP approach has delivered some improvements in other areas such as IPC and the HEWM concerns and these items are being transferred to business as usual

Where we are heading

Worcestershire **NHS**
Acute Hospitals NHS Trust

- Three top improvement priorities:
  - Urgent Care and Patient Flow
  - Avoidable Mortality
  - Organisation Development and Staff Engagement
- Applying lessons learnt:
  - New governance structure:
  - Executive Improvement Board
  - Executive Sponsors
  - Individual programme structures
- Project plans –Built 'bottom up'
  - Granular plans including key milestones and 30/60/90 day actions
  - Reporting based on key project metrics to provide evidence of sustained improvement

Urgent Care and Patient Flow Programme - Governance

Worcestershire NHS
Acute Hospitals NHS Trust

TRUST EXECUTIVE IMPROVEMENT BOARD

URGENT CARE/ECIP PROGRAMME BOARD

MORTALITY REDUCTION PROGRAMME BOARD

STAFF ENGAGEMENT/OD PLAN PROGRAMME BOARD

SAFER Bundle
Ann Carey

ED and Acute Care Model
Randeep Kular

Frailty Pathway
Caroline Lister

Patient Flow Centre
Chris Cashmore
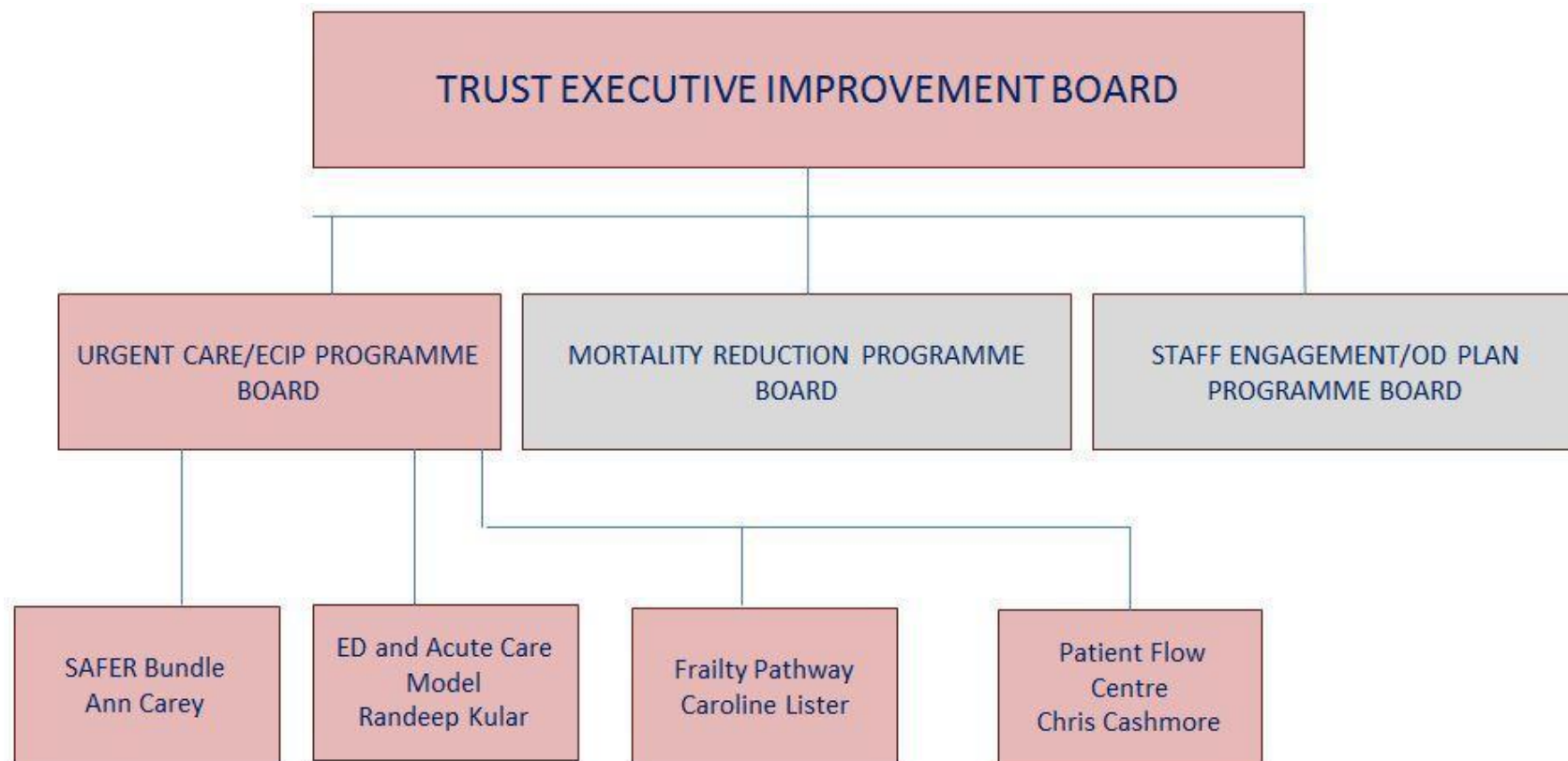
Urgent Care and Patient Flow Programme Measures

Worcestershire **NHS**
Acute Hospitals NHS Trust

SAFER Bundle	% stranded patients (NEL LoS > 7 days)	% discharges before 10am	% compliance best practice ward rounds		
ED & Acute Care Model	Increase in NEL 0-48 hours LoS	Reduction in admission conversion rate	Reduction in bed occupancy		
	Time to initial assessment in ED	Patients in ED corridor	Patients spending > 12 hours in ED	% specialty review within 1 hour	% unplanned reattendance
Patient Flow Centre	% stranded patients (NEL LoS > 7 days)	Time to start of planning – post acute care	Time from referral to discharge		
Frailty Pathway	Reduction in admission conversion rate > 75 years	Reduction in NEL LoS > 75 years	% stranded patients > 75 years (NEL LoS > 7 days)		

Urgent Care and Patient Flow - High Level Programme Structure

Urgent Care and Patient Flow—Programme Structure

Programme

Programme Board
To Include: COO, DOP—Medicine, DMD—Medicine, CCG, DND—Medicine, ECIP, Comms, Finance, Patient Rep, Non Exec Director

Projects

SAFER Care Bundle
Project Lead: Ann Carey
Clinical Lead: Dr Hudson

Frailty Pathway Development
Project Lead: Caroline Lister
Clinical Lead: Dr Mildner

Acute Care Model
Project Lead: Randeep Kular
Clinical Lead: Dr Jenkins

PFC Evaluation
Project Lead: Ann Carey
PFC Lead: Chris Cashmore

Work streams

Aim—reduce LOS through
- Implement and roll out Best Practice Ward Rounds
- Systematic reduction in stranded patients

Aim—establish admission avoidance and rapid assessment of elderly care patients
- Front Door Services CGA/OPAL
- Short Stay Pathway (Silver)
- Primary/Community Care Involvement

ED
Aim—improve ED response time to improve quality and flow
- increase 15 Minute Triage compliance
- Improve ambulance turnaround-
- Specialty Review
- Review Planned re-attendance

MAU/AEC
Aim—establish acute medical service to support flow
- Develop AEC/Extended Workforce
- Review Consultant Model
- Consultant on Ward (>1 day review)
- Daily specialist Review

Aim—PFC responsiveness to support flow and patient needs
- PFC Evaluation; Referral, Service Response, DTA Pathway, Triage
- Re-ablement provision
- Pathway 1 Pilot

Each work stream will require input from: ECIP, Information, Patient Rep, Transformation Team, Finance, Comms

Patients | Respect | Improve and innovate | Dependable | Empower

Taking **PRIDE** in our healthcare services

Mortality Reduction Programme - Governance

Worcestershire **NHS**
Acute Hospitals NHS Trust

Trust Executive Improvement Board

- Urgent Care Programme Board
- Avoidable Mortality Review and Improvement Board
- Organisation Development Programme Board

- Sepsis Bundle
  Andy Phillips
- Mortality Reviews
  Steve Graystone
- Fractured NoF
  Charlie Docker
- National Early Warning Score (NEWS)
  Chris Doughty
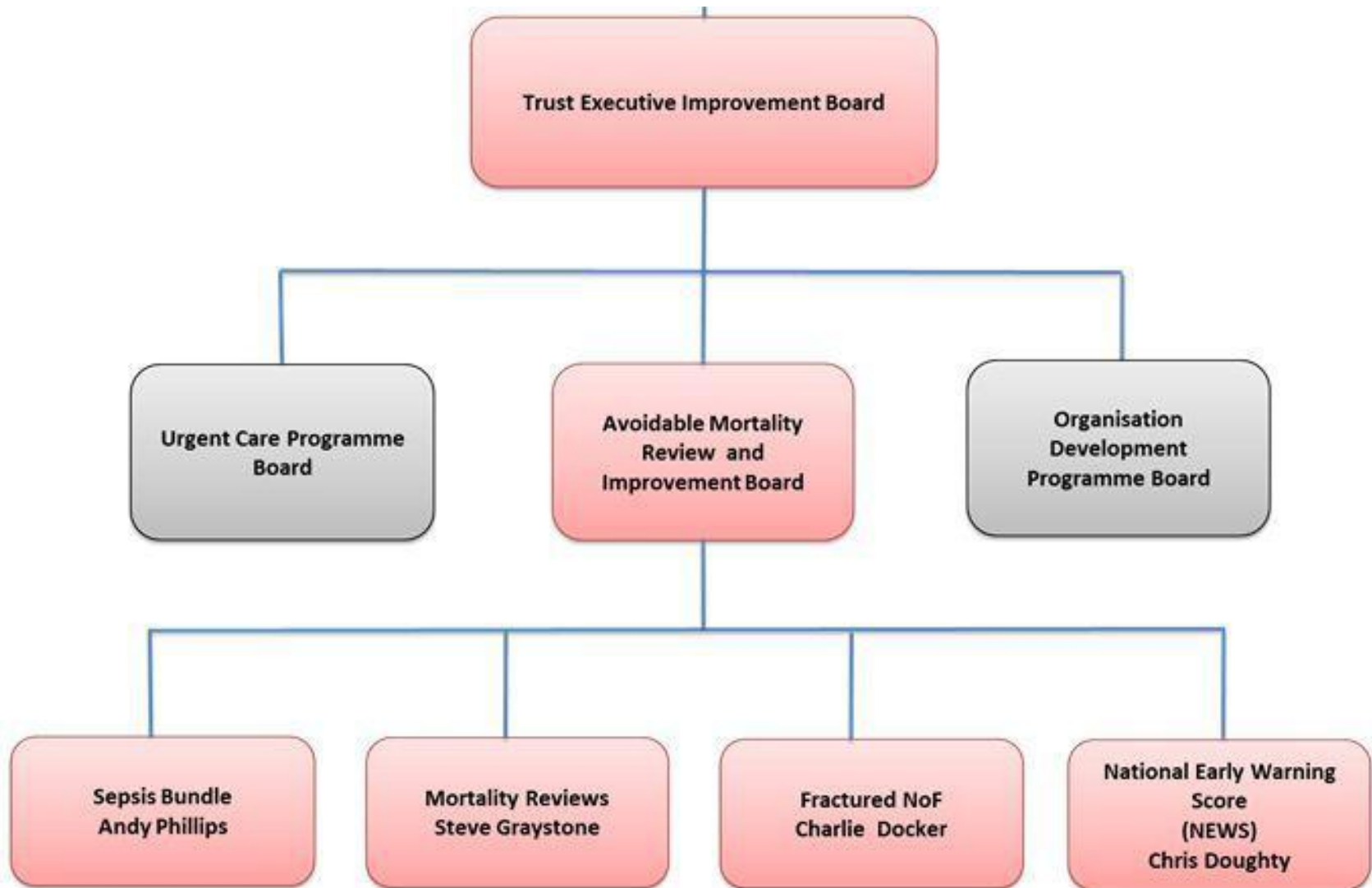
Mortality Reduction Programme Measures

Worcestershire **NHS**
Acute Hospitals NHS Trust

Sepsis Bundle	% Sepsis Screening	% eligible patients receiving antibiotics within 1 hour	Time to antibiotic administration	Sepsis Bundle compliance	% patients with confirmed sepsis who died
Mortality Reviews	% deaths for which primary review requested	% primary review forms returned	% primary review forms returned within target time	% secondary review forms returned within target time	% secondary review forms returned with X days of patient death
# NoF	% patients undergoing surgery within 36 hours	% eligible patients undergoing surgery within 36 hours	% patients with confirmed # NoF who died	Los # NoF	
NEWS	No of cardiac arrests per 1000 bed days	% patients with resuscitation status recorded	% clinical areas with NEWS rolled out		

Worcestershire **NHS**
Acute Hospitals NHS Trust

Reducing Mortality—Programme Structure

Programme

Mortality Programme Board

To Include: , CMO , DMDs, Non Exec Director, Trust Consutlants

Projects

Mortality Review
Project Lead: Sue Batch-elor
Clinical Lead: Dr Graystone

Sepsis Management
Project Lead: TBA
Clinical Lead: TBA

#NOF
Project Lead: Rita Rai
Clinical Lead: Mr Docker

NEWS
Project Lead: TBA
Clinical Lead; TBA

Work streams

Aim— establish effective review of all patient deaths

- **Establish prima-ry / secondary documentation**
- **Establish review process**
- **Establish moni-toring process**

Aim—Implement Sepsis Six

- early detection and screening of patients with sus-pected sepsis
- Antibiotic therapy within 1 hour of presentation

Aim—access to thea-tre within 36 hours for patients who present with # NOF

- pathway review
- Bed provision
- Theatre slot avail-ability

Aim—establish best practice approach to management of the deteriorating patient

- Documentation devel-opment
- Roll out and implemen-tation clinical areas
- Establish cardiac and peri- cardiac arrest monitoring

Each work stream will require input from: Clinical Governance Team, Information, Patient Rep, Transformation Team, Finance, Comms

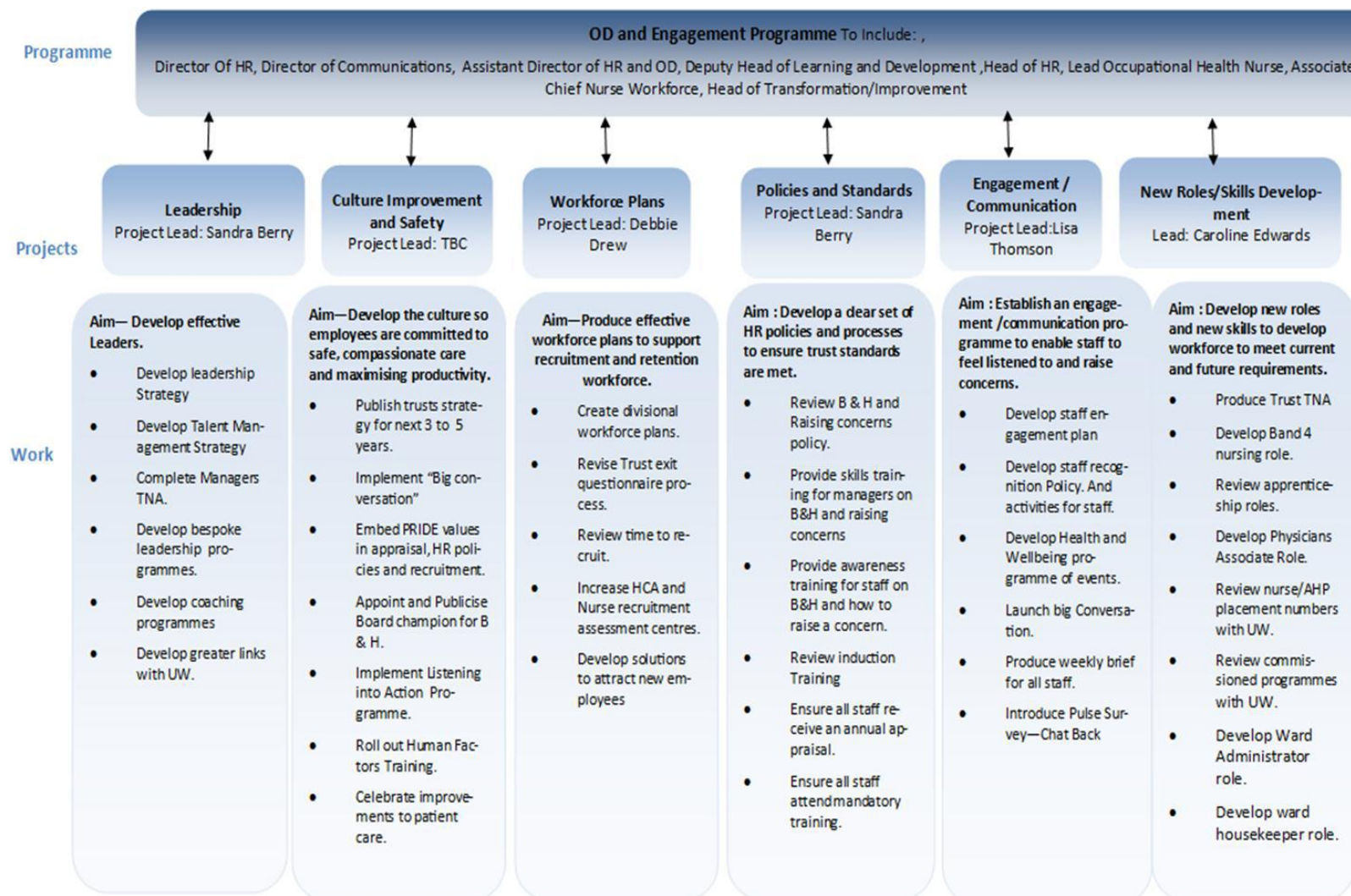# Organisation Development and Staff Engagement Programme - Measures

Worcestershire **NHS**
Acute Hospitals NHS Trust

Leadership	Staff Turnover %	Exit Interview Data. Number of comments relating to poor leadership	Staff Opinion Survey Key Factor 1 – Recommending Trust as a place to work and receive treatment.	Staff Opinion Survey KF5- Recognition and valued by managers and organisation.	Staff Opinion Survey KF10 – support from Managers.	Chat-Back Survey results.	
Culture	Staff Opinions Survey- KF31- staff confidence to report unsafe practise	Chat-Back Survey results	Reported Patient safety incidents	HR Case work B&H cases	Occupational Health Referrals • No of Stress referrals • No of counselling referrals		
Workforce Plans	Vacancy Numbers	No of New roles implemented • PA • Band 4 Nurse • Ward Administrator • Ward Housekeeper.	Number of Agency shifts. • M&D • N&M	Number of compliant rotas • M&D • N&M	Staff Opinion Survey KF15- Staff satisfaction with working patterns		
Policies and Standards	B & H concerns raised.	Mandatory Training compliance rates	Staff Opinion Survey – KF11 – staff received an appraisal in last 12 months.	Appraisal Compliance % • Medical • Non-Medical	Staff Opinion Survey KF12 – Quality of Appraisals.	Sickness Absence % • Long Term Cases • Short Term	Staff. Opinion Survey KF20 – Staff experiencing discrimination.
Communic-ation and Engage-ment	National SOS Results - Total engagement Score	Chat-Back Survey Results	Staff Turnover %	Sickness Absence % • Long Term Cases • Short Term	Exit Interview Data. Number of comments relating to poor communication		
New Roles	Vacancy Numbers	Patient complaints • No of complaints regarding staff shortages.	Number of compliant rotas • M&D • N&M	Number of Agency shifts. • M&D • N&M	Staff Opinion Survey Q49 – There are enough staff to do the job.		

OD and Engagement—Programme Structure

Programme

OD and Engagement Programme To Include: ,

Director Of HR, Director of Communications, Assistant Director of HR and OD, Deputy Head of Learning and Development ,Head of HR, Lead Occupational Health Nurse, Associate Chief Nurse Workforce, Head of Transformation/Improvement

Projects

Leadership Project Lead: Sandra Berry	Culture Improvement and Safety Project Lead: TBC	Workforce Plans Project Lead: Debbie Drew	Policies and Standards Project Lead: Sandra Berry	Engagement / Communication Project Lead:Lisa Thomson	New Roles/Skills Development Lead: Caroline Edwards

Work

Aim— Develop effective Leaders.	**Aim—Develop the culture so employees are committed to safe, compassionate care and maximising productivity.**	**Aim—Produce effective workforce plans to support recruitment and retention workforce.**	**Aim : Develop a dear set of HR policies and processes to ensure trust standards are met.**	**Aim : Establish an engagement /communication programme to enable staff to feel listened to and raise concerns.**	**Aim : Develop new roles and new skills to develop workforce to meet current and future requirements.**
• Develop leadership Strategy	• Publish trusts strategy for next 3 to 5 years.	• Create divisional workforce plans.	• Review B & H and Raising concerns policy.	• Develop staff engagement plan	• Produce Trust TNA
• Develop Talent Management Strategy	• Implement "Big conversation"	• Revise Trust exit questionnaire process.	• Provide skills training for managers on B&H and raising concerns	• Develop staff recognition Policy. And activities for staff.	• Develop Band 4 nursing role.
• Complete Managers TNA.	• Embed PRIDE values in appraisal, HR policies and recruitment.	• Review time to recruit.	• Provide awareness training for staff on B&H and how to raise a concern.	• Develop Health and Wellbeing programme of events.	• Review apprenticeship roles.
• Develop bespoke leadership programmes.	• Appoint and Publicise Board champion for B & H.	• Increase HCA and Nurse recruitment assessment centres.	• Review induction Training	• Launch big Conversation.	• Develop Physicians Associate Role.
• Develop coaching programmes	• Implement Listening into Action Programme.	• Develop solutions to attract new employees	• Ensure all staff receive an annual appraisal.	• Produce weekly brief for all staff.	• Review nurse/AHP placement numbers with UW.
• Develop greater links with UW.	• Roll out Human Factors Training.		• Ensure all staff attend mandatory training.	• Introduce Pulse Survey—Chat Back	• Review commissioned programmes with UW.
	• Celebrate improvements to patient care.				• Develop Ward Administrator role.
					• Develop ward housekeeper role.

Next steps – granular project plans

- Developed for mortality reduction programme

- Support in place for further development of OD/Staff Engagement and Urgent Care /Patient Flow project plans during early April – next iteration of plans will be available in time for Trust Improvement Board on 13th April 2016

- Trust adopting this project planning methodology for key improvement plans

  – Including use of metrics to set improvement ambitions and to monitor delivery and sustainability

- PMO support now more appropriately aligned to support programme management, project planning and service change

Example - Programme management and reporting

Worcestershire **NHS**
Acute Hospitals NHS Trust

Programme	SRO: XXXX	Lead: XXXX
Workstream	Date: 01/04/2014	

Worcestershire **NHS**
Acute Hospitals NHS Trust

Workstream Summary	Status

Status
Green In control
Amber At risk, needs support
Red Will not deliver on time

Metrics

Metric 1
Metric 2
Metric 3
Metric 4
Metric 5

Planned / Actual
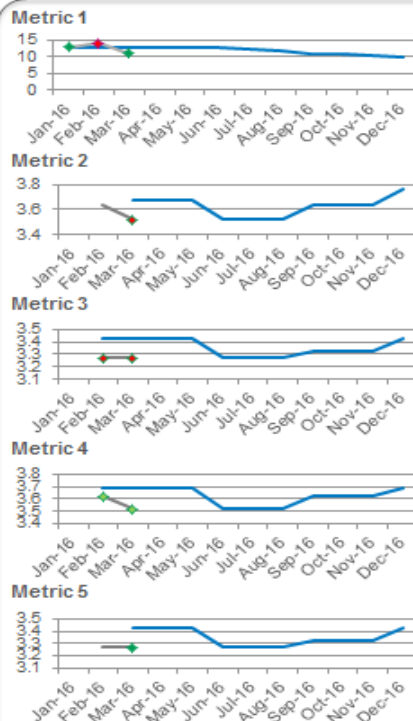
Milestones	Due Date	RAG
Milestone 1	01/03/2016	
Milestone 2	01/06/2016	

Tasks

6 On Plan
8 Overdue

Milestone 1   Milestone 2   Milestone 3

Jan 2016   Jan 2017

Risks / Issues	RAG	Mitigation
Risk 1		Mitigation 1
Risk 2		Mitigation 2

Risk/Issue Status

1 High
2 Medium
4 Low
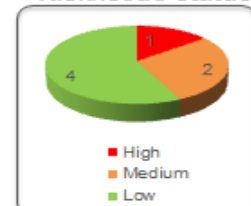
Support Required / Decisions Needed

- [ ] Roles & Responsibilities Defined
- [ ] Stakeholders analysed & listed
- [ ] Comms / Engagement Plan in place
- [ ] Inter-dependencies / enablers defined

CIH/CQC Monitoring Report

- Public- facing, single repository of information and reporting in relation to the key 'Must do' and priority 'Should do' actions identified in the December 2015 report

- Will be updated monthly in relation to progress and projections, based on accompanying dashboard

- Underpinned by Patient Care Improvement Plan and the work of the Trust Quality Champions

Report to Trust Board

Title	Workforce Assurance Group (WAG) Update
Sponsoring Director	**John Burbeck** Chair of the Workforce Assurance Group
Author	**Denise Harnin** Director of Human Resources and Organisational Development
Action Required	To receive assurance in respect of the items discussed at the Workforce Assurance Group, specifically in relation to: • BAF risks • Workforce Key Performance Indicators • Workforce Planning • Development of the OD Strategy
Previously considered by	*N/A*

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	

Related Board Assurance Framework Entries	• Risk 2678: If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels. • Risk 2893: Failure to engage and listen to staff leading to low morale, motivation and productivity as well as missed opportunities • Risk 2894: Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems.
Legal Implications or Regulatory requirements	
Glossary	

Title of Report	**Workforce Assurance Group**
Name of director	**Denise Harnin**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – APRIL 2016

1.   Situation

To inform the Trust Board on the actions and progress of the Workforce Assurance Group (WAG) at its March meeting.

2.   Background

The Workforce Assurance Group provides assurance to the Trust board on all workforce issues.

3.   Assessment

3.1   **Board Assurance Framework**

The Committee discussed and received assurance in relation to the following BAF risks:

Risk 2678: If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels: Discussed under the Key Performance Indicator item

Risk 2893: Failure to engage and listen to staff leading to low morale, motivation and productivity as well as missed opportunities: Discussed under the Staff Survey and Staff Engagement Plan item

Risk *2894: Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems*: Discussed under the OD strategy

I consider that WAG is able to provide assurance to the Trust Board on these key strategic risks.

3.2   **Agency Spend**

The Committee were pleased to see the considerable reduction in agency spend which has consistently reduced for the last 4 months.

3.3   **Key Performance Indicators**

Vacancies: Assurance was received on the activity being undertaken to reduce vacancies. This will be shown in the KPIs for April. The pay bill has reduced.

Total Staff Turnover: This has now stabilised, including turnover in respect of nurses.

Exit questionnaires: The results of the renewed drive for the completion of exit interviews will form part of the WAG report in the future.

3.4   **Workforce Planning**

The Trust is working towards an integrated workforce plan by merging the current nursing and medical workforce plans. This will be achieved by September 2016. WAG requested milestones to be set in relation to this piece of work.

3.5   **Organisation development (OD) strategy**

WAG received assurance on the contents and the plans for development of the strategy. It covers leadership; cultural improvement; workforce plans, policy and standards; engagement and communications and new roles. The Group could see the clear links between the Strategy and the PCIP.

Title of Report	Workforce Assurance Group
Name of director	Denise Harnin

3.6   **Policy Signoff**
        WAG signed off the following policies:
        - Management of celebrities
        - Media
        - Management of Incremental Pay Progression

3.7   **Reports discussed at WAG which are Board agenda items**
3.7.1   **Nurse Workforce Report**
        The Interim Chief Nurse's report (enclosure F2) was presented and assurance was given on the following areas:
        - Safe Staffing status and performance against TDA benchmark
        - Progress on the reduction in agency staff use
        - Update on Nursing/Midwifery workforce review
        - Update on Nurse/Midwifery revalidation

3.7.2   **Review of Nursing Establishment**
        Assurance was received on the contents of this report (enclosure F3).

3.7.3   **Medical Workforce Report**
        A summary report (enclosure F4) on progress being made and assurance provided that current key priorities are being taken forward on management of the Medical workforce. The Committee was assured that recruitment activity progressed but concerns were remain in respect of appraisal and job plans. However, the data are distorted with the addition of newly appointed doctors into the baseline. These doctors will not receive an appraisal immediately. The presentation of the data will be reviewed.

3.7.4   **Staff Survey 2015**
        The results of the national staff survey for 2015 have been received (enclosure F5) and actions being taken to improve staff engagement are outlined. I should like to draw the board's attention to the proposals for a revised employee recognition scheme which WAG endorsed.

4   **Recommendations**
        To receive assurance in respect of the items discussed at the Workforce Assurance Group, specifically in relation to:
        - BAF risks
        - Workforce Key Performance Indicators
        - Workforce Planning
        - Development of the OD Strategy

John Burbeck
Chair of the Workforce Assurance Group

Title of Report	Workforce Assurance Group
Name of director	Denise Harnin

Date of meeting: 6 April 2016   **Enc: F2**

Report to Trust Board (in public)

Title	Nursing and Midwifery Workforce Report
Sponsoring Director	**Mari Gay, Chief Nursing Officer**
Author	**Sonya Murray, Associate Chief Nursing Officer**
Action Required	The Board is asked to note the report on: - Nursing and Midwifery Workforce metrics and associated actions - Safe Staffing Status - Progress with the Nursing Workforce Review - State of preparedness for revalidation
Previously considered by	Workforce Assurance Group

Strategic Priorities (√)	
Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	

Related Board Assurance Framework Entries	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels.
Legal Implications or Regulatory requirements	Quality Commission standards, NICE Safer Staffing Guidelines
Glossary	HCSW – Health Care Support Worker TDA – Trust Development Authority NICE –National Institute for Health and Care Excellence NMC Nursing and Midwifery Council NQB National Quality Board

Key Messages
- Assurance of positive safe staffing status and performance against TDA benchmark.
- Progress with the trust's nursing and midwifery workforce review launched in November 2015 continues and implementation of a revised ward based workforce is imminent.
- The use of agency staff for nursing has reduced
- Positive assurance should be noted with preparation towards nursing and midwifery revalidation.

Title of report	Nursing and Midwifery Workforce Report
Name of director	Mari Gay, Interim Chief Nursing Officer

Date of meeting: 6 April 2016   **Enc: F2**

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
Report to Trust Board – April 2016

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1   Situation

This paper provides the latest position related to the Nursing and Midwifery Workforce including

- compliance with safe staffing guidance
- current vacancy position and actions taken to improve recruitment
- progress with implementation of the nursing and midwifery workforce review
- preparedness for nurse revalidation

2   Background

In November 2013 The National Quality Board (NQB) published *A guide to support providers and commissioners in making the right decisions about nursing, midwifery and care staffing capacity and capability.* Subsequently in July 2014 NICE published recommendations on safe staffing for adult-inpatient wards. It is recognised that there is no right answer for nurse and midwifery staffing and that services are complex requiring different solutions. Establishing appropriate staffing levels is complex and depends upon a range of factors including patient's dependency and acuity, patient flow, the capacity and capability of nurses and midwives and the environment of care provision.

The Secretary of State has since requested a refresh of the NQB Staffing Guidance and in February 2016 the Safe Sustainable Staffing Guidance Programme was launched. This will result in eight Safe Sustainable Staffing Guidance documents for different care settings during 2016. These will include Urgent and Emergency Care, Maternity Services, Children's Services and Inpatient wards for adults in acute hospitals.

Key points within the new NQB guidance will be :

- Expectations in terms of delivery will be reframed and reduced in number.
- Boards have shared responsibility for staffing.
- Staffing models to include at multi-professional teams.

3   Assessment

3.1   **Nursing and Midwifery workforce metrics.**

The nursing and midwifery vacancy position reported as of 29th February 2016 is outlined below

	Funded Establishment		Vacancies wte/% of funded	
	Qualified	Unqualified	Qualified	Unqualified
September 2015	1696.43	710.28	135.75 **8.0%**	36.3 **5.1%**
October 2015	1865.08	735.91	171.21 **9.1%**	25.72 **3.4%**
November 2015	1865.08	735.91	172.2 **9.23%**	38.1 **5.1%**

Title of report	Nursing and Midwifery Workforce Report
Name of director	Mari Gay, Interim Chief Nursing Officer

			160.0 **8.54%**	45.0 **6.0%**
December 2015	1871.61	737.84		
January 2016	1872.42	740.77	195.8 **10.45%**	42.6 **5.7%**
February 2016	1872.74	740.77	166.26 **8.87%**	39.46 **5.32%**

The number of wte funded qualified nursing and midwifery posts have remained mostly static during February 2016. Vacancies for both qualified and unqualified staff have decreased reflecting the on-going recruitment activity.

Divisional Positions
Surgery
The position in relation to registered nurses within Surgery remains static overall for the fourth month in a row with 42.40.wte registered nurse vacancies reported for February 2016 against 43.00 wte for January 2016 .The vacancy position for HealthCare Support Workers shows improvement at 2.5 wte for February 2015 against 5.1 wte for January 2016. This reflects the continued active recruitment of HCSWs to support areas where there are registered nurse vacancies.

Medicine
The vacancy position in Medicine has declined in February with an increase in registered nurse vacancies from 80.47 wte in January 2016 to 96.64 wte in February 2016. The majority of vacancies are within the Medical Assessment Units (MAU) at both Worcestershire Royal Hospital and the Alexandra Hospital. A workforce review is being undertaken in MAU at the Alexandra Hospital with a view to creating smaller speciality areas within the overall foot print with the intention that this may make vacancies more attractive to potential candidates.

TACO/Clinical Support
Vacancies within TACO/Clinical Support remain largely for Registered Nurses within theatres and Operating Department Practitioners (ODPs). There are currently 16.4 wte registered practitioner vacancies in theatres across the county. The vacancy position within theatres continues to improve with continued recruitment including attendance at regional recruitment events. Arrangements are also now in place for the in –house bank aiming to reduce the reliance on agency.

Women & Children
Within Women and Children's Division the vacancy position has remained static for registered staff, 20.83 wte vacancies in February compared with 21.12wte in January 2016. Vacancies for HCSWs has increased with 12.86 wte. HCSW vacancies reported for February compared to 6.30 wte in January 2016. Recruitment is on-going and regular establishment reviews are being undertaken since the centralisation of services. A recruitment exercise has successfully recruited experienced and newly qualified midwives into vacancies.

Trust Recruitment Actions
On March 2nd a recruitment event was held at the University of Worcester with senior nursing students. This was attended by 50 students and senior staff from the trust showcased what the Trust could offer newly qualified staff. Feedback from the event

Title of report	Nursing and Midwifery Workforce Report
Name of director	Mari Gay, Interim Chief Nursing Officer

Worcestershire **NHS**
Acute Hospitals NHS Trust

was very positive and future student events are planned. Both the Medical and Surgical Divisions have in place bespoke rotational programmes for Band 5 posts to attract student nurses to take up qualified roles.

The next planned recruitment event is Saturday April 14th 2016 at the Alexandra Hospital in Redditch. This event will have a particular focus on theatre recruitment.

3.2 **Safer staffing**
Trust overall fill rates for February 2016

Site Name	Day		Night	
	Average fill rate - registered nurses midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
AGH	93.8	95.7	85.8	112.0
KGH	94.7	88.8	100.0	129.0
WRH	95.1	99.5	90.8	99.2

The above table indicates that overall our hospital sites are working either to or above the required 80% benchmark set by the TDA for safer staffing.

The table below outlines the wards who did not meet the 80% fill rates required by the TDA for February 2016. 15 out of the 43 wards had a fill rate of less than 80%. A slight decline when compared with January 2016 where 12 wards had fill rates of below 80% on one or more occasion.

Ward name	Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Ward 12 Medicine	81.5%	92.6%	62.7%	114.2%
Ward 2 Specialist Med	98.7%	119.3%	78.4%	134.6%
Ward 6	96.5%	79.4%	97.3%	96.6%
Ward 9	86.7%	81.4%	65.4%	96.4%
Ward 10	77.9%	88.0%	64.8%	191.3%
Ward 11	92.5%	92.0%	72.1%	182.5%
Ward 16	73.8%	97.4%	65.0%	168.2%
Ward 18	89.2%	98.4%	74.8%	164.3%
SCDU & SHDU	111.9%	119.0%	78.6%	100.7%
Beech A	96.3%	138.4%	66.2%	100.7%
Chestnut	81.4%	101.5%	58.8%	66.0%
Severn Unit & HDU	114.4%	68.0%	101.3%	96.1%
WRH Delivery Suite & Theatre	106.6%	80.0%	89.3%	73.4%
WRH Riverbank	81.4%	91.9%	65.7%	89.0%
Laurel 3 WRH	96.7%	100.0%	71.6%	100.0%

Title of report	Nursing and Midwifery Workforce Report
Name of director	Mari Gay, Interim Chief Nursing Officer

Worcestershire **NHS**
Acute Hospitals NHS Trust

Key

- 80%	■
80-94.9%	■
95% +	■

Surgery
Fill rates under 80% within the Surgical Division are attributed to the unavailability of a third planned registered nurse on night shifts due to continued vacancies. Additional HCSWs were rostered to cover the shortfalls and maintain overall numbers of staff on duty. There is no correlation with any patient safety incidents.

Medicine
Within the Medical Division fill rates under 80% are attributed to vacancies and short term sickness. Where the shortfall is related to Registered Nurses the skill mix was supplemented by additional HCSWs. Some overfill rates were patients requiring 1:1 supervision and specialing.

Women and Children
Low fill rates within the Women and Children's Division on paediatric wards have been due to vacancies which have now been recruited to. As these wards currently have low numbers of HCSWs within their skill mix, any shortfall has a significant impact on fill rates. Whilst the data reflects a fill rate of 73.1% for midwives on night shifts, staffing of maternity areas is shared across the unit and staff are re-deployed across areas dependant on acuity and patient need.

Staffing across all areas within maternity is managed on a shift by shift basis and there are clear escalation procedures in place to cover shortfalls including the use of the use of bank and agency staffing where appropriate.

3.3 **Nursing and Midwifery Workforce Review**
The trust's nursing and midwifery workforce review has focused on certain areas initially.

Matrons review. The review has analysed the current matron function and using three principles of
- Equity of matron patches
- Alignment to the patient pathway
- Efficiency and effectiveness of the role

A revised matron portfolio, agreed with the divisions, is within human resource processes and will be implemented within the next month.

Corporate nurses. To date the review has analysed vacant roles for skill mix and up to date requirements. A deputy director of governance has been recruited. There is acknowledgement that there is a need to enhance the safeguarding function within the trust and this is being addressed.

Ward based establishments The ward based review has focussed on appropriate skill mix and introduction of new roles which are outlined in the board paper entitled six monthly establishment review

| Title of report	Nursing and Midwifery Workforce Report
Name of director	Mari Gay, Interim Chief Nursing Officer

Advanced practice roles Scoping of the Advanced Nurse Practitioner and Emergency Nurse Practitioner Roles has been undertaken and the results of this demonstrate there is a lack of consistency across the Trust in terms of the roles, skills sets and competencies of this group and a strategy will be developed to address this by the senior nursing team.

The next stage of the review will be a review of the specialist nurse workforce. A template for job planning for Clinical Nurse Specialists and Advanced Practitioners is being developed for this purpose.

3.4   **Progress with the use of Bank and Agency Staffing**
The current NHSP contract has been temporarily extended with no changes in contractual terms and conditions whilst a longer term solution is agreed.

February saw a further decrease in agency usage with an overall reduction illustrated below
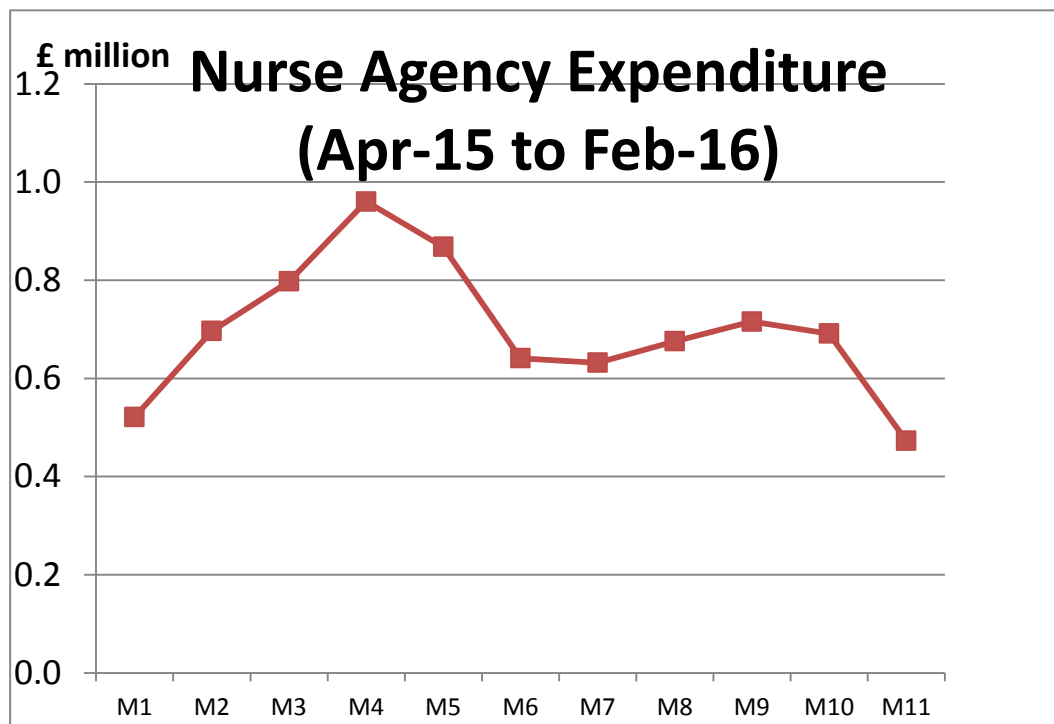
The highest usage of non-cap compliant agencies continues to be theatres, Emergency Departments and MAU at the Alexandra Hospital. A number of actions have been taken to further reduce the agency spend   including:

- Introduction of in house bank in theatres which commenced March 21st
- Temporary increase in pay rates for NHSP staff in Emergency Departments
- A pilot is currently underway within the Medical Division to reduce the use of qualified agency staff for specialing. The 8 week trail commenced on March 1st and the results will determine future specialing policy.
- Rules related to the use of agency have been agreed within the senior nursing team and exceptions will be authorised by senior nurses in the organisation

Title of report	Nursing and Midwifery Workforce Report
Name of director	Mari Gay, Interim Chief Nursing Officer

only.

3.5   **Nursing & Midwifery Revalidation – update**
Awareness raising sessions continue across the Trust in preparation for April 1st with no major issues identified. The first wave of nurses to revalidate on or shortly after April 1st 2016 have now received notification from the NMC to start the process. 550 registered nurses and midwives have attended revalidation awareness sessions so far. The sessions will continue during April and May 2016.

4   Recommendation
The board is asked to receive assurance related to:

* Nursing and Midwifery Workforce metrics and associated actions
* Safe Staffing Status
* Progress with the Nursing and Midwifery Workforce Review
* State of preparedness for Nursing and Midwifery revalidation

Mari Gay
Interim Chief Nursing Officer

Title of report	Nursing and Midwifery Workforce Report
Name of director	Mari Gay, Interim Chief Nursing Officer

Report to Trust Board

Title	**Six Monthly Staffing Establishment Review**
Sponsoring Director	**Mari Gay, Interim Chief Nursing Officer**
Author	**Lisa Miruszenko, Deputy Chief Nursing Officer**
Action Required	• To receive assurance in relation to the outcomes of the establishment review • To support the changes to the workforce profile of the ward establishment.
Previously considered by	Workforce Assurance Group

Strategic Priorities (√)	
Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	
Develop and sustain our business	

Related Board Assurance Framework Entries	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels
Legal Implications or Regulatory requirements	
Glossary	WMQRS – West Midlands Quality Review Service. HCSW Health Care Support Worker SNCT -Safer Nursing Care Tool

Key Messages

This paper provides the required six monthly establishment review for nursing and the agreed changes to the skill mix on the base wards to maintain safe staffing levels and ensure appropriate roles are undertaking appropriate tasks. This paper supports the outcomes of the nursing and midwifery workforce review and introduces to the trust associate practitioner/associate nurse roles, ward house keeper roles and ward administrator roles.

Title of report	6 Monthly Staffing Establishment Review
Name of director	Mari Gay

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD

1. **Situation**

   This paper provides the required six monthly review of the nursing establishment levels in relation to the acuity of the patients.

   The review has taken into account a variety of recommended methods for reviewing and setting safe staffing levels, namely;
   - Use of the Sheldon Model Safer Nursing Care Tool
   - Nurse sensitive indicators
   - Registered Nurse: bed ratio modelling
   - Use of Professional guidelines on staffing
   - Professional scrutiny
   - Registered Nurse: HCSW ratio
   - Care Contact Time Audit

2. **Background**

   The National Quality Board Guidance (2013) recommends that Trusts undertake a formal review of their inpatient staffing on a biannual basis with recommendations made to the Board by the Chief Nurse. In October 2015 the NHS Regulators reinforced the message related to safe staffing and the responsibility of provider boards to use professional judgements to support staffing requirements. This message also reinforced the requirement to explore efficient methods of working and innovative workforce approaches to staffing to support both the safety agenda and the financial challenges facing the NHS.

   The Secretary of State has since requested a refresh of the National Quality Board (NQB) Staffing Guidance and in February 2016 a Safe Sustainable Staffing Guidance Programme was launched. This will result in eight Safe Sustainable Staffing Guidance documents for different care settings during 2016. These will include the following which are applicable to the Trust:

   - Urgent and Emergency Care
   - Maternity Services
   - Childrens Services and
   - Inpatient wards for adults in acute hospitals

   However for the purposes of this report current NICE and Professional recommendations and guidelines are used to inform the assessment of safe staffing levels in addition to the principles of the October 2015 regulator letter.

3. **Assessment tools used in review**

   Since January 2011 the Trust has undertaken a biannual acuity census using a variety of recognised tools The main tool used is the Shelford Safer Nursing Care Tool, an evidence based tool that enables assessment of patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity / dependency terms.

Title of report	6 Monthly Staffing Establishment Review
Name of director	Mari Gay

The Shelford Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (*Comprehensive Critical Care, DH 2000*). These classifications have been adapted to support measurement across a range of wards / specialties.

Acuity is measured across a range classified from 0, where the patient requires hospitalisation and needs are met by the provision of general ward based care to Level 3 – where patients need advanced respiratory support and / or therapeutic support of multiple organs.

In addition to using this tool the organisation has undertaken a care contract observational tool based on the Productive Ward Methodology. This involved an observational audit of nursing activity and measuring how much time was spent providing direct patient contact care. The results indicated that qualified and unqualified roles were undertaking tasks that could and should be delegated within an agreed skill mix.

Other tools used by the trust to undertake the six monthly review are:

- A draft Shelford Tool has been produced for Paediatrics which has been utilised in this census.
- The BEST' Tool – Baseline Emergency Staffing Tool as recommended by the Royal College of Nursing.
- The Birth Rate Plus tool is used within Midwifery and is normally conducted every three years. The last assessment was undertaken two years ago.
- Care contact time audit.

3.1 Outcomes of review

Medicine Division
The Acuity Census for January 2016 remains unchanged since September 2015 with the majority of patients in categories 0 – 1b. Patients with a higher acuity tending to be in Acute Stroke Unit, Silver Assessment Unit and Coronary Care.

Staffing within the Medicine Division is compliant with NICE guidance (1:8) across base medical wards during day shifts. Often at night the qualified ratio is diluted by using HCSW with no impact on quality indicators. The Acute Stroke Unit, Silver Assessment Unit and Coronary Care work to 1:6 which is in line with national guidelines. The medical high care units flex their workforce between 1-2 and 1-4 nursing based on acuity of the patients.

The ratio of qualified to unqualified staff is 64/36 which is slightly higher than the traditional 60/40 recommendations. This relates to the higher care areas above.

A detailed workforce plan is currently being agreed for the Emergency departments. For the Worcester Royal site this enhances the nursing workforce aligning with the ED expansion. Paediatric trained nurses in ED are below WMQRS recommendations. It is recognised this a national challenge

Title of report	6 Monthly Staffing Establishment Review
Name of director	Mari Gay

and despite numerous attempts to recruit either paediatric nurses or dual trained nurses it has been unsuccessful. To mitigate this, the trust is working in collaboration with Worcester University to provide a bespoke training programme for ED nurses to achieve paediatric competencies.

The uplift for training within the Medicine Division is 23.8% which is line with professional recommendations.

Investment in targeted recruitment activity has seen improvement in the vacancy position for Medicine over the last 6 months.

Surgical Division

Staffing within the Surgical Division is mostly compliant with NICE guidance (1:8) across base surgical wards during day shifts and at times exceeds this for example some wards on some days have a ratio of 1:5. This is in response to the increased acuity of the patients on the colorectal surgical wards at the Worcester Royal Hospital, following the changes in the emergency surgical and major elective surgical pathways. The division is proposing a permanent increase in the workforce in the annual review and has identified the funding to support this increase in nursing numbers. There is variation of nurse to patient ratios across the 7 day week acknowledging the times of higher activity. This is also reflected at night, although due to recruitment challenges the planned three Registered Nurses at night has not been achievable on all surgical wards and staffing has been supplemented by HCSWs to ensure patient safety. This has resulted in higher than ideal nurse to patient ratios at times based on the current ward profile.

The ratio of qualified to unqualified staff meets the traditional 60/40 recommendations.

The uplift for training within the surgical Division is 23.8% which is line with professional recommendations.

The management of vacancies within the Surgical Division at the Alexandra Hospital has continued to be challenging for a variety of reasons. For this reason the Trusts quarterly nursing recruitment events have focused on the Alexandra site. This appears to have met with some success into recruiting to vacancies at the Alexandra particularly when enhanced with wider advertising in the north of the county and surrounding areas.

TACO/Clinical Support Division

Within theatres, guidelines from the Association of Perioperative Practitioners are used to guide staffing levels. Recruitment to theatres however is challenging and has been extensive use of agency to supplement the substantive workforce and to meet the required guidelines. This is challenging in the light of agency caps and an in- house bank with enhanced rates of pay has been set up to encourage staff to move from agency to bank.

Intensive Critical Care Units are staffed according British Association of Critical Nurses guideline and works within these guidelines. Staff work across both units and there are no staffing concerns. The uplift for critical care is 23%.

Title of report	6 Monthly Staffing Establishment Review
Name of director	Mari Gay

The recruitment of chemotherapy trained nurses has proved challenging within the Division and this has resulted on a reliance on third party agency staff to meet guidelines. Plans are now in place to develop the training of chemotherapy nurses in house.

Haematology/Oncology in – patient areas are compliant with WMQRS staffing guidelines for such units. The Acuity of in- patients within haematology remains consistent, with most patients between level 1a and 1b with some staffing shortfalls due to the challenges around the recruitment of chemotherapy nurses.

All areas within TACO/Clinical Support have a 19.78% uplift with the exception of critical care which has an uplift of 23%. This was an agreed decision and is monitored closely for impact.

Women & Children Division
The midwife to birth ratio determines the number of midwives commissioned.

The establishment was last formally reviewed with the use of Birth-rate plus and reported in January 2013. This is in accordance with the new NICE guidelines for safe staffing in maternity which recommends three yearly review. It is now due to be repeated and a table top exercise is scheduled for April 2016 to achieve this and to comply with the midwifery specification. This will be reported in the May board report.

The current position with Midwifery to birth ratio is 1:28 but this has fluctuated over recent months. The community case load remains at 1:118 against a recommendation of 1:98 with up 10% adjustment downward to reflect Public Health Deprivation scores.

Emergency centralisation of maternity inpatient services took place in November 2015. The staffing rosters have been combined to provide safe staffing for the maternity inpatient areas at WRH. Staffing is managed as a whole across acute and community, with redeployment of staff to work in areas of need.

The senior ward sisters are each allocated a day per week for non-clinical duties to manage their areas. There is no additional supernumerary time allowance within the establishments – a proposal was submitted for this and the increase of uplift from 19% to 23% in line with the wider Trust and this is being considered.

3.2   Changing the skill mix to deliver safe and effective care
The trust has aligned the work of the Nursing and Midwifery review launched in November 2015 to this establishment review. It is nationally recognised there is a significant challenge to maintain the recruitment of qualified nurses for the numbers required. The establishment review has shown a need for a change in skill mix on the wards and the need to incorporate new roles to ensure we have appropriate roles undertaking appropriate tasks and to maintain safe care. These new roles will support both the qualified and unqualified nurses thus enabling more patient contact time and providing better clarity of role definition.

Title of report	6 Monthly Staffing Establishment Review
Name of director	Mari Gay

The new roles that will be included within the ward areas are:

Ward Housekeeper - band 3. Following the divisional workforce reviews we have confirmed across the Trust we require 33 WTE ward housekeepers. The ward housekeeper role is a nationally recognised role which is non-clinical. The role will be responsible for organising and maintaining the ward and its environment on a daily basis. The housekeeper's role will free up HCA's freeing them up to provide direct patient care. The ward housekeeper's role will be phased in over the coming months.

Ward Administrator - band 3, Following the divisional workforce reviews we have confirmed across the Trust we required 26 WTE ward administrators. The ward administrator works directly to the ward manager and supports the junior sisters, this role is key to ensuring that all the administrative functions on the ward are done by appropriate non-clinical administration. This will support the ward manager in ensuring that PDRs, mandatory training, sickness reviews and general administrative duties are maintained effectively. This will enable the ward manager to be provide enhanced clinical leadership and able to support the smooth co-ordinating and running of their wards. This will support the concept of supervisory status. The ward administrator role will be phased in over the coming months.

Assistant Practitioners,/Associate Nurse -Band 4. Following the divisional workforce reviews we have confirmed across the Trust we required 42 WTE Assistant Practitioners/Associate Nurse. This role will be able to support both the registered and unregistered nurses as an advanced clinical support role. These posts will enhance the unregistered nurse skills by delivering many tasks within a ward, traditionally provided by a qualified nurse. The Trust has secured 42 placements for the first cohort with the University and it is hoped these will be fully integrated into the wards imminently and their full training will be complete in 18 months.

The resource for these roles will be identified as part of current ward budgets/vacancies and once introduced will be evaluated. These roles are common across many acute hospitals with positive outcomes but they will change the current ward workforce profiles within the trust. To date the risk assessments being undertaken for each ward area to support this change are indicating minimal risk and therefore the recruitment to these posts is about to commence with the aim of attracting local people into the posts, to offer an enhanced career progression for the unqualified practitioner.

To monitor the quality of care the trust now has ward quality dashboard which includes both staffing and a suite of quality indicators. The triangulation of these indicators will be used to inform Divisional quality and governance performance reports and the evaluation of these workforce changes.

4.   **Recommendations**
- To receive assurance in relation to the outcomes of the establishment review
- To support the changes to the workforce profile of the ward establishment.

Title of report	6 Monthly Staffing Establishment Review
Name of director	Mari Gay

Worcestershire **NHS**
Acute Hospitals NHS Trust

Date of meeting: 6 April 2016 **Enc: F4**

Report to Trust Board

SUBJECT	Medical Workforce Report
NAME/TITLE OF DIRECTOR	**Andy Phillips** **Interim Chief Medical Officer**
AUTHOR OF REPORT	**Sarah Allan** **Human Resources Manager**

Action Required	The Trust Board is requested to:
	 • Receive assurance in respect of
	     o Management of medical vacancies
	     o Job planning
	 • Receive an update on Health Education England Doctors in Training posts
	 • Receive the report

Previously considered by	Workforce Assurance Group (WAG)

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	√
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	√

Related Board Assurance Framework Entries	• Risk 2678: If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels. • Risk 2893: Failure to engage and listen to staff leading to low morale, motivation and productivity as well as missed opportunities • Risk 3079: Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care.
Legal Implications or Regulatory requirements	Duty of care for our staff and patients.
Glossary	HEE – Health Education England CEA – Clinical Excellence Awards

Key Messages

This paper provides assurance on progress with the Medical Workforce agenda. Significant progress has been made to reduce the number of medical vacancies. The Trust is remaining vigilant in planning for further strike action by junior doctors and is awaiting national guidance for the implementation of the new contract. HEE has commissioned three new posts and decommissioned two posts with effect from 1 August. Planning is taking place to mitigate for the decommissioned posts. Appraisal rates amongst the doctors with a prescribed connection to the Trust continue to rise.

Title of report	**Medical Workforce Report**
Name of director	**Andy Phillips – Interim Chief Medical Officer**

Worcestershire **NHS**
Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
Report to Trust Board

1.   Situation
This report provides assurance on the key areas in relation to the medical workforce.

2.   Background
To provide an update on key performance indicators for the medical workforce. The report also includes an update on the progress of related projects. This report was considered in detail at the Workforce Assurance Group at its most recent meeting.

3.   Assessment
3.1   **Workforce Capacity**
3.1.1   **Medical Vacancies**
Validated recruitment plans existed for 76% of all medical vacancies as of 29th February, compared to 57% in January 2016. The detail was discussed at the Workforce Assurance Group. Regular review meetings involving Divisional leads, HR and Finance have been implemented to develop plans and track progress with recruitment strategies.

Some medical vacancies have validated reasons for non-progression of recruitment:
- Trust positions converting to training posts (e.g. recruited through Health Education England);
- Staggered recruitment strategy (e.g. filling posts an individual basis rather than "flooding" the labour market with several posts);
- A part-time doctor in a full-time post, where the decision is taken by the Division not to recruit to the shortfall whole time equivalent (WTE).

3.1.2   **Junior Doctors Contract and Industrial Action**
a   **Industrial Action**
The British Medical Association (BMA) has confirmed further dates of industrial action.
- 8am on Wednesday 6 April to 8am on Friday 8 April (48 hours, emergency cover only)
- The planned industrial action (48 hours, emergency cover only) on Tuesday/Wednesday 26/27 April has been changed to "a full withdrawal of labour by junior doctors between 8am and 5pm on Tuesday 26th and Wednesday 27th April 2016 (18 hours in total)"- *correct as of 29th March 2016.*

Trust senior management will meet ahead of the planned actions in April, as they did ahead of the March action, to agree plans to minimise the disruption to patients and Trust activity whilst maintaining patient safety and service continuity. The Trust will continue to liaise with local health care provider partners to identify opportunities for working together to support the provision of care.

b   **Junior Doctors' Contract**
In February and March 2016, NHS Employers conducted a series of webinars and staff engagement events regarding the new junior doctors' contract identifying the following key actions for NHS Trusts:
- Implementation of the role of independent Guardian of Safe Working.
- Remodelling and consultation of junior doctor rotas to comply with new working arrangements.

Title of report	**Medical Workforce Report**
Name of director	**Andy Phillips – Interim Chief Medical Officer**

- Provisions to accommodate the change in monitoring of hours arrangements – with implementation of an exception reporting model.
- Establish payment and protection arrangements for doctors on the new contract with collaboration of ESR and Trust payroll teams.

Further national guidance is awaited in respect of implementing the contract.

3.1.3 Health Education England (HEE) Doctors in Training Posts
a **Post Commissions**

The Trust was successful in securing bids for two Emergency Medicine posts and one Acute Medicine post at Worcestershire Royal Hospital. This will enable expansion of numbers on rota and conversion of existing long-term vacant career grade posts, thus reducing reliance on locum bookings and agency expenditure. A Medical Oncology post has also been commissioned, expanding the remit of training the Trust provides to Doctors in Training in this specialty.

b **Post Decommissions**

The Trust has received notice two Anaesthetics Core Training posts at the Alexandra Hospital will be decommissioned. Work is in progress to confirm Divisional plans by April 2016, to enable sufficient time to re-model rotas and undertake associated recruitment activity where required.

3.2 Clinical Excellence Awards (CEA)

The 2015 CEA scheme was launched on the 8th February 2016. Eligibility checks are currently being undertaken by HR to inform the Trust Clinical Excellence Awards Committee which will meet in April.

3.3 Workforce Efficiency
3.3.1 Medical Casework

As at 29 February 2016, there were twelve active medical cases in progress. The detail of this was considered by the Workforce Assurance Group.

3.3.2 Locum Co-ordinator Centralisation

This will take place in early April and will reduce the number of high cost locum doctors and support cessation of agency locum doctors booked over the TDA/Monitor Capped rates.

3.4 Workforce Compliance
3.4.1 Medical Revalidation and Appraisal

As at 29th February 2016, 371 doctors hold a prescribed connection to the Trust with 287 doctors revalidated which is in line with the GMC revalidation trajectory timeline for doctors' initial revalidation.

Appraisal completion rate (as at 29/2/16)	Direction of travel since 31/1/16	Medical Staff Group
83.02%	⬆ 1.62%	All eligible medical staff
85.16%	⬆ 1.66%	Consultant Staff
75.0%	⬆ 1.56%	SAS and career grade

- Since 31st January 2016, the appraisal rate for all medical staff has improved by

Title of report	**Medical Workforce Report**
Name of director	**Andy Phillips – Interim Chief Medical Officer**

1.62% to 83.02%, with the rate of consultant appraisal being 85%.
- Clinical Lead for Medical Revalidation and Appraisal: the post remains unfilled following three rounds of recruitment. A decision regarding the future recruitment plan is under consideration by the Interim Chief Medical Officer.

3.4.2 Job Planning
Divisional activity continues to deliver the target for all Consultant and SAS doctors to have a current job plan by 31st March 2016. A detailed discussion took place at the Workforce Assurance Group in relation to this.

4 Recommendation
The Trust Board is requested to:
- Receive assurance in respect of
    o Management of medical vacancies
    o Job planning
- Receive an update on Health Education England Doctors in Training posts
- Receive the report

Andy Phillips
Interim Chief Medical Officer

Title of report	**Medical Workforce Report**
Name of director	**Andy Phillips – Interim Chief Medical Officer**

Worcestershire NHS
Acute Hospitals NHS Trust

Report to Trust Board (in public)

Title	**2015 National Staff Survey**
Sponsoring Director	**Denise Harnin, Director of HR and OD** **Lisa Thomson, Director of Communications**
Author	**Lisa Thomson, Director of Communications**
Action Required	The Board is requested to • Receive the results of the staff survey 2015 • Note the key findings of the survey • Receive assurance on the actions being taken to engage with staff, in particular ChatBack, The Big Conversation, Listening into Action • Discuss any further areas for consideration on staff engagement • Agree to receive further assurance via the Workforce Assurance Group which will be monitoring the actions agreed. • To note the content of the report
Previously considered by	*Workforce Assurance Group*

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	√

Related Board Assurance Framework Entries	2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity and missed opportunities.
Legal Implications or Regulatory requirements	NHS Constitution National NHS Staff Survey Workforce Race Equality Standards Protection from Harassment Act 1997
Glossary	

Key Messages

A sample of Trust staff (850) were surveyed in the 2015 National Staff Survey (some four months ago) with a response rate of 44% (372 staff) which is average for acute trusts in England.

The overall Trust results show no improvement on 2014 with some areas declining.

To ensure that the Trust addresses the issues raised a new OD strategy has been developed and a programme of activity is planning including real time surveys to monitor progress and a tried and tested programme called *Listening into Action (LiA)* which has already led to increased engagement and morale of staff in other NHS trusts.

Progress is to be monitored via the Workforce Assurance Group, subcommittee of the Board

Title of report	2015 National Staff Survey
Name of director	Denise Harnin/ Lisa Thomson

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 6 April 2016

1. **Situation**

   The 2015 NHS Staff Survey (the 13th national survey) involved 297 NHS organisations in England. Over 741,000 NHS staff were invited to participate using a self-completion postal questionnaire survey or online. Fulltime and part-time staff who were directly employed by an NHS organisation on September 1st 2015 were eligible to take part and the survey was carried out between September and December 2015.

   The Trust selected to sample 10% of its workforce. In total a randomly selected sample of 850 staff employed across the Trust were offered the opportunity to complete and return the national anonymous questionnaire. The process was independent and external to the Trust with questionnaires returned to an external survey contractor (Quality Health).

   In total 372 staff at Worcestershire Acute Hospitals NHS Trust took part in this survey. This is a response rate of 44% which is average for acute trusts in England, and compares with a response rate of 38% in this Trust in the 2014 survey.

   At the time the survey, the Trust was taking part in CQC and TDA reviews and the temporary move of birthing services from the Alexandra to Worcestershire Royal took place.

   This report presents the summary findings of the 2015 national NHS staff survey conducted in Worcestershire Acute Hospitals NHS Trust based on four of the seven pledges to staff in the NHS Constitution which was published in March 2013 plus three additional themes:

   - Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities;
   - Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential;
   - Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety;
   - Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families;
   - Additional theme: Equality and diversity;
   - Additional theme: Errors and incidents; and
   - Additional theme: Patient experience measures.

2. **Background**

   As highlighted in the 2015 research findings from the NHS national staff survey, a variety of research reports have demonstrated clear links between levels of engagement (a mixture of how motivated staff are, how much they are able to suggest and implement

Title of report	2015 National Staff Survey
Name of director	Denise Harnin/ Lisa Thomson

improvements, and how prepared they are to speak positively about their organisation) and a range of outcomes - including patient satisfaction, patient mortality, trust performance ratings, staff absenteeism and turnover. The more engaged a workforce is, the better the outcomes for patients; the difference between an average and good trust on engagement would be equivalent to around a 5% decrease in absenteeism or turnover, or about a 4% decrease in mortality.

Appendix 1 highlights a summary of the national 2015 staff survey and show no improvement and in many areas a decline against the Trust's 2014 position and the national average score for acute trusts. The Trust was in the bottom 20% of acute trusts for 23 of the 32 key findings and was worse than average in 4; average in 4 key findings and better than average in 1.

The results provide an indication that:
- There is evidence of a healthy reporting culture
- The results are statistically similar to last year
- 3 areas that have deteriorated specifically:
  KF22 – physical violence from patient/public increased from 14% to 22%
  KF6 – good communication between senior managers and staff deteriorated from 28% to 19%
  KF21 – agree that equal opportunities to career progression/promotion deteriorated from 90% to 80%

This position is being addressed with urgency as employee engagement is seen as fundamental to the Trust's improvement journey.

3.   Assessment
To address the issues raised in the survey and ensure that the organisation has more regular timely information to measure and monitor progress a number of actions are being implemented:

3.1   Organisational Development Strategy
The Trust is in the final stages of finalising an OD strategy aimed at supporting the delivery of an efficient and effective organisation with at its heart a health culture focused on excelling at delivering safe quality, patient and person centred care. This is based on six pillars:
1. Inspiring vision and values;
2. Goals and performance set at every level;
3. Supportive and compassionate behaviours;
4. Learning and innovation;
5. Effective team working; and
6. Collective leadership.

Key to achieving this is investing in our workforce, developing new roles as well as enhancing skills. Working with Health Education West Midlands, the Trust has secured additional external funding to support a programme to enable more staff throughout the Trust take advantage of developing and improving their skills. This includes a focus on leadership knowledge and skills programmes.

Title of report	2015 National Staff Survey
Name of director	Denise Harnin/ Lisa Thomson

3.2   Real-time Surveys

Quarterly surveys, commencing at the end of April will encompass the staff Friends and Family tests, where staff are asked if they would recommend us as a place to work and a place to receive care. These surveys will be based on the National Staff Survey methodology and enable the Trust to test what is driving people's views. It will also be open to all staff and not just a sample. Data and information from these surveys will be available in a few weeks following each survey enabling progress to be measured and support given to specific areas. Information will be provided at a Trust and Divisional level.

3.3   The Big Conversation

In addition to the executive team joining local team and directorate meetings, a series of events have been held in public areas on all sites to gain additional employee feedback. Over December and January this has included asking staff over a period of a week to contribute and leave their thoughts and feedback on a number of questions. The Trust has received over 200 comments and held many more conversations. This work will continue focused on elements of the National Staff Survey to gain in-depth insight on what changes are required to deliver improvements.

3.4   Listening into Action (LiA) building on the Big Conversation

As part of changing culture, the Trust has signed up (in parallel with nine other NHS trusts) to be a 'National Pioneer on Staff Engagement and Empowerment'. The aim is to change the way we work, allowing staff to remove the barriers that get in the way of delivering quality for patients. This will be achieved through a tried and tested programme called *Listening into Action (LiA)* which has already led to increased engagement and morale of staff in other NHS trusts.

The Trust LiA is about re-engaging with employees and unlocking their potential so they can get on and contribute to the success of the organisation, have a direct impact on improving patient care in a way that makes them feel proud.

LiA supports an important aim of Trust strategy – to listen to what frustrates staff at work, what they would like to see improve and change, and how leaders can support, enable and 'unblock the way' for staff to make that change happen.

The journey over the initial 12 months will include a high profile round of LiA Staff Conversations to create an clear view of 'what matters to staff', a series of 'big impact' actions in response, and support for the first 10 and then next 20 teams 'on the ground' to adopt LiA as a vehicle for change.

There are literally hundreds of stories about the measurable impact of LiA on quality of care and the patient experience, with more coming in every week. In responses from 80,000 plus NHS staff to the LiA Pulse Check which is done at the beginning of the journey highlights that only 20% of staff feel valued for their contribution, 18% feel day-to-day frustrations are quickly identified and resolved, 24% feel managers encourage them to share ideas. In LiA trusts, these results have shifted by up to an astonishing 65% within the first 12 months.

Title of report	2015 National Staff Survey
Name of director	Denise Harnin/ Lisa Thomson

3.5 **Reward and Recognition**

Based on feedback given by staff from previous reward and recognition events held last year, and the need to improve the Trust's overall engagement the score (3.64) as measured by the National Staff Survey, a new reward and recognition programme has been developed. The aim is to drive improvements in this overall position and in particular how valued employees feel. This includes opportunities weekly, monthly and annually to thank individual members of staff and teams who have gone above and beyond in delivering against the Trust's values. This is to be driven by the feedback received from patients, patient friends and family tests and compliments received into the Trust from external peers. In addition, it has been developed to recognise achievement through long service awards and learning and development awards. A programme of events is being discussed with the Staff Engagement Group to ensure co-design.

3.6 **Staff Engagement Group**

The NHS Constitution includes the following pledge: The NHS commits … to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families. To assist with this approach the Trust is developing a Staff Engagement Group (STG) with the purpose of promoting staff engagement by providing an additional means through which staff members can raise issues about actions or decisions that affect them and the services they provide. Through the Big Conversation over 25 people have already expressed an interest in being part of the group and an inaugural meeting focused on ways to increase the membership to ensure cross site and cross Division representation.

A formal reporting process has been developed with progress and outcomes reported to the Workforce Assurance Group, and through this to the Board.

4 **Recommendation**

The Board is requested to

- Receive the results of the staff survey 2015
- Note the key findings of the survey
- Receive assurance on the actions being taken to engage with staff, in particular ChatBack, The Big Conversation, Listening into Action
- Discuss any further areas for consideration on staff engagement
- Agree to receive further assurance via the Workforce Assurance Group which will be monitoring the actions agreed.

Lisa Thomson
Director of Communications

Title of report	2015 National Staff Survey
Name of director	Denise Harnin/ Lisa Thomson

Worcestershire NHS
Acute Hospitals NHS Trust

Summary - Staff Survey 2015 – Worcestershire Acute Hospitals NHS Trust

The Trust was in the bottom 20% of Acute Trusts for 23 of the 32 key findings (highlighted in red). The Trust was worse than average in 4 (highlighted in amber) and average in 4 key findings (highlighted in black), and better than average in 1 (highlighted in green)

KF NO.	KEY FINDING	KF NO.	KEY FINDING
KF1 =	Staff recommendation of the organisation as a place to work or receive treatment	KF17 =	% of staff suffering work related stress in the last 12 months
KF2	Staff satisfaction with the quality of work and patient care they are able to deliver	KF18 =	% of staff feeling pressure in the last 3 months to attend work when feeling unwell
KF3	% of staff agreeing that their role makes a different to patients	KF19	Organisation and management interest and action on health and wellbeing
KF4 =	Staff motivation at work	KF20 =	% of staff experiencing discrimination at work in last 12 months
KF5	Recognition and value of staff by managers and the organisation	KF21 →	% of staff believing that the organisation provides equal opportunities for career progression or promotion.
KF6 →	% of staff reporting good communication between senior management and staff	KF22 →	% of staff experiencing physical violence from patients, relatives or the public in last 12 months
KF7 =	% of staff able to contribute towards improvements at work	KF23 =	% of staff experiencing physical violence from staff in last 12 months
KF8 =	Staff satisfaction with level of responsibility and involvement	KF24 =	% staff/colleagues reporting most recent experience of violence
KF9	Effective team working	KF25 =	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
KF10 =	Support from immediate managers	KF26 =	% of staff experiencing harassment, bullying or abuse from staff n last 12 months
KF11 =	% of staff appraised in last 12 months	KF27 =	% of staff/colleagues reporting most recent experience or harassment, bullying or abuse
KF12	Quality of appraisals	KF28 =	% of staff witnessing potentially harmful errors, near misses or incidents in last month
KF13	Quality of non-mandatory training, learning or development	KF29 =	% of staff reporting errors, near misses or incidents witnessed in the last month
KF14	Staff satisfaction with resourcing and support	KF30	Fairness and effectiveness of procedures for reporting errors, near misses and incidents
KF15	% of staff satisfied with the opportunities for flexible working patterns	KF31 =	Staff confidence and security in reporting unsafe clinical practice
KF16 =	% of staff working extra hours	KF32 =	Effective use of patient/service user feedback

Overall Staff Engagement deteriorated from 3.71 to 3.64, and **Recommendation of place to work and receive treatment** deteriorated from 3.63 to 3.52

The symbol next to the KF No show position compared to last year. Trust has remained unchanged (=) from 2014 results in 19 of the 32 key findings, improved in 0 (+), and declined in 3 (-). There are 10 key findings that are unable to be compared with last year due to changes to question format.

Title of report	2015 National Staff Survey
Name of director	Denise Harnin/ Lisa Thomson

Report to Trust Board

Title	**Finance & Performance Committee Report**
Sponsoring Director	**Andrew Sleigh – F & P Committee Chairman/ Non-Executive Director**
Author	**Andrew Sleigh – F & P Committee Chairman/ Non-Executive Director**
Action Required	The Board is asked to: • Consider the recommendations in Section 2. • Consider and endorse the revised Terms of Reference.
Previously considered by	*N/A*

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	✓
Develop and sustain our business	

Related Board Assurance Framework Entries	2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service. 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability
Legal Implications or Regulatory requirements	The Trust must ensure plans are in place to achieve the Trust's financial forecasts. The Trust has a statutory duty to breakeven over a 3 year period.
Glossary	*Commissioning for Quality and Innovation (CQUINs)* – payments ensure that a proportion of providers' income (currently up to 2.5%) is conditional on quality and innovation and is linked to service improvement. The schemes that qualify for CQUIN payments reflect both national and local priorities. *Earnings before interest, taxation, depreciation and amortisation (EBITDA)* – is a measure of a trust's surplus from normal operations, providing an indication of the organisation's ability to reinvest and meet any interest associated with loans it may have. It is calculated as revenue less operating expenses less depreciation less amortisation.

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

Liquidity – is a measure of how long an organisation could continue if it collected no more cash from debtors. In Monitor's Risk Assessment Framework, it is measured by the number of days' worth of operating costs held in cash or cash-equivalent forms and is a key component of the continuity of services risk rating.

Quality, innovation, productivity and prevention (QIPP) – is a programme designed to identify savings that can be reinvested in the health service and improve quality of care. Responsibility for its achievement lies with CCGs; QIPP plans must therefore be built into planning (and performance management) processes.

Marginal rate emergency tariff (MRET) – is an adjustment made to the amount a provider of emergency services is reimbursed. It aims to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid 70% of the national price for each patient admitted as an emergency over and above a set threshold.

Introduced in 2003, *payment by results (PBR)* was the system for reimbursing healthcare providers in England for the costs of providing treatment. Based on the linking of a preset price to a defined measure of output of activity, it has been superseded by the national tariff.

Key Messages

Finance
- Forecast of an outturn deficit of £59.9m likely to be achieved, providing no new changes to the agreement with Commissioners occurs.
- 2016/17 Contract is yet to be finalised, failure to reach an agreement will result in arbitration.
- Actions have been completed that achieve £9.6m reduction in run-rate with further reductions planned to meet the target.
  Assurance received that plans for achieving £14.3m FRP savings in 2016/17 are realistic and well advanced.
- 2016/17 Financial Plan noted and will be submitted as part of the Trust's Operational Plan on 11 April.

Performance
- Significant pressures continue in A & E and bed occupancy at WRH over 100% due to excessive demand.
- Trajectory to gradually reduce stranded patients by September to be finalised.
- Agency cap adherence being monitored regularly and robustly, compliance continues to improve.

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

6 April 2016   **Enclosure G1**

REPORT TO TRUST BOARD

1.   **Decisions made within delegated responsibilities**
        There were no decisions made within delegated responsibilities.

2.   **Recommendations to the Board**
        The Board is recommended to agree:

- The four Actions identified in the Financial Plan 2016/17. This followed a detailed discussion of the supporting analysis in scrutinising the Divisional plans for savings. Additional assurance was derived from the elements in the bridge from 2015/16 forecast outturn, and from the approach of baking in the Cost Improvement Plan /Financial Recovery Plan (CIP/FRP) savings into the budget lines for each management unit. It should be noted that the Capital plan requires certain project specific loans. The Cash plan requires agreement of a longer term solution to providing liquidity. The Board should note the assumptions implicit in the Risks identified and the Committee has asked that these assumptions be made explicit in the finalisation of the Plan, and be monitored in the light of any variances going forward.

- The Committee was unable to make any recommendations on the contracting position with Commissioners as details are not yet sufficiently mature. The merits of different contracting models were reviewed, reiterating the need to ensure that any arrangement that modifies Payment by Results must ensure incentives across the local health economy are matched to the ability to manage risks. Given that agreement of the Contract was likely to be needed before the next Finance & Performance Committee (FPC), it was agreed that the draft contract(s) should be reviewed by the FPC Chair, Trust Chief Executive and Director of Finance before been taken by the Board, if necessary by an extraordinary meeting.

3.   **Principal Areas of Performance Scrutinised**

- The financial performance at Month 11 was reviewed, noting assurance that the previous forecast of an outturn deficit of £59.9m was likely to be achieved, providing no new changes to the agreement with Commissioners occurs.

- Each Division was probed on their achievement of the objective to take £10m out of the pay run-rate by April 2016. Assurance was received that actions have been completed that achieve £9.6m reduction in run-rate with further reductions planned to meet the target.

- The compliance with the Agency Cap limits was reviewed. It is evident that whilst the number of agency appointments breaching the Cap has reduced significantly, the number of breaches remain significant especially as the Cap steps down. It was agreed to introduce formal sign off of all current and requested Cap breach cases essential for patient safety by Chief Operating Officer or Chief Medical Officer.

- The Divisional Plans for the budgeted £14.3m CIP savings were reviewed. Focus was on identifying achievability and risks. There was considerable assurance that plans are realistic and well advanced. The Committee stressed the importance of the associated Quality Impact Assessments (QIAs), and the role of the Quality Governance Committee (QGC) in overseeing the approval of these.

- The Capital Programme and Cash Plan were reviewed, noting the dependence of each on agreement of loan and liquidity arrangements for the Trust.

- The issues, corrective actions and risks highlighted in the Integrated Performance Report were noted. There was particular focus on stranded patients (over 7 day stay) and what reduction trajectory was planned and agreed with partners. It was agreed there would in future be a routine specific report to FPC on this subject.

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

- Progress on the PCIP and ECIP programmes was questioned, noting the significant impact these programmes will have on future performance. It was agreed that the Improvement Board should provide a regular update to the FPC in future.

4   Observations Drawn to attention of the Board

- There has been successful recruitment in several areas across the Trust's Divisions.
- Demand for emergency activity has risen to the highest levels yet seen. This has delayed the move of Silver Ward.
- Maintaining RTT performance is likely to be challenging until successful demand management and reduction in stranded patients can be achieved.
- The Terms of Reference had been updated and approved by the Committee and are attached for consideration and endorsement by the Board.
- The 3 FPC BAF associated risks all have actions that are being progressed.

Andrew Sleigh
F & P Committee Chairman

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

Terms of Reference

FINANCE AND PERFORMANCE COMMITTEE

Version: **1.6**

Terms of Reference approved by: **Trust Board**

Date approved: March 2016

Author: **Deputy Director of Finance**

Responsible directorate: **Finance**

Review date: September 2016

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1. Introduction

The purpose of the Finance and Performance Committee (F&P) is to act as a sub-committee of the Trust Board to give the Board assurance on the management of the financial and corporate performance of the Trust and to monitor and support the financial planning and budget setting process. The Committee will also review and approve business cases and oversee developments in financial systems and reporting, e.g. SLR/PLICS.

The Committee will also review the performance strategy of the Trust and hold the Trust to account on national and local targets.

2. Membership

- Three non-executive directors
- Chief Executive
- Chief Operating Officer
- Director of Finance
- Chief Nursing Officer
- Director of Strategy, Planning & Improvement

In attendance:
- Deputy Director of Finance
- Other senior finance staff as required
- Director of Asset Management &ICT as required
- Divisional representatives and other staff as appropriate

2.1 The Chair of the Committee is appointed by the Trust Board.

3   Arrangements for the conduct of business

3.1   Chairing the meetings
A non-executive director will chair the meetings. In the absence of the Chair, another non-executive director will chair the meeting.

3.2   Quorum
The Committee will be quorate when two non-executive officers and two executive directors are present.

3.3   Frequency of meetings
The Committee will meet monthly.

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

3.4 Frequency of attendance by members

Members are expected to attend each meeting, unless there are exceptional circumstances.

3.5 Declaration of interests

If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the subject consideration has been completed. All declarations of interest will be minuted.

3.6 Urgent matters arising between meetings

If there is a need for an emergency meeting, the Chair will call one in liaison with the Director of Resources and/or DOF.

3.7 Secretariat support

Secretarial support will be through the Finance Directorate.

4 Authority

The Committee is authorised by the Trust Board.

5 Purpose and Functions

5.1 Purpose

To act as a sub-committee of the Trust Board to:

- Give the Board assurance on the management of the financial and corporate performance of the Trust
- Monitor and support the financial planning and budget setting process
- Review and approve business cases within its delegated limit.
- Oversee developments in financial systems and reporting, e.g. SLR/PLICS
- To conduct post implementation reviews of all major business cases
- To authorise the TDA return on behalf of the Board
- To review procurement strategy development and delivery
- The following sub-groups will report to the F & P Committee on a frequency determined by their business cycle:
  - Capital Prioritisation Group
  - Sustainable Development Management Committee

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

5.2   Duties
In discharging the purpose above, the specific duties of the F&P Committee are as follows:

5.2.1 Financial Management
To provide key assurances on the financial governance of the Trust through a programme of review work incorporating the following:

- To oversee and evaluate the development of the Trust's financial strategy to deliver its integrated business plan.
- To regularly review the financial standing of the Trust
- Review and endorsement of the annual revenue and capital budgets before they are presented to the Board for approval.
- Monitor income and expenditure against planned levels and make recommendations for corrective action should excess variances occur.
- Review expenditure against the agreed capital plan.
- To review the key financial risks facing the trust and ensure appropriate mitigation plans are in place
- To review financial aspects of key policy areas
- To review the planning and delivery of the Trust's (and as appropriate CCG) QIPP programmes.
- To review the financial impact on quality of the financial strategy
- To receive reports relating to the financial recovery plan
- To commission work as needed to enhance the work of the Committee

5.2.2 Performance Management
- To oversee and evaluate the development of the Trust's performance strategy to performance manage against strategy and against plan.
- Review the performance report and dashboards against local/national targets
- Review performance against the CQUIN targets
- Review areas of underperformance and agree corrective actions
- Horizon scan regarding new targets
- Develop performance dashboards for reporting to the Board

5.2.3 Other Duties
- To scrutinise and approve business cases/investment proposals as necessary.
- Receive updates on the contract negotiations giving direction as necessary.
- Periodically review financial policies and procedures including the SFIs, scheme of delegation, etc. to ensure that they are still relevant and appropriate.
- Review the outputs of benchmarking exercises and consider appropriate actions.
- To identify any training needs for Committee members and to ensure that all members are competent in ensuring they can undertake their duties as members of the Committee.

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

- To review and assess the Trust's compliance with relevant national guidance and policies.

6.   Relationships and reporting

6.1   The F&P Committee is accountable to the Trust Board and will report monthly to the Board.

6.2   The F&P Committee will retain a close relationship with the Quality Governance Committee and the Audit and Assurance Committee and the Strategy & Transformation Committee. This will include referring matters to those committees and receiving referrals from those committees.

7   Review of the Terms of Reference

These Terms of Reference will be reviewed in September 2016 or earlier if deemed appropriate by the Chair.

ACS – March 2016

Title of report	Finance & Performance Committee Report
Name of director	Andrew Sleigh

Worcestershire NHS
Acute Hospitals NHS Trust

6 April 2016   **Enclosure G2**

Report to Trust Board in Public

Title	Integrated Performance Report (February 2016)
Sponsoring Director	Sarah Smith, Director of Planning and Development
Author	COO, CNO, CMO, Director of HR & OD
Action Required	The Board is asked to receive the Integrated Performance Report for February 2016. The report describes the key performance issues and gives assurance showing the mitigating actions.
Previously considered by	Finance and Performance Committee

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	√

Related Board Assurance Framework Entries	2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability 3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances
Legal Implications or Regulatory requirements	Section 92 of the Care Act 2014 ("the Act") creates an offence of supplying, publishing or otherwise making available information, which is false or misleading in a material respect. The offence will apply: to such care providers and such information as is specified in regulations; and, where the information is supplied, published or made available under an enactment or other legal obligation
Glossary	IPR – Integrated Performance Report SHMI – Summary Hospital Mortality Indicator HSMR – Hospital Standardised Mortality Ratio YTD – Year to Date RTT – Referral to Treatment

Title of report	Integrated Performance Report
Name of director	Sarah Smith

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

IPR – FEBRUARY 2016

1. Situation

This paper presents an integrated corporate performance report (IPR) for February 2016.

2. Background

This paper updates the Board on the Trust's current performance against nationally and locally agreed targets and other key priorities, and summarises the actions being taken or planned to address non - compliance.

3. Assessment

Please refer to the IPR report for the full detail. The main exceptions and priorities as agreed by the Executive Team are as follows:

3.1 Emergency Access Standard

The Trust did not achieve the 95% Emergency Access Standard (EAS) in February 2016. Following a step improvement in October 2015, with performance for the Trust exceeding 90% for the first time since November 2014, performance dipped below 90% in December and January, and in line with levels of pressure and resulting performance elsewhere in the country, has dropped to 82.4% in February.

The Trust failed to deliver the national 15 minute standard for assessment in Emergency Department (ED) for the 95th percentile wait (all patients); performance was 32 minutes in January and 42 minutes in February 2016. The median wait for treatment in the ED was 62 minutes in February 2016, which exceeded the national standard of 60 minutes for the first time since April 2015.

3.2 18 weeks Referral to Treatment (RTT)

For the first time in the last four months in February 2016, the Trust was unable to report compliance with the 18 Week referral to treatment incomplete pathways target (92%); Trust total 91.5%.

3.3 Cancer Performance

After two months of above target performance, the 62 day target for 85% for cancer first treatment was not achieved in February 2016 with performance at 82.1% at the time of writing this report.

The 2ww targets have not been achieved in February however over the past five months there has been a marked improvement in performance and performance levels in February were much closer to the 93% target at 88.8%(all) and 93.1% (breast symptomatic).

3.4 Diagnostics Waiting Time Standard

In February 2016, the Trust achieved the target of < 1% of patients waiting longer than 6 weeks for diagnostic tests.

Title of report	Integrated Performance Report
Name of director	Sarah Smith

3.5　Finance

At Month 11 (February 2015/16) the Trust reported a £55.1m deficit position. The in - month variance was £4.8m which is £0.4m better than the preceding month. Further detail including turnaround actions is provided in the Financial Performance report.

4　Recommendation

The Board is asked to receive the Integrated Performance Report for February 2016. The report describes the key performance issues and gives assurance showing the mitigating actions.

Sarah Smith
Director of Strategy, Planning and Transformation

Title of report	Integrated Performance Report
Name of director	Sarah Smith

Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire NHS — Acute Hospitals NHS Trust

Reporting Period: February 2016

Patient Safety

Area	Indicator Type		Indicator	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Current YTD	Prev Year	Tolerance Type	On Target	Of Concern	Action Required	SRO	Data Quality Kitemark
Incidents and Never Events	Local	QPS3.3	Incidents - SI's open > 60 days (Awaiting closure - WAHT)			3	10	6	6	5	14	5	3	3	8	9	-	-	Local	0	-	>0	CMO	(blue)
	National	QPS4.1	Never Events	0	0	0	0	0	0	0	0	0	1	1	0	0	2	-	National	0	-	>0	CMO	(blue)
	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	1	4	1	5	2	2	1	3	0	2	2	6	2	26	24	Local	<=1	-	>=2	CNO	(yellow)
	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	1	0	2	0	2	0	0	3	2	0	1	0	0	10	22	Contractual	0	1 - 3	>=4	CNO	(yellow)
	Contractual	QPS7.7	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 4 Avoidable (Monthly)	1	0	0	0	0	1	0	0	0	0	0	0	0	1	2	Contractual	0	-	>=1	CNO	(yellow)
Mortality	National	QPS9.0	Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge - monthly	121	120	108	108	95	109	98	98	97					104	113	National	<100	>=100 to UCL	> UCL	DPS	(yellow)
	National	QPS9.1	Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge - rolling 12 months			108	109	112	113	113	112	111							National	<100	>=100 to UCL	> UCL	DPS	(yellow)
	National	QPS9.8	Mortality - HSMR (HED tool) - Monthly*	110	104	119	109	86	111	100	110	97	115						National	<100	>=100 to UCL	> UCL	DPS	(yellow)
	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months*			114	113	109	109	109	109	108	108						National	<100	>=100 to UCL	> UCL	DPS	(yellow)
Safety Thermometer	National	QPS10.1	Safety Thermometer - Harm Free Care Score	93.37%	93.55%	93.63%	95.12%	95.78%	93.25%	94.57%	92.86%	93.09%	94.20%	92.86%	94.28%	94.82%	-	-	National	>=95%	90% - 94%	<90%	CMO	(blue)
VTE	National	QPS11.1	VTE Risk Assessment	95.60%	95.01.%	95.41%	95.31%	95.71%	96.67%	95.43%	96.17%	95.65%	94.91%	94.19%	93.20%	93.80%	95.10%	95.01.%	National	>=95%	94.9 - 94%	<94%	CMO	(red)
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	1	7	3	3	3	2	4	2	3	0	2	2	3	27	36	National	14/15 Threshold <=40.8 15/16 Threshold <= 33			CNO	(blue)
	National	QPS12.4	MRSA Bacteremia - Hospital Attributable (Monthly)	0	1	0	0	0	0	0	0	0	0	0	0	1	1	1	National	0	-	>0	CNO	(yellow)
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective - NEW**			97.00%	97.58%	97.01%	96.65%	96.68%	99.14%	91.86%	95.70%	97.97%	95.31%	98.61%	96.68%	-	National	>=95	-	<95%	CNO	(green)
	Contractual	QPS12.15	MSSA Cases (Trust Attributable)	0	2	0	3	0	3	2	3	1	0	1	1	2	16	9	Local	-	-	-	CNO	(yellow)
CQUIN screening	Contractual	QCQ1.0	Patients with acute kidney injury who have the completed key items in their discharge summaries (sample) - as defined by the CQUIN - %						29.0%	32.0%	27.0%	10.0%	34.0%	26.0%			-	-	Local	>=60%	-	<60%	CNO	(blue)
	Contractual	QCQ1.1	Patients receiving Sepsis screening that have been identified as eligible (sample) - as defined by the CQUIN - %						53.0%	40.0%	100.0%	53.0%	21.0%	64.0%	32.0%		-	-	Local	>=75%	-	<75%	CNO	(blue)

Patient Experience

Area	Indicator Type		Indicator	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Current YTD	Prev Year	Tolerance Type	On Target	Of Concern	Action Required	SRO	Data Quality Kitemark
Complaints & Compliments ***	Local	QEX1.1	Complaints - Numbers (In Month)	41	54	41	37	53	59	47	50	53	68	36	63	60	567	554	Local	-	-	-	CNO	(blue)
	Local	QEX1.3	Complaints - Number per 10,000 Bed Days (YTD)	19.33	19.48	16.65	15.87	17.70	19.09	19.31	19.58	19.58	21.03	20.25	20.52	20.93	20.93	19.48	Local	-	-	-	CNO	(blue)
	Local	QEX1.14	Complaints - % of Category 2 complaints responded within 25 days (WAHT)	78.0%	63.0%	66.0%	59.0%	53.0%	53.0%	64.0%	86.0%	81.0%	62.0%	77.0%	81.0%	70.0%	70.0%	63.0%	Local	>=90	80-90%	<79%	CNO	(blue)
Friends & Family ****	National	QEX2.1	Friends & Family - A&E (Score)			73.5	77.2	72.5	68.0	66.2	61.9	69.6	76.6	70.7	72.4	61.6	70.8	-	National	>=71	67-70	<67	CNO	(green)
	National	QEX2.61	Friends & Family - Acute Wards (Score)											77.0	74.6	76.0	76.0		National	>=71	67-70	<67	CNO	(green)
	National	QEX2.7	Friends & Family - Maternity (Score)	80.0	77.8	88.4	84.5	80.7	87.4	86.4	88.5	86.0	82.5	84.9	86.7	78.2	82.9	83.0	National	>=71	67-70	<67	CNO	(green)

Effectiveness of Care

Area	Indicator Type		Indicator	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Current YTD	Prev Year	Tolerance Type	On Target	Of Concern	Action Required	SRO	Data Quality Kitemark
Readmissions	Local	QEF2.1	Emergency Readmissions (Within 28 Days of Elective Discharge) - WAHT	0.0%	0.1%	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%	0.5%	0.3%	0.5%	0.3%	0.4%	0.4%	0.0%	Local	-	-	-	CMO	(yellow)
EDS	Local	QED1.0	Completion of Electronic Discharge Summaries - PLACEHOLDER																Local	-	-	-		
Hip Fracture	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	84.3%	84.1%	51.3%	70.4%	70.0%	68.0%	71.0%	78.0%	56.0%	76.0%	61.8%	59.0%	76.0%	66.6%	64.0%	National	>=90%	-	<90%	CMO	(blue)
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Treatment Pts	93.5%	91.4%	69.0%	79.2%	84.0%	76.0%	75.0%	88.0%	63.0%	87.0%	76.0%	68.0%	80.0%	76.5%	84.9%	National	>=90%	-	<90%	CMO	(blue)

Risk Register Activity

Area	Indicator Type		Indicator	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Current YTD	Prev Year	Tolerance Type	On Target	Of Concern	Action Required	SRO	Data Quality Kitemark
Risks	Local	QR1.1	% of approved risks with overdue actions*****			30.0%	25.0%	26.0%	29.0%	32.0%	23.0%	18.0%	26.0%	29.0%	20.0%	20.0%	20.0%		Local	<15	15-29	>=30	CNO	(blue)

*Indicators QPS9 are reported in arrears in accordance with published data in HED benchmarking tool. The HED data is not fully locked down until the Sept following the reported financial year, so some small changes may still occur. These metrics have previously been reported in month, these are now reported 'rolling 12 months', this is on advice from HED and the Trust Mortality lead. All months have been changed.

**MRSA data for February is provisional as the final submission has not been confirmed.

*** Complaints and Compliments are reported one month in arrears

**** Friends and Family metrics have been reviewed and have been adjusted in accordance with latest guidance. The A&E & Wards metric has been replaced with separate ones.

*****QR metrics - data reported for February was extracted on 01/03 and may be reported as March month commencing figures.

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

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

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Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire NHS Acute Hospitals NHS Trust

Reporting Period: February 2016

Area	Indicator Type		Indicator	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Current YTD	Prev Year	Tolerance Type	On Target	Of Concern	Action Required	SRO	Data Quality Kitemark
Waits	Local	PW4.0	Backlog > 18 weeks (Outpatients + Day Case + Elective Inpatients)	2489	2921	3715	3628	3119	2952	3008	3122	2997	3134	2764	2770	3083	3,083	2,921	Local	-	-	-	COO	
	National	PW1.1.3	6 Week Wait Diagnostics (Proportion of waiting list)	0.85%	0.95%	1.31%	0.81%	1.06%	1.30%	0.95%	0.98%	0.87%	0.97%	1.55%	1.05%	0.71%	1.05%	1.05%	National	<1%	-	>1%	COO	
	National	CW3.0	RTT - Incomplete 92% in 18 Weeks	90.14%	88.93%	87.33%	87.68%	89.07%	90.25%	89.42%	88.81%	89.00%	92.05%	92.05%	92.04%	91.50%	91.50%	88.93%	National	>=92%	-	<92%	COO	
	Local	CW4.1	Over 52 week waiters who have been treated in month - NEW										3	1	2	0			Local	0	-	>0	COO	
Theatres	Local	PT2.1	Booking Efficiency - ALX	72.00%	74.00%	74.00%	72.00%	72.00%	73.00%	70.00%	71.00%	70.00%	72.00%	71.00%	71.00%	77.00%	-	-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT2.2	Booking Efficiency - WRH	88.00%	85.00%	92.00%	84.00%	81.00%	86.00%	82.00%	81.00%	82.00%	84.00%	77.00%	82.00%	77.00%	-	-	Local				COO	
	Local	PT2.3	Booking Efficiency - KGH	72.00%	71.00%	72.00%	70.00%	67.00%	67.00%	74.00%	68.00%	69.00%	70.00%	70.00%	70.00%	71.00%	-	-	Local				COO	
	Local	PT1.1	Utilisation - ALX	69.00%	70.00%	70.00%	66.00%	69.00%	70.00%	69.00%	71.00%	68.00%	70.00%	70.00%	70.00%	72.00%	-	-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT1.2	Utilisation - WRH	72.00%	72.00%	75.00%	75.00%	73.00%	74.00%	74.00%	76.00%	72.00%	73.00%	70.00%	72.00%	70.00%	-	-	Local				COO	
	Local	PT1.3	Utilisation - KGH	68.00%	67.00%	68.00%	66.00%	63.00%	65.00%	71.00%	67.00%	68.00%	68.00%	66.00%	65.00%	68.00%	-	-	Local				COO	
	Local	PT3.1	Cases per Session - ALX	2.39	2.55	2.64	2.50	2.62	2.58	2.60	2.40	2.53	2.56	2.51	2.60	2.59	2.59	2.63	Local	-	-	-	COO	
	Local	PT3.2	Cases per Session - WRH	1.71	1.69	1.98	1.85	1.83	1.82	1.90	1.90	1.90	1.73	1.76	1.68	1.60	1.60	1.92	Local	-	-	-	COO	
	Local	PT3.3	Cases per Session - KGH	3.42	3.25	3.43	3.42	3.18	3.34	3.30	3.50	3.10	3.25	3.50	3.27	3.20	3.20	3.42	Local	-	-	-	COO	
A & E**	National	CAE1.1	4 Hour Waits (%) - Trust *	79.63%	82.55%	83.99%	86.71%	85.46%	85.61%	86.43%	85.00%	88.21%	88.83%	86.97%	81.37%	78.70%	85.30%	90.22%	National	>=95%	-	<95%	COO	
	National	CAE1.1a	4 Hour Waits (%) Trust inc. MIU - from September 14 *	82.90%	85.40%	86.89%	88.59%	87.64%	88.35%	88.83%	87.64%	90.25%	90.66%	89.07%	84.30%	82.40%	87.90%	-	National	>=95%	-	<95%	COO	
	Local	CAE1.5	A&E Attendances (Trust)	10,775	12,576	12,259	12,688	12,700	13,134	12,568	12,711	12,882	12,591	12,467	12,159	12,097	101,533	149,058	-	-	-	-	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile ^ (inc Kidd MIU)			45	20	23	25	34	31	28	28	28	35	49	30	-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment (All Patients) (Mins) - 95th Percentile ^ (inc Kidd MIU)			37	22	23	24	27	31	24	28	28	32	42	29	-	National	<=15mins	-	>15mins	COO	
	National	CAE5.0	Unplanned Reattendance within 7 days of original Attendance (%) (inc Kidd MIU)	4.90%	5.20%	5.30%	5.30%	4.90%	5.40%	5.40%	5.10%	5.30%	5.50%	5.70%	5.80%	5.80%	5.80%	5.60%	National	<=5%	-	>5%	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	37.08%	42.09%	43.66%	49.65%	47.14%	43.50%	41.16%	38.20%	41.09%	42.04%	41.58%	41.74%	38.40%	43.43%	46.68%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	77.97%	84.09%	86.47%	92.16%	90.85%	89.69%	87.99%	86.34%	87.23%	88.10%	88.18%	86.02%	85.58%	88.62%	88.61%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes	113	75	51	6	17	30	29	39	22	26	38	47	58	363	-	Local	0	-	>0	COO	
Cancer*	National	CCAN1.0	31 Days: Wait For First Treatment: All Cancers	98.26%	98.39%	98.23%	95.72%	95.49%	98.50%	100.00%	97.90%	96.40%	97.20%	98.10%	98.50%	96.70%	97.60%	96.64%	National	>=96%	-	<96%	COO	
	National	CCAN2.0	31 Days: Wait For Second Or Subsequent Treatment: Surgery	87.50%	88.00%	93.60%	85.70%	86.80%	90.30%	90.90%	95.00%	92.00%	89.20%	96.00%	88.90%	94.30%	91.70%	95.87%	National	>=94%	-	<94%	COO	
	National	CCAN3.0	31 Days: Wait For Second Or Subsequent Treatment: Radiotherapy			100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	National	>=94%	-	<94%	COO	
	National	CCAN4.0	31 Days: Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	100.00%	100.00%	100.00%	93.30%	94.40%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.50%	100.00%	National	>=98%	-	<98%	COO	
	National	CCAN5.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	77.69%	90.00%	80.73%	85.12%	75.37%	78.10%	86.50%	75.10%	79.30%	79.40%	89.10%	86.30%	82.10%	81.40%	82.39%	National	>=85%	-	<85%	COO	
	National	CCAN6.0	62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers (Small numbers)	85.71%	100.00%	94.74%	100.00%	95.83%	100.00%	100.00%	92.60%	94.40%	100.00%	96.60%	94.40%	100.00%	96.90%	91.40%	National	>=90%	-	<90%	COO	
	National	CCAN8.0	2WW: All Cancer Two Week Wait (Suspected cancer)	96.64%	96.38%	91.47%	90.28%	86.84%	83.10%	81.80%	81.40%	85.00%	88.30%	90.40%	84.10%	88.80%	86.40%	93.13%	National	>=93%	-	<93%	COO	
	National	CCAN9.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	96.39%	94.94%	85.28%	98.15%	84.21%	63.50%	83.10%	66.90%	71.40%	80.10%	82.60%	82.90%	91.30%	80.10%	91.72%	National	>=93%	-	<93%	COO	
	National	CCAN10.1	Cancer Long Waiters (104 Day +) includes suspected and diagnosed - treated in month - NEW			7	5	14	10	2	6	12	10	6	2	4	-	-	-	-	-	COO	
Stroke	Local	CST1.0	80% of Patients spend 90% of time on a Stroke Ward (Final)	94.30%	80.00%	97.67%	95.56%	80.39%	77.80%	81.00%	80.77%	83.33%	74.60%	73.20%	72.55%	81.10%	81.48%	85.57%	Local	>=80%	-	<80%	COO	
	Local	CST2.0	Direct Admission (via A&E) to a Stroke Ward	76.70%	76.90%	94.29%	92.86%	76.92%	67.70%	75.00%	68.18%	77.08%	66.00%	69.20%	69.23%	77.30%	75.28%	78.94%	Local	>=70%	-	<70%	COO	
	Local	CST3.0	TIA	73.70%	70.70%	68.75%	62.00%	61.20%	66.70%	61.50%	56.41%	71.05%	68.20%	65.90%	62.07%	69.40%	65.10%	69.39%	Local	>=60%	-	<60%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH **	98%	97%	103%	100%	103%	100%	100%	101%	101%	102%	102%	108%	102%	102%	93%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX **	89%	85%	93%	93%	91%	85%	91%	93%	94%	96%	94%	104%	104%	94%	82%	Local	<90%	90 - 95%	>95%	COO	
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute***	63	77	57	37	48	41	39	31	59	25	34	26	33	430	725	-	-	-	-	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute***	2457	2541	2532	2198	1146	1178	1010	778	1,362	817	918	807	1,090	13836	23610	-	-	-	-	COO	
	Local	PIN4.2	Bed Days Lost Due To Acute Bed No Longer Required (Days)	3,325	3,352	3,237	3,359	2,876	2,783	3,438	3,057	3,900	3,133	3,832	3,966	3,320	36,901	32,017	-	-	-	-	COO	
Elective*****	National	PEL3.0	28 Day Breaches as a % of Cancellations****	13.2%	12.7%	25.0%	15.9%	10.2%	23.8%	16.4%	18.4%	12.3%	12.7%	42.6%	19.7%	25.0%	19.9%	16.6%	TBC	<=5%	6 - 15%	>15%	COO	
	National	PEL3.1	Number of patients - 28 Day Breaches (cancelled operations)									7	7	17	14	14			TBC	-	-	-	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	0	0	0	0	0	0	0	0	1	1	1	1	0	4	0	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	5.6	5.2	5.3	5.1	5.1	5.3	4.9	4.8	4.5	4.3	4.6	5.0	4.6	4.9	4.8	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	7.4	6.9	6.9	6.7	6.7	7.0	6.5	6.4	6.3	5.9	6.5	6.9	6.5	6.6	6.5	Local	-	-	-	COO	

Header note: 2015/16 Tolerances — On Target / Of Concern / Action Required

* Cancer _this involves small numbers that can impact the variance of the percentages substantially.
**April 15 figures onwards for indicators CAE1.1, CAE1.1a, CAE1.2, CAE1.3, CAE1.4, CAE2.0, CAE3.1, CAE3.2, CAE4.0 are calculated using a slightly different methodology to previously reported numbers.
**Bed occupancy data source is Bed State Report.
***w/c 22nd Oct was not available, so the previous week has been used to calculate October performance.
****Some of these figures may have been updated in later months due to validation - however the Trust dashboard data remains as published, this means that there may be a slight discrepancy between PEL3.0 and PEL3.1 for months prior to February 2016.
*****Cancelled Operations is calculated based on the 2011 national guidance.

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

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Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Workforce Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: February 2016

Area	Indicator Type		Indicator	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Current YTD	Prev Year	Tolerance Type	On Target	Of Concern	Action Required	SRO
																				2015/16 Tolerances			
Vacancies & Recruitment	Local	WVR1.0	Number of Vacancies - Total	249	224	274	311	391	400	408	375	329	374	392	408	379		224	Local	<=200	201-229	>=230	DCE
Turnover	Local	WT1.0	Staff Turnover WTE %	10.5%	10.4%	10.2%	10.5%	10.5%	11.0%	11.4%	11.6%	12.3%	11.9%	12.3%	12.8%	12.7%		10.42%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.3	Nursing Staff Turnover - Qualified	10.5%	10.6%	10.1%	10.7%	10.7%	10.9%	10.9%	11.2%	12.1%	12.8%	13.2%	14.0%	13.7%		10.6%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.4	Nursing Staff Turnover - Unqualified	12.6%	12.6%	11.8%	11.6%	11.1%	11.6%	12.9%	13.2%	14.0%	13.9%	13.9%	13.6%	13.7%		12.6%	Local	9-10%	<>9-10%	-	DoHR
Sickness & Absence	Local=	WSA1.0	Sickness Absence Rate Monthly (Total %)	4.12%	4.25%	3.84%	4.02%	4.12%	4.21%	4.34%	4.49%	4.81%	4.35%	4.61%	4.64%	4.42%		4.25%	Local	<= 3.50%	>=3.51% & <=3.99%	>= 4.00%	DoHR
Temporary Staffing	Local	WTS1.0	Agency Staff - Medics (WTE) Indicative	163.3	146.9	148.0	157.6	158.1	165.8	173.0	176.0	176.7	170.7	163.4	159.4	154.8		146.9	Local	<=85	85.1-100	>100	DCE
Induction	Contractual	WIN1.3	% of eligible staff attended Induction	79.0%	84.7%	85.1%	89.7%	95.5%	89.2%	92.1%	93.5%	73.8%	87.3%	94.6%	100.0%	73.4%	88.3%	72.8%	Contractual	>= 90%	80 - 89%	< 80%	DoHR
Statutory and Mandatory Training*	Contractual	WSMT10.2	% Of Eligible Staff completed Training*	81.8%	82.2%	82.6%	83.7%	84.5%	85.8%	82.1%	84.2%	84.4%	85.5%	87.2%	87.1%	86.9%	84.9%	82.9%	Contractual	>= 90%	60.1-89.9%	<=60%	DoHR
Appraisals	Contractual	WAPP1.0	Non-medical staff who are eligible for appraisal	4982	5015	5026	5004	4983	4962	4933	4958	4965	4999	4953	5008	5003	54794	59400	-	-	-	-	DoHR
	- Contractual	WAPP2.2	% Of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	79.0%	84.7%	85.6%	83.6%	83.8%	86.4%	85.1%	84.1%	84.0%	82.7%	81.6%	81.4%	83.0%	83.7%	72.8%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP3.2	% Of Eligible Consultants Who Have Had An Appraisal	83.2%	88.8%	89.7%	89.1%	90.0%	88.3%	87.2%	85.5%	85.3%	85.3%	82.0%	83.5%	85.2%	86.4%	77.8%	Contractual	>= 85%	71 - 84%	< 71%	DoHR

* Please note that the thresholds for Mandatory Training now reflect the required CCG reporting trajectory of 95% by year end.

With the exception of IG the mandatory training target has been revised from 95% to 90% effective from Feb 2016. Data from Feb 2015 is now calculated against 90% (except IG)

Note: If YTD is blank, then YTD is last reported month.

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Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Maternity Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: February 2016

Area	Indicator Type		Indicator	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Current YTD	Prev Year	Tolerance Type	2015/16 Tolerances			SRO	Data Quality Kite mark
																			On Target	Of Concern	Action Required		
Deliveries	Contractual	MDEL1.0	Deliveries	434	461	469	515	514	503	469	482	492	479	439	447	462	5271	5676	Contractual	<=465	466 - 516	>516	CNO	
Births	Contractual	MBIR1.0	Births	441	469	475	525	527	511	475	488	500	487	447	454	470	5359	5741	Contractual	<=480	481 - 531	>532	CNO	
Scheduled Bookings	National	MSB1.1	Women Booked Before 12 + 6 Weeks	84.0%	85.3%	88.6%	85.6%	88.0%	89.0%	87.7%	89.0%	88.5%	93.2%	92.0%	88.9%	89.6%	89.1%	87.8%	National	>=90%	-	<90%	CNO	
Normal Vag. Deliveries	Contractual	MNVD1.0	Maintain Normal Vaginal Delivery Rate	61.8%	62.9%	62.5%	57.5%	56.6%	57.7%	62.7%	63.7%	56.9%	56.8%	56.7%	57.3%	60.6%	59.0%	60.7%	Contractual	>63%	63% - 60%	<60%	CNO	
C- Section	Contractual	MCS1.0	Total Caesareans	28.8%	28.4%	25.8%	28.2%	33.7%	32.6%	28.1%	26.6%	31.3%	32.6%	30.5%	29.8%	28.6%	29.8%	27.3%	Contractual	<27%	27% - 30%	>30%	CNO	
	Contractual	MCS1.1	Elective Caesareans	14.3%	15.2%	12.8%	9.3%	12.8%	12.3%	10.0%	11.0%	15.0%	13.6%	13.2%	11.6%	13.0%	12.2%	13.3%	Contractual	<=11.2%		>11.2%	CNO	
	Contractual	MCS1.2	Emergency Caesareans	14.5%	13.2%	13.0%	18.8%	20.8%	20.3%	18.1%	15.6%	16.3%	19.0%	17.3%	18.1%	15.6%	17.6%	14.0%	Contractual	<=15.2%		>15.2%	CNO	
Outcome Indicators	National	MOI1.0	Breast Feeding Initiation Rates	73.4%	73.0%	70.2%	71.1%	72.5%	73.0%	72.0%	74.6%	73.0%	68.6%	69.7%	70.1%	71.1%	71.5%	74.2%	National	> 70%	67% - 70%	< 67%	CNO	
	Contractual	MOI3.0	Midwife Led Care %	29.0%	38.0%	23.7%	21.0%	22.0%	21.1%	20.5%	23.9%	20.1%	20.9%	19.4%	18.3%	22.5%	21.2%	35.3%	Contractual	>= 37.7%		<37.7%	CNO	

NB: Please note that tolerances are adjusted between financial years

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

Patients | Respect | Improve and innovate | Dependable | Empower

Taking **PRIDE** in our healthcare services

INTEGRATED PERFORMANCE REPORT

February 2016

Release date: March 23rd, 2016

Please note:

All data relates to February 2016 performance, unless stated otherwise.

Please note – the vertical axis on graphs differ depending the subject data. Some graphs have a reduced vertical axis to highlight detailed performance trends.

Worcestershire Acute Hospitals NHS Trust (WAHT) is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register (Corporate risk 2908).

This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Sarah Smith, Director of Planning and Development

Overview

Performance, efficiency, quality, safety and workforce metrics

Notes: This diagram is indicative only, and is based on trend direction of previous months' performance. Indicators on the Trust dashboard which are not RAG rated / have no set tolerances / are a subset of a high level indicator are not included. Financial performance is covered in more detail in the Trust Board Finance report.

Performance on /above target with positive trend	**Performance on /above target with negative trend**
• Number of grade 4 pressure ulcers • Number of grade 3 pressure ulcers • Friends and Family Test - Acute wards score • Never events • MRSA screening (including high risk wards) • Stroke – TIA • Stroke - direct admission on to stroke ward • Stroke - 80% of stroke patients spend 90% of time on stroke ward • 6 week wait for diagnostics • Urgent operations cancelled for a second time	• CDifficile • 31 day cancer – first treatment (all cancers) • Friends and Family Test - Maternity score
Performance under target with positive trend	**Performance under target with negative trend**
• Safety thermometer • Falls with serious harm • VTE • Category 2 Complaints responded to within 25 days • Hip fracture - time to theatre • Cancer - 2 week wait (breast symptomatic) • Cancer - 2 week wait (all cancers) • *Bed occupancy (WRH) & (ALX) (DASHBOARD ONLY – REPORTED THROUGH EAS CAS)* • *A&E - unplanned re-attendance within 7 days (DASHBOARD ONLY – REPORTED THROUGH EAS CAS)* • *Workforce – agency staff medics (DASHBOARD ONLY - MANAGED AND REPORTED THROUGH FINANCIAL PERFORMANCE REPORT)* • Workforce - % of medical staff that have had appraisal • Workforce – staff turnover • Workforce – nursing staff turnover (qualified) • % approved risks with overdue actions	• MRSA bacteraemia • Friends and Family Test - A&E score • Serious Incidents open over 60 days and awaiting closure • *CQUIN – AKI (DASHBOARD ONLY - MANAGED AND REPORTED THROUGH CQUIN PROGRAMME)* • *CQUIN – Sepsis (DASHBOARD ONLY - MANAGED AND REPORTED THROUGH CQUIN PROGRAMME)* • Category 2 Complaints responded to within 25 days • 18 week Referral to Treatment – Incomplete • *Cancer - 62 days wait for first treatment from all GP referral (all cancers) - (NO CAS REQUESTED – DASHBOARD ERROR)* • 28 day breaches as % of cancellations • *Delayed Transfers of Care (DTOC) – DASHBOARD ONLY - DATA RECEIVED TOO LATE FOR INCLUSION IN IPR)* • A&E - Ambulance handover over 60 minutes • A&E - Ambulance handover within 30 minutes • A&E - Ambulance handover within 15 minutes • A&E - 4 hour Emergency Access Standard • A&E - Time to initial assessment (all patients) – 95th percentile • Workforce – sickness absence monthly • Workforce - % of non-medical staff that have had appraisal • Workforce - % of eligible staff completing statutory and mandatory training • Workforce – nursing staff turnover (unqualified)

Summary

National / NHS Constitution Standards

The Trust achieved > 90% against the emergency access standard in October and November 2015 however in line with the peak of the winter pressures, performance declined in December and January and this trend continued into February 2016, with the percentage attending A&E and waiting four hours or less to be seen, treated, admitted or discharged at 82.4%.

For the past three months, the Trust was able to report compliance with the target of 92% of elective care pathways being completed within 18 weeks however this has dipped just below to 91.15% in February 2016. The backlog of patients waiting over 18 weeks also increased. Performance against the 62 - day referral to treatment standard for (all) cancers wasn't achieved in February following two months of greater than target achievement and there was a small increase in the number of cancer long waiters (104+ days).

Although improving over the past 4 months, the Trust continues to underperform with respect to the percentage of urgent cancer referrals seen within 2 weeks of referral and there continue to be rectification plans in place.

Following some unpredictable equipment failures in December 2015, in February 2016, the Trust has recovered its performance and achieved the target of greater than 99% of those on the diagnostic waiting list being seen within 6 weeks.

Key factors impacting performance

Patient flow remains sub optimal at both acute hospital sites with levels of bed occupancy at around 100% most days at WRH. There are a number of improvement initiatives to expedite discharges from the wards and there has been an increased focus at the front door of the hospital to promote ambulatory assessment and care and to avoid unnecessary admissions to hospital inpatient beds. There remains however a high proportion of bed days lost due to patients remaining in hospital after their acute episode of care has finished.

Issues with patient flow in the hospital can lead to overcrowding in the A&E department, in particular when there are surges in ambulance arrivals. Since the start of the year the Trust had made significant improvements against process measures that reflect flow and prioritisation in the A&E department including the 95th percentile time to initial assessment of 15 minutes, however for the past two months performance has deteriorated and there is further to go in terms of achieving and sustaining target performance.

Poor patient flow and high levels of bed occupancy also impact the Trust's elective programme and this is reflected in the number of operations cancelled for non-clinical reasons and the number of 28 day breaches (within in which the operation should be rescheduled) as a percentage of all cancellations.

Quality, workforce and finance indicators

There are separate Board reports from the Board sub committees relating to quality, workforce and financial performance indicators however, alongside key operational performance indicators, the remainder of this report provides corrective action statements where there are performance issues.

Key maternity performance indicators are provided for information in the accompanying dashboard, following the temporary emergency centralisation of maternity and neonatal services at the WRH site

Corrective Action Statements: Performance and Efficiency

Key Performance Indicator:

- 18 Week referral to treatment (RTT) - incomplete pathways (CW3.0)
- A&E - 4 hour waits (%) Trust including MIU (CAE1.1a)
- Cancer – 62 days wait for first treatment from GP referral
- All patients with suspected Cancer being seen within two weeks (CCAN8.0)
- 2 week wait for symptomatic breast patients (Cancer Not initially Suspected) (CCAN9.0)
- Time to initial assessment (patients arriving by ambulance) (mins) – 95th percentile (inc Kidd MIU); Time to initial assessment (all patients) (mins) – 95th percentile (inc Kidd MIU)
- Ambulance Handover within 15 minutes (%) – WMAS data (CAE7.0); Ambulance Handover within 30 minutes (%) – WMAS data (CAE8.0); Ambulance Handover within 60 minutes– WMAS data (CAE9.0)
- 28 day breaches as a percentage of cancelled operations (PEL3.0)
- Theatre Booking and Utilisation (all sites) (PT2)

Forecast Key	
Forecast to achieve	
Potential risk target will not be achieved	
Forecast not to achieve	

Key Performance Indicator: 18 Week referral to treatment (RTT) - incomplete pathways (CW3.0)

Headlines

Historically the Trust was consistently failing the RTT Incomplete standard between December 2014 and October 2015 inclusive. The target was met for three consecutive months in November 2015 (92.05%), December 2015 (92.05%) and January 2016 (92.04%). Following the implementation of the changes to the WLI policy combined with emergency pressures, the performance has deteriorated in February 2016 and is below standard at 91.53%. The total backlog of patients waiting over 18 weeks has increased by 313; the main increase has been in T&O (+118), ENT (+66), Cardiology (+33), Gastroenterology (+25) and Urology (+23). The challenged specialties remain Dermatology (72.83%), Thoracic Medicine (80.17%), Trauma and Orthopaedics (84.55%), Oral Surgery (84.64%), Gynaecology (86.25%) and Neurology (89.57%). The Trust has not had any 52+week waiters since November 2015 inclusive. Current and forecast performance is RAG rated red as it is anticipated that the reduction of additional activity will continue to have an impact and the performance will not be recovered until Q3 in 2016/17 in line with the STP trajectory. Year - end performance is RAG rated red due to the underperformance in Q1, Q2 and predicted underperformance for the reminder of Q4.

Corrective Actions

A substantial validation exercise is on-going, however, significant data quality issues remain and further monthly waiting list validation is required on a specialty by specialty basis. In addition, telephone contact continues being made with patients waiting over 18 weeks who had not had their first appointment to establish if the patient still requires to be seen or if the patient's condition has changed and an appointment needs to be expedited. Partial booking letters are being sent to those patients that cannot be contacted by phone. Specialty specific action plans for reduction of 18+ week backlog are in place for all underperforming specialties and have been shared with the CCGs. The specialty level RTT performance is monitored via fortnightly PTL meetings and monthly Divisional Performance Reviews.

Risks to Delivery

Non - delivery of this target poses significant reputational, financial and patient safety risks. These are mitigated by the remedial action plans that are in place; in addition, long waiters over 18 weeks are reviewed at regular intervals and findings reported via Quality Governance Committee (QGC). Retrospective RCAs with a particular focus on harm reviews were undertaken for all patients who had waited over 52 weeks for treatment. Following the changes to the WLI policy s there is a further risk that there will be insufficient short and medium term capacity to maintain this standard.
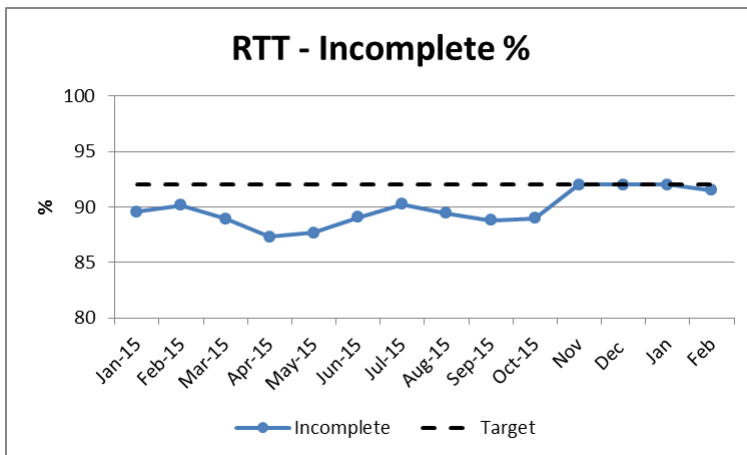
RTT - Incomplete %

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	92%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	91.5%	⬇	Forecast next reported month	
Last reported month performance	92.04%	➡	Forecast month after	
YTD performance	Not applicable		Forecast month after	
Revised date to meet the standard			Forecast year end	

Key Performance Indicator Name: 4 hour waits (%) Trust including MIU (CAE1.1a)

Headlines

Trust performance on the Emergency Access Standard, (EAS) declined in February (82.4% compared to 84.3% in January). There were 12,097 A&E attendances in February (12.3% higher than February 2015). We failed the national 60 minute 'Time from Arrival to Treatment' target in February (Median 62 mins). There was no change on the 5% target for 'Unplanned Re-attendance within 7 days of Original Attendance' in February at 5.8%. We continued to experience 'exit block' from A&E throughout February, but there were no breaches of the 12 hour trolley wait standard. Other key facts:

- Bed occupancy remained high at 102% at WRH and 104% at AGH for the month on average.
- Emergency admissions rose by 19.7% in February 2016 compared to February 2015, from 3,479 to 4,166.
- Emergency Length of Stay reduced from 5.0 days in January to 4.6 days in February

Corrective Actions

We closed 31 winter capacity beds in early February and continued to focus on improving patient flow and reducing the numbers of 'stranded' patients. The Medicine Division task and finish group to reduce the total number of Medically Fit for Discharge patients focussed on implementing Length of Stay reviews at patient level, and implementing other recommendations from the MADE event including Patient Flow Centre in-reach, embedding MDT discharge coordination on the wards, and improving access to discharge planning information at weekends.

Risks to Delivery

This indicator has a reputational risk to the organisation and health economy if not achieved. To mitigate the risk of underperformance we will continue to focus on patient flow and stranded patients.

4 Hour Waits (%) - Trust inc. MIU - from September 14

SRO:COO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	95%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	82.4%	↓	Forecast next reported month	
Last reported month performance	84.3%	↓	Forecast month after	
YTD performance	87.9%	–	Forecast month after	
Revised date to meet the standard			Forecast year end	

Key Performance Indicator: 62 days – Wait for first treatment from urgent GP referral – All cancers (CCAN5.0)

Headlines

For the past two months the Trust has achieved the target of >85% of patients with cancer receiving their first treatment within 62 days following urgent referral by their GP.   In February 2016, performance dropped below target to 82.1%.   The reasons for underachievement can vary by specialty and include increased numbers of 2ww referrals, capacity constraints at various stages of the pathways including the diagnostic phases, and sub-optimal patient tracking processes. In February, there were 18.5 breaches of the target recorded. The greatest number of breaches were in Urology (8), the rest are spread out across the other specialties – Breast (1.5), Colorectal (2), Haematology (1) Head and Neck (2) Lung (2), Skin (1), Upper GI (1).   Year - end performance is RAG rated red due to the underperformance in Q1 and Q2.

Corrective Actions

The Deputy COO continues to lead weekly PTL meetings with the challenged specialties.   The Urology delays were mainly due to Christmas holidays and as the delays were incurred at the beginning of the pathways they subsequently continue to impact on the February performance. There are on-going capacity issues in Urology which are being mitigated through plans for additional Consultant staffing and theatre realignment.

Risks

The achievement of the 62 day standard is high on the national agenda therefore there is a reputational risk to the organisation; also there is a potential risk for harm to patients due to extended waiting times. The latter is mitigated via weekly patient by patient review of patients who are waiting over 104 days for treatment. In line with the new national 'backstop' policy, formal harm reviews of patients with confirmed diagnosis of cancer that have been treated post 104 days commenced in November 2015.

Cancer - 62 days urgent GP referral %

SRO:COO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	85%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	82.1%	⬇	Forecast next reported month	
Last reported month performance	86.3%	⬆	Forecast month after	Not provided this month
YTD performance	81.4%	–	Forecast month after	Not provided this month
Revised date to meet the standard	Not provided this month		Forecast year end	Not Provided this month

Key Performance Indicator: All patients with suspected Cancer being seen within two weeks (CCAN8.0)
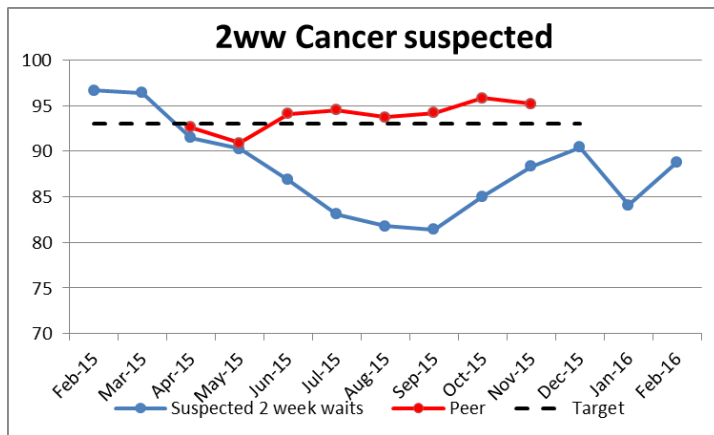
Headlines

There has been a marked increase in 2ww referral numbers (for example up 13% compared to the same period last year (April to October)) which has led to significant capacity constraints in a number of specialties. As a result a significant proportion of clinics continue to be set up ad-hoc and patients are contacted at short notice to be offered appointments. Subsequently a significant number of patients decline the offer to attend within the 14 day target; a smaller proportion of declined appointments are due to patient choice (holidays and other commitments). Current February performance shows improvement compared to January (88.8% versus 84.05%) and is RAG rated red as it remains below the standard. Year - end performance is RAG rated red due to the underperformance in Q1, Q2 and Q3. The biggest numbers of breaches in February were in Urology (43), Skin (27) and Colorectal Surgery (21) followed by Breast (19) and Head and Neck (19).

Corrective Actions

Initial version of an electronic 2ww PTL/escalation report has been implemented and is available to all Directorates; further enhancements to this report were introduced in December 2015. Capacity and demand by specialty is being monitored via a fortnightly Cancer PTL meeting. 2ww booking office protocols and standard operating procedures are currently under review with a view to establish a rolling audit programme for both internal processes and external adherence to referral parameters. Work is on-going with Commissioners to develop a project outline for implementation of the new 2ww NICE guidance and required changes to the referral forms. Following the changes to the WLI policy the Directorates are exploring all options to prioritise cancer including replacing routine activity with cancer appointments.

Risks to Delivery

This indicator has reputational risk for the organisation and also links to the 62 day cancer standard as it is the first stage in the 62 day referral to treatment pathway. The implication of not delivering this target will be potential underachievement against the 62 day standard. Historically the risk was being mitigated with ad-hoc additional capacity whilst longer term specialty by specialty demand and capacity modelling was being undertaken. In the short to medium term, following the changes to the WLI policy there is a further risk that there will be no sufficient ad-hoc capacity to mitigate the demand.

2ww Cancer suspected

Legend: Suspected 2 week waits — Peer — Target

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	93%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	88.8%	⬆	Forecast next reported month	
Last reported month performance	84.1%	⬇	Forecast month after	
YTD performance	86.4%	–	Forecast month after	
Revised date to meet the standard			Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: All patients with symptomatic breast being seen within two weeks (cancer not initially suspected) (CCAN9.0)

Headlines

2ww referral volumes for 2ww breast symptomatic have remained broadly the same compared to the same period last year; however, the Directorate has had a reduction in capacity following the loss of two GP practitioners who were undertaking 2ww clinics at the WRH. The Directorate has been covering this shortfall in capacity with waiting list initiative clinics. As a result a significant proportion of clinics are set up ad-hoc and patients are contacted at short notice to be offered appointments. Consequently a significant number of patients decline the offer to attend within the 14 day target; a smaller proportion of declined appointments are due to patient choice (holidays and other commitments). Whilst February performance shows further improvement - 91.3% versus 82.9% in January - it is RAG rated red as it remains well below the standard. Year - end performance is RAG rated red due to the underperformance in Q1, Q2, Q3 and Q4 to date.

Corrective Actions

The Directorate is exploring other ways of increasing capacity; two new registrars are in post and one has commenced seeing two week wait patients, the other one is still under assessment, however, will be finishing in April. The post is out for locum cover. The Directorate is working closely with Breast Radiology to ensure maximum utilisation of all available capacity.

Risks to Delivery

This indicator has reputational risk for the organisation and also links to the 62 day cancer standard as it is the first stage in the 62 day referral to treatment pathway. The implication of not delivering this target will be potential underachievement against the 62 day standard. Short term the risk was being mitigated with ad-hoc additional capacity whilst a longer term, demand and capacity modelling is being undertaken. In the short to medium term, following the changes to the WLI policy there is a further risk that there will be no sufficient ad-hoc capacity to mitigate the demand.

2ww Breast Symptomatic (%)

Please note this graph has a reduced Y axis to demonstrate detailed movement in performance

2WW breast symptomatic — Peer — Target

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	93%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	91.3%	⬆	Forecast next reported month	
Last reported month performance	82.9%	⬆	Forecast month after	
YTD performance	80.1%	–	Forecast month after	
Revised date to meet the standard			Forecast year end	

Key Performance Indicator: Time to initial assessment (patients arriving by ambulance) (mins) – 95th percentile (inc Kidd MIU); Time to initial assessment (all patients) (mins) – 95th percentile (inc Kidd MIU)
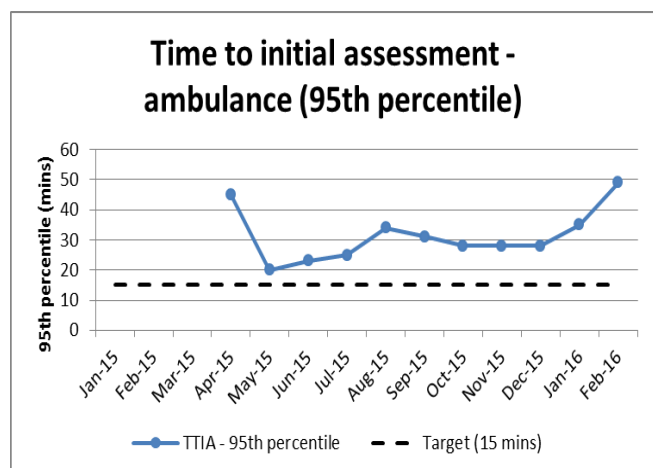
Headlines

The Trust failed to reach the national 15 minute "Time to Initial Assessment" target in February 2016 (95th percentile: All patients; 42 mins, Ambulance arrivals; 49 mins). There was a further significant deterioration in assessment times for both ambulance and walk in patients on both the AGH and WRH sites largely due to overcrowding in both Trust A&E Departments.

Corrective Actions

The Trust and partners in the Worcestershire health and care system are working with the Emergency Care Improvement Programme (ECIP) to address the underlying causes of poor patient flow that result in 'exit block' from the A&E department. In February 2016 compared with February 2015, there were 10.9% more A&E attendances and 19.7% more patients presenting at the Trust requiring emergency admission. The overcrowding issue is most acute at the WRH. Expansion of the ED at WRH is underway and on track for the first phase to open in the Summer of 2016, offering more space to accommodate patients waiting for handover, triage and admission. Within existing resources the Trust has deployed Senior Immediate Assessment Nurses (SIANs) to take the handover of patients from the ambulance Trust. These nurses are deployed at times of peak demand in ED. A further review of staffing is in train.

Risks to Delivery

The major risk to delivery remains the very high levels of bed occupancy at the Trust and the need to ensure that patient flow is optimised.

Time to initial assessment - ambulance (95th percentile)

SRO:COO	Current Reporting Month: Feb 2016			
	Performance TTIA	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<=15	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	49	⬆	Forecast next reported month	To be completed
Last reported month performance	35	⮕	Forecast month after	To be completed
YTD performance	30	–	Forecast month after	To be completed
Revised date to meet the standard	To be completed		Forecast year end	To be completed

Time to initial assessment - All Patients (95th percentile)

SRO:COO	Current Reporting Month: Feb 2016			
	Performance TTIA	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<=15	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	42	⬆	Forecast next reported month	To be completed
Last reported month performance	32	⬆	Forecast month after	To be completed
YTD performance	29	–	Forecast month after	To be completed
Revised date to meet the standard	To be completed		Forecast year end	To be completed

Key Performance Indicator: Ambulance Handover within 15 minutes (%) – WMAS data (CAE7.0); Ambulance Handover within 30 minutes (%) – WMAS data (CAE8.0); Ambulance Handover within 60 minutes– WMAS data (CAE9.0)

Headlines

In February 2016, there was a deterioration in Ambulance handover times however, handover performance in respect of the 30 and 60 minutes thresholds remain significantly improved from the same period last year - there was a 48% reduction in ambulances waiting over an hour waiting to handover (58 in February 2016 compared to 113 in February 2015).   38.4% of ambulances handed over in 15 minutes (37.1% in Feb 2015) and 85.6% were handed over in 30mins (78% in January 2015). The majority of breaches of the 15 minute standard were during periods of surge in ambulance attendance.   We continued to experience 'exit block' from A&E throughout February, particularly at WRH, and performance on ambulance handover times was impaired by the consequent over-crowding in A&E.

Corrective Actions

In February 2016 we agreed a handover protocol with WMAS to support early handover, including a letter jointly signed by WMAS and WAHT COOs to all front line staff. Extra admin support has been organised for the ambulance desk at WRH, and there are early discussions on staff rotation between the two organisations of paramedic and emergency care staff. Expansion of the ED at WRH is underway and on track for the first phase to open in the Summer of 2016, offering more space to accommodate patients waiting for handover, triage and admission.   Within existing resources the Trust has deployed Senior Immediate Assessment Nurses (SIANs) to take the handover of patients from the ambulance Trust. These nurses are deployed at times of peak demand in ED. A further review of staffing is in train.
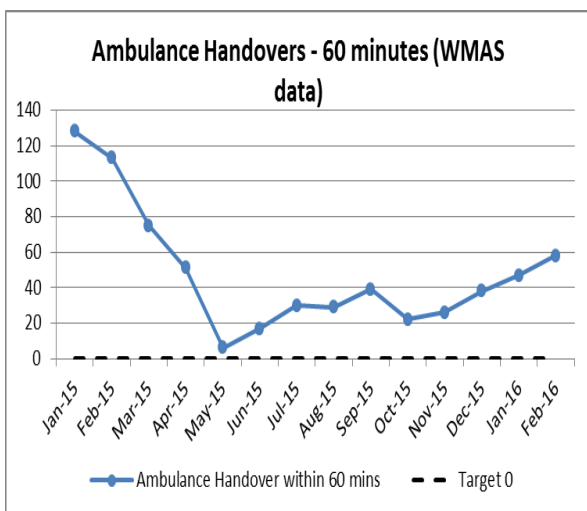
Risks to Delivery

The major risk to delivery remains 'exit block' from the very high levels of bed occupancy at the Trust and the need to ensure that patient flow is optimised.

Ambulance Handovers (WAHT) (15 mins)

Please note this graph has a reduced Y axis to demonstrate detailed movement in performance

— Ambulance Handover within 15 mins   - - Target (80%)
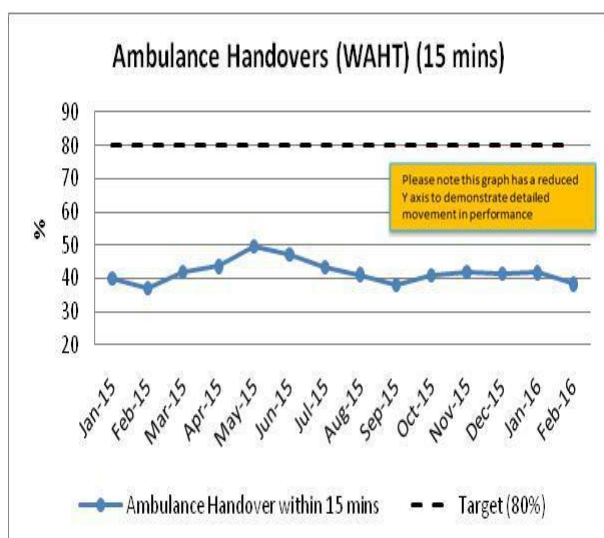
SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>80%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	38.40%	⬇	Forecast next reported month	
Last reported month performance	41.74%	⬆	Forecast month after	To be completed
YTD performance	43.43%	–	Forecast month after	To be completed
Revised date to meet the standard			Forecast year end	

Ambulance Handovers (WAHT) (30 mins)

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	85.58%	⬇	Forecast next reported month	
Last reported month performance	86.02%	⬇	Forecast month after	To be completed
YTD performance	88.62%	-	Forecast month after	To be completed
Revised date to meet the standard			Forecast year end	

Ambulance Handovers - 60 minutes (WMAS data)

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	58	⬆	Forecast next reported month	To be completed
Last reported month performance	47	⬆	Forecast month after	To be completed
YTD performance	-	-	Forecast month after	To be completed
Revised date to meet the standard	To be completed		Forecast year end	To be completed

Key Performance Indicator: 28 day breaches as a percentage of cancelled operations (PEL3.0)

Headlines

This indicator measures performance in terms of rebooking patients within 28 days of a cancelled operation and in February 2016 is at 25% against target of 5%. In total 14 patients were affected. The decision to cancel operations for non-clinical reasons is taken by the Divisional Director for Surgery or Chief Operating Officer at the point the team is confident that all options have been explored. Due to on - going high levels of bed occupancy, the number of procedures cancelled on the day of surgery, due to a lack of surgical beds (timely) remains a challenge.

Corrective Actions

The Surgical Division has developed a number of new approaches to include daily prioritisation of elective patients requiring admission and improved information on the 'to come in' (TCI) lists. Each of the Clinical Directorates has been asked to review their own internal process for managing this cohort of patient. The Directorate's performance against this target is to be monitored at the Divisional Board

Risks to Delivery

The key risk of not delivering against this target is a delay in a patient's treatment plan which could change the clinical presentation. This is in addition to poor patient experience as patients wait longer to be treated. This indicator also has a reputational risk for the organisation and is linked to the access targets (RTT and Cancer), resulting in higher financial penalties.
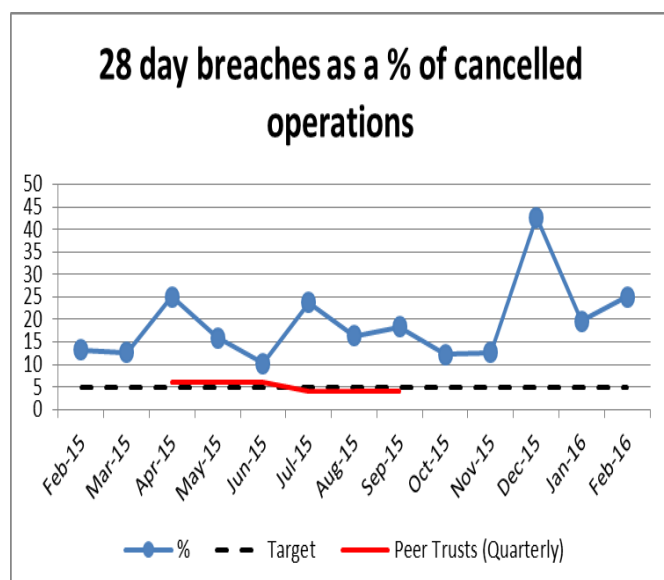
28 day breaches as a % of cancelled operations

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<5%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	25.0%	⬆	Forecast next reported month	
Last reported month performance	19.2%	⬆	Forecast month after	
YTD performance	19.5%	–	Forecast month after	
Revised date to meet the standard			Forecast year end	

Key Performance Indicator: Theatre Booking and Utilisation (all sites) (PT2)

Headlines

WRH continues to struggle with theatre booking and utilisation, this is in part is due to the on-going issues in relation to bed capacity and on – the - day cancellations. In addition, theatre maintenance continued into the beginning of February on the WRH site. Moving forward it has been agreed that theatre maintenance will go ahead on weekends and evenings to allow for uninterrupted operating. KTC remains under booked and underutilised. Twenty eight sessions were not utilised on the KTC site during the month of February. The AGH site has also suffered due to site capacity issues. The booking of theatre sessions and session utilisation is driven by the surgical specialties.

Corrective Actions

The TACO division is working closely with the surgical division to ensure sessions and lists are fully utilised. The weekly meeting between Surgery and TACO has highlighted numerous issues and as such Theatres and Surgery have arranged a process mapping event with the intention of improving theatre utilisation on the KTC site. The process will aid the design of a new model of working for the surgeons, anaesthetists and theatre staff with the aim of achieving more efficient patient throughput and turnaround. This review was due to commence on Monday 8th February however, this has been rescheduled for April. The weekly meetings also monitor the effective use of the anaesthetic staff by ensuring that mixed GA and LA lists are not booked. In order to address the underutilisation of theatre 4 (second emergency and trauma theatre) at WRH there has been an executive decision that we should close this theatre (except for the 2 sessions per week of elective surgery) until business cases have been written to demonstrate the requirement for reopening.

Risks to Delivery

Underutilisation of elective theatre capacity and poor list efficiency risks impact on 18ww target, cancer targets and may result in the potential for increased WLI sessions which in turn impacts unfavourably on the patient experience impacts on the trust financially.
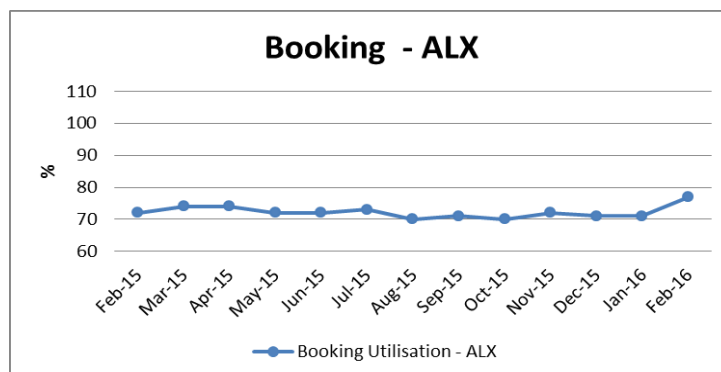
Booking - WRH

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	-	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	77%	⬇	Forecast next reported month	Not provided
Last reported month performance	82%	⬆	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided

Booking - WRH

Worcestershire NHS
Acute Hospitals NHS Trust
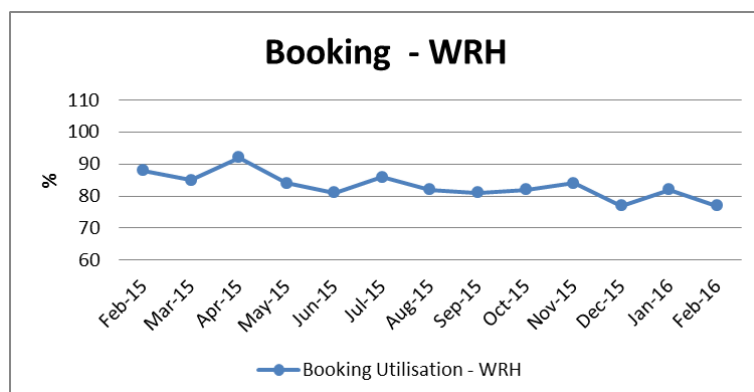
Booking - ALX

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	-	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	77%	⬆ (red)	Forecast next reported month	Not provided
Last reported month performance	71%	➡ (white)	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided

Booking - ALX

Booking Utilisation - ALX

Booking - KGH

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	-	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	71%	⬆ (green)	Forecast next reported month	Not provided
Last reported month performance	68%	⬇ (red)	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided

Booking - KGH

Booking Utilisation -KGH

Utilisation – WRH

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	-	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	70%	⬇ (red)	Forecast next reported month	Not provided
Last reported month performance	72%	⬆ (green)	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided

Utilisation - WRH

Utilisation - WRH

Utilisation – ALX

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	-	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	72%	⬆	Forecast next reported month	Not provided
Last reported month performance	70%	➡	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided
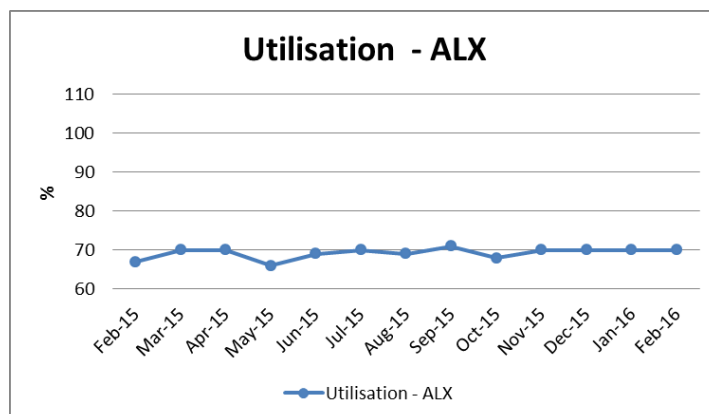
Utilisation - ALX

Utilisation – KGH

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	-	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	68%	⬆	Forecast next reported month	Not provided
Last reported month performance	65%	⬇	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided

Utilisation - KGH
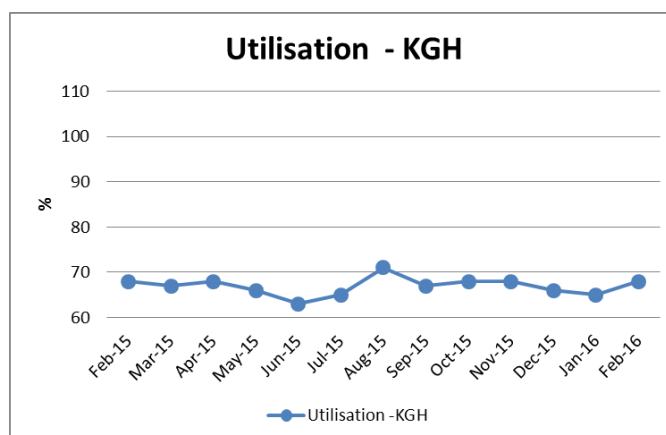
Corrective Action Statements: Workforce

Key Performance Indicators:

- All Staff Turnover – Total (WT1.0)
- Nursing Staff Turnover – Qualified (Total) (WT1.3)
- Nursing Staff Turnover – Unqualified (Total) (WT1.4)
- Sickness Absence Rate Monthly (Total %) (WSA1.0)
- Medical, Non -Medical and Consultant Appraisals (Total) (WAPP1.2, WAPP2.2 and WAPP3.2)
- % of eligible staff completed training (WSMT10.2)
- Consultant and SAS Doctor Job Planning (additional information)

Forecast Key	
Forecast to achieve	
Potential risk target will not be achieved	
Forecast not to achieve	

Key Performance Indicator: All Staff Turnover – (Total) (WT1.0)

Headlines

Trust turnover has increased from 10.5% in February 2015 to 12.7% in February 2016. There has been a small 0.1% improvement in month in February 2016. The highest increase in turnover during the period February 2015 to February 2016 is in Women & Childrens at 5.40%. Medicine turnover has reduced from 5.34% in the year to January 2016 to 4.58%.

Corrective Actions

An analysis of the divisions with the highest turnover has identified that the departments with the highest leavers are:

- A&E Nursing WRH   20.64 wte (all voluntary resignation apart from 1 retirement)
- Physiotherapy   18.55 wte (2 end of fixed term contract, 2.85 wte retirements and 7 relocations)
- Maternity WRH   15.93 wte (0.8 wte MARS, 1.6wte retirement)
- A&E Nursing AGH   13.84 wte (0.8wte retirements, 0.96wte end of fixed term contract with 3.64 wte leaving due to lack of opportunities, and 3.48wte due to work life balance)
- MAU AGH   12.21 wte (9.61 wte due to voluntary resignations with 4.01 wte stating work life balance)
- Radiology   12.03 (2.42 wte retirements, voluntary resignations include incompatible working relationships and work life balance)

A 'reasons for leaving' report for all trust leavers has identified the top five reasons as retirement (124.95 wte), work life balance (101.89 wte), relocation (98.45 wte), better reward package (56.72 wte), promotion (55.15%). There were 53.13 wte staff last year for whom we have no stated reason for leaving. Further steps need to be taken to encourage managers to meet with staff who have indicated their intention to leave which may include removing the "other" category on the form. Out of this 53.13 wte, 21.36 wte went to other NHS organisations but their manager has not determined why.

An action plan is monitored through the Nursing and Midwifery Workforce Assurance Group and the Trust Workforce Assurance Group for approval. The following actions have been agreed:
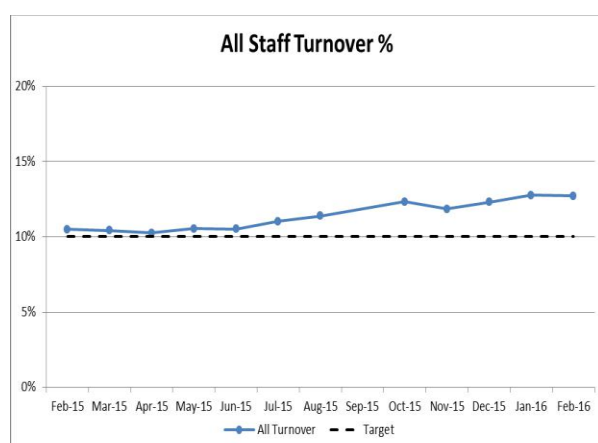
- A range of recruitment initiatives and careers fairs are in progress or planned.
- Internal transfer process implemented for qualified nurses.
- University Worcester Semester 6 graduates recruitment event. Tracking and follow up system for University of Worcester graduates presented to NWAG monthly as percentage offers accepted requires further analysis.
- Recruitment incentives for qualified nurses being considered in specific hard to fill areas e.g. theatres.
- Band 5 Assessment Centre test is being revised with the Worcester University, Professional Development and Pharmacy.
- Fortnightly divisional vacancy returns to track actual vacancies still on-going.

Future actions include:

- A range of educational programmes are being agreed with Worcester University to support development of new roles e.g. Band 4 Assistant Practitioner role.
- Development of a campaign to encourage qualified nurses and AHP's to return to practice.
- Review exit questionnaire to understand reason for leaving in more detail.

Risks to Delivery

If we do not attract and retain qualified nursing staff we will be unable to ensure safe and adequate staffing levels. We also will need to rely on agency and bank staff which will affect patient experience, quality and financial position. High turnover impacts on staff morale and health and wellbeing so is a high priority for the Trust.

All Staff Turnover %

SRO: DoHR/COO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<10%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	12.7%	⬇	Forecast next reported month	
Last reported month performance	12.8%	⬆	Forecast month after-	
YTD performance	–	–	Forecast month after	
Revised date to meet the standard			Forecast year end	

Key Performance Indicator: Nursing Staff Turnover – Qualified (Total) (WT1.3)

The qualified nursing turnover figure for February 2016 is 13.68% (against the target of 10%) which is a slight decrease in the January 2016 figure of 14.0%. The figure has stabilised between September 2015 and February 2016 at between 13%-14%. Qualified nurse recruitment continues to be a challenge, however in February 2016, 23.35 wte qualified nurses commenced in post due to the February graduation.

Corrective Actions

A number of actions continue to be developed and monitored by the Nurse Recruitment Task and Finish Group and the action plan is monitored through the Nursing and Midwifery Workforce Assurance Group and then into the Trust Workforce Assurance Group for approval. The following actions have been achieved:

- Fortnightly divisional vacancy return to track actual vacancies.
- Local Recruitment event in Jan 2016 with interviews on the day for qualified staff (17 offers made on the day).
- University Worcester and Birmingham Community College graduates recruitment event.
- Tracking and follow up system for University of Worcester graduates presented to NWAG monthly as percentage offers accepted requires improvement.
- Recruitment incentives for qualified nurses being considered in specific hard to fill areas e.g. theatres.
- Band 5 Assessment Centre test is being revised with the Worcester University, Professional development and Pharmacy.
- Analysis of exit interviews to identify reasons for nursing leavers with 12 months or less continuous service.
- Review of mentoring ratio of mentor to student undertaken to increase student number intake from next intake.

Future actions are:

- A range of educational programmes are being agreed with Worcester University to support development of new roles e.g. Band 4 Assistant Practitioner role.
- Development of a campaign to encourage qualified nurses and AHP's to return to practise.
- Review of exit interview process to ensure all leavers are provided with the opportunity to participate in the process.

Risks to Delivery

If we do not attract and retain qualified nursing staff we will be unable to ensure safe and adequate staffing levels. We also will need to rely on agency and bank staff which will affect patient experience, quality and financial position. High turnover impacts on staff morale and health and wellbeing so is a high priority for the Trust.

Nursing Staff Turnover - Qualified%

Legend: Qualified — Target

SRO: DoHR/ COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	10%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	13.68%	⬇	Forecast next reported month -13%	
Last reported month performance	14%	⬆	Forecast month after	
YTD performance	–	–	Forecast month after	
Revised date to meet the standard			Forecast year end	

Key Performance Indicator: Nursing Staff Turnover – Unqualified (Total) (WT1.4)

Headlines

The unqualified nursing turnover figure for Feb 2016 is 13.7%, which is 0.1% higher than the January 2016 figure. This is above the trust target of 10% although this is in line with national average turnover of 14% for unqualified nursing and regional benchmarking. This figure reflects the improved recruitment figures from April 2015 to February 2016 and an increase in the numbers of starters in comparison to the number of leavers for 10 of the 11 months. The leavers are distributed across the Divisions. The Trust continues to attract an average of 50 applications per advertisement with sufficient quality applications to fill vacancies and a list of reserve candidates. Analysis of the reasons for leaving indicate the top reasons are work-life balance and relocation.

Corrective Actions

A number of actions have been developed by the Nurse Recruitment Task and Finish Group and the action plan is monitored through the Nursing and Midwifery Workforce Assurance Group and then into the Trust Workforce Assurance Group for approval. The following actions have been achieved:
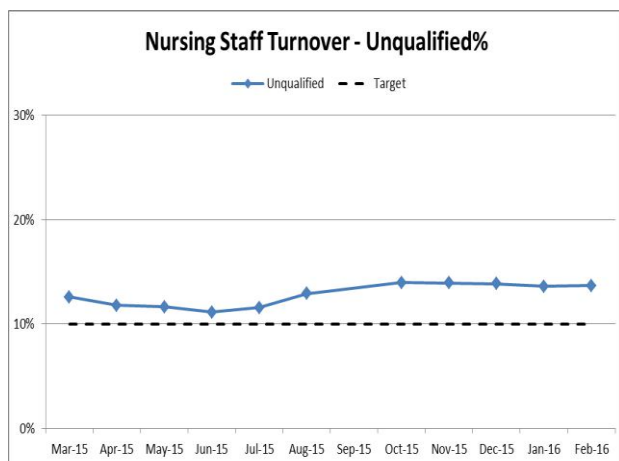
- Continue to provide 6 -day care certificate course for all new unqualified nursing staff.
- Improved assessment centre process to provide a reserve candidate list.
- Automatic offer of posts to all HCA apprentices on completion of apprenticeship.
- Commissioned Band 4 programme with UW to offer to existing Band 3 HCA's career progression opportunities to improve retention.

Future actions are:

- Analysis of exit interviews to identify reasons for nursing leavers with 12 months or less continuous service.
- Use the Band 4 development programme to improve retention by attracting applicants who want to pursue a career in nursing.
- Recruitment event planned at Alexandra Hospital April 2016.
- Implementation of local staff survey with quick feedback of results to enable early intervention in hotspot areas.

Risks to Delivery

If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels. We also will need to rely on agency and bank staff which will affect patient experience, quality and financial position. High turnover impacts on staff morale and health and wellbeing so is a high priority for the Trust.

Nursing Staff Turnover - Unqualified%

SRO: DoHR/COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	10%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	13.7%	⬆	Forecast next reported month	
Last reported month performance	13.6%	⬇	Forecast month after	
YTD performance	–	–	Forecast month	
Revised date to meet the standard	Not provided		Forecast year end	

Worcestershire **NHS**

Acute Hospitals NHS Trust

Key Performance Indicator: Sickness Absence Rate Monthly (Total %) (WSA1.0)

Headlines

The Trust sickness absence 'in-month' for February is 4.42% which shows a small decrease on last month (4.64%) and small increase on last year's February figure of 4.25%; we remain above the Trust target of 3.5% but comparable with other NHS Trusts. The 12 month cumulative figure is 4.33% an increase of 0.16% on the February 2015 cumulative figure. Long-term sickness has remained consistent at on or around 2.8% over the last 12 months. Short-term sickness remains consistently under Trust target.

With the exception of the Surgery Division, all Divisions have shown a decrease 'in month'. Areas of concern previously i.e. TACO have moved from 6.54% in December 2015 to 5.66% in February 2016 and Asset Management have shown an improvement from 6.54% to 5.25%.

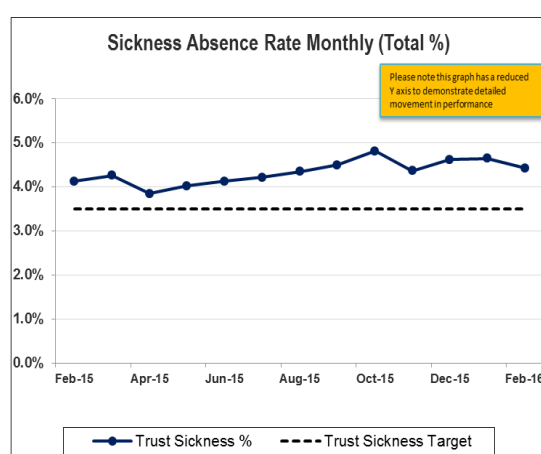Top 3 reasons for sickness absence are:
- Anxiety and stress (1196 calendar days lost in February)
- Colds and Flu (838 days lost)
- Back problems (680 days lost).

Corrective Actions

Given the main concern for the Trust remains long-term sickness, the HR Team in conjunction with line managers have reviewed all 97 long-term sickness absences cases across the Trust and all have active management plans in place where appropriate in line with Trust policy. Of the 97 cases, 40 have been off less than 2 months, 45 less than 6 months, 10 less than 12 months. We have 2 cases over 12 months but these will be drawn to appropriate conclusion within the next month.   The HR Team are equally working with Line Managers to support due process for episodic absences in support of employees' health and wellbeing and attendance at work.

Risks to Delivery

Higher levels of sickness absence affect patient experience, team working and Trust finances due to the need for bank or agency cover; as well as the cost of Occupational and Statutory Sick Pay.

Sickness Absence Rate Monthly (Total %)

Please note this graph has a reduced Y axis to demonstrate detailed movement in performance

SRO: DoHR/COO	Current Reporting Month: Feb 2016			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	=<3.5%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	4.42%	⬇	Forecast next reported month	
Last reported month performance	4.64%	⬆	Forecast month after	
YTD performance	-	-	Forecast month after	
Revised date to meet the standard			Forecast year end	

Key Performance Indicator: Medical, Non-medical Appraisals and Consultant (Total) (WAPP1.2, WAPP2.2 and WAPP3.2)

Headlines

Medical Staff:

The appraisal rate for all medical staff is 83.02% as at 29th February 2016 against the Trust target of 85%, which has increased by 1.26% since 31st January 2016. The consultant appraisal rate for this period is 85.16% which is above the Trust target of 85%. The SAS appraisal rate is 75% which is an increase of 1.56% from 31st January 2016. As at 29th February there were 55 missed appraisals, however 11 of these are now complete with a further 5 scheduled to take place in April 2016. The remaining 39 doctors who are due an appraisal will be escalated to Divisional Management Team for urgent implementation of appraisal completion plans. Four of the five divisions are currently below the 85% Trust target however 3 divisions increased the appraisal rate for all medical staff in February 2016 as detailed below:

- Surgery   81.93%   (increase of 3.36% from January 2016)
- Medicine   78.13%   (decrease of 0.56% from January 2016)
- Women and Children   84.62%   (increase of 5.67% from January 2016)
- Clinical Support   81.82%   (decrease of 1.82% from January 2016)
- TACO   89.02%   (increase of 2.94% from January 2016)

Non-Medical staff:

The appraisal rate for all non-medical staff is 76.2% against a target of 85%. Non-medical appraisal showed a decline in performance from August 2015 until October 2015. There was some slight improvement in November and December 2015 to 78.2% but has now declined again in January and February 2016. Managers have reported performance has been affected due to operational pressures and managers' non-completion of either required documentation to report appraisal or not entering the appraisal onto ESR once completed.

Corrective Actions

Medical Staff Appraisal

Current corrective actions:

- The hotspot areas which are currently being targeted are SAS doctors in Medicine and Surgery and the Consultant Staff Group in Clinical Support. **The SAS Tutor is making contact with SAS doctor with missed appraisals to offer additional support**. Anaesthetist appraisers have now been allocated to appraise colleagues in Clinical Support to expedite appraisal within the Clinical Support Division.
- Monthly RAG rated appraisal reports are issued to Divisional Management Teams and action plans have been requested to address expired appraisals. Responses to action plans are being followed up on a monthly basis.

Future corrective actions:

- Appraiser training for current appraisers and new appraisers is scheduled to take place in April 2016. New Appraiser training will increase the appraiser pool and reduce the risk of appraisal non-completion due to the appraiser availability in some specialties.

- Future recruitment plans for the post of Clinical Lead for Medical Revalidation are currently under consideration by the Chief Medical Officer.

Non-Medical Appraisal

The following actions have been completed:

- All employees who have not received an appraisal in the last 12 months have received a letter reminding them of the importance of their appraisal.
- All managers whose departmental performance is below 85% have been sent a reminder regarding their obligation to ensure that all staff receive an annual appraisal.
- Development of an electronic appraisal form which can be submitted directly to ESR for monitoring, this is planned to be launched by the end of February 2016.
- Monthly report on appraisal performance is now refreshed fortnightly.
- Learning and Development Lead for appraisal meeting with low compliance heads of departments to assist with planning of appraisals.

Risks to Delivery

The Clinical Lead role for Revalidation and Appraisal remains vacant. Staff are expected to have received a formal appraisal every year so that they are aware of their performance. Where staff do not have an appraisal they do not have the opportunity to receive feedback and to give feedback to their manager.

Non medical, Medical and Consultants completing Appraisals (%)
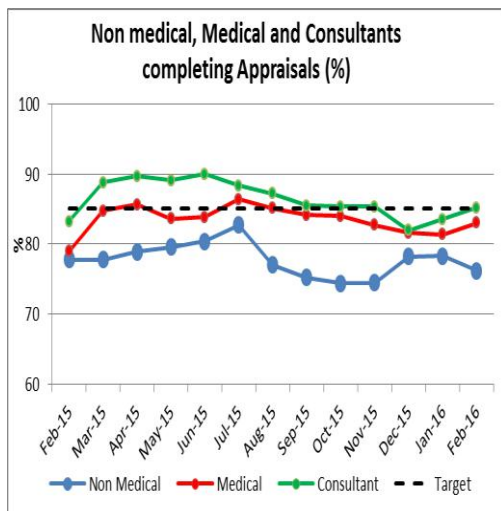
SRO:DoHR	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	85%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	83.0% Medical, 76.2% Non-medical, 85.2% Consultant		Forecast next reported month Medical – 83% Non-Medical 80%	
Last reported month performance	81.4% Medical, 78.3% Non-medical, 83.5% Consultant		Forecast month after Medical – 84% Non-Medical – 83%	
YTD performance	83.7% medical, 77.8% non – medical. 86.4% Consultant	-	Forecast month after Medical – 85% Non-Medical 85%	
Revised date to meet the standard	March 2016		Forecast year end Medical and Non-Medical 85%	85% non-medical 85% medical

Key Performance Indicator: % of eligible staff completed training (WSMT10.2)

Headlines

The Trusts mandatory training performance as at February 2016 is 86.9% which shows a 0.2% decline since January 2016 against an agreed revised 90% target. However there are 18 mandatory training topics and currently 7 topics have met the 90% target, 6 further topics are on track to achieve the 90% target by 31st March 2016. The remaining five topics are currently achieving between 47% and 66% and these are being reviewed with the topic lead and Mandatory Training Lead. Analysis of the data shows that in identifying the clinical/non-clinical split in mandatory training rates, the focus has been on clinical staff with over 82% compliance in all areas and high 90% and above in safeguarding and infection prevention / hand hygiene. Non-clinical staff have made some improvement in all topics and key areas such as information governance and fire safety are over 90%.

Corrective Actions

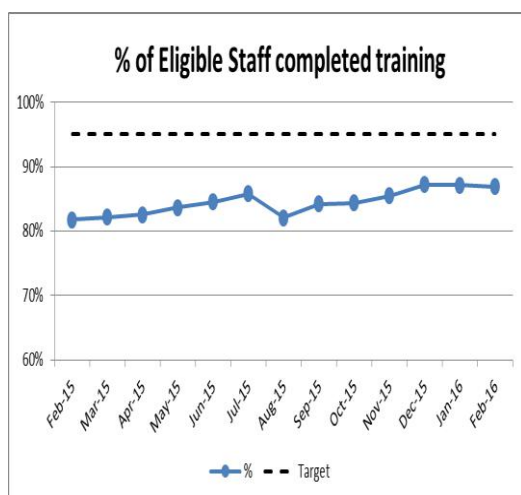For the five topics that are not on track to reach the 90% target corrective actions have been agreed:

- Provision of additional training sessions and weekends and evenings.
- Alternative methods of training delivery
- Written assessments to replace e-learning for staff that have limited IT contact
- Additional administration support resourced to support managers to validate mandatory training data and records.
- Knowledgeable management staff supporting staff to complete e-learning training in Trust libraries.
- Workforce Assurance Group agreed revised target for all mandatory training topics to 90% except Information Governance which is a national target for all trusts of 95%.

Future Actions include:

- Networking continues with all 27 Trusts engaged in the West Midlands Mandatory Training Streamlining Project to develop new ideas and agree transferable training records between Trusts to improve compliance.
- Competencies attached to each job role on ESR to enable easier access to correct e-learning programme.

Risks to Delivery

One of the key risks in not meeting their mandatory training targets will be financial penalties from CQR Group and potential for breaches in health and safety legislation.

% of Eligible Staff completed training

SRO: DoHR/COO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>90%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	86.9%	⬆	Forecast next reported month	
Last reported month performance	87.1%	⬇	Forecast month after-	
YTD performance	87.1%	–	Forecast month after	
Revised date to meet the standard	March 2016		Forecast year end	

Key Performance Indicator Name: Consultant and SAS Doctor Job Planning (additional information)

As at 29th February 2016, 42% of the Trust's medical and dental workforce have a current job plan which is a decrease of 6% from 31st January 2016. The substantive consultant job plan percentage for February 2016 is 49% which is a decrease on the 31st January 2016 figure of 52%. The SAS doctor job plan percentage for February 2016 is 12% which is a decrease on the 31st January 2016 figure of 27%. Underperforming divisions remain as Medicine (all specialties) Surgery (all specialties), and Clinical Support (Clinical Haematology). Job planning meetings have taken place in A&E, Orthodontics, ENT, Urology, Dermatology, Urology and some of the medical specialities however these job plans have not yet all been submitted to HR. The outstanding job plans are being followed up and this will have an impact on meeting the Trust target. This month there was also a significant reduction in the TACO compliance as 26 job plans were due in January and February and these did not take place but are currently in the process of being scheduled.

Corrective Actions

The Interim Chief Medical Officer has committed to achieving 100% of all consultants and SAS doctors having a current job plan by 31st March 2016. To support this requirement monthly RAG rated reports are issued to divisions and action plans requested to identify required activity. The actions undertaken to date include:

- Monthly Divisional RAG rated reports are issued to identify areas of non-compliance with action plans requested to address this
- Analysis of diary exercise data within some specialties to inform discussion at job planning meetings
- Escalation to Chief Medical Officer in respect of underperforming divisions on a monthly basis.

Future actions are:

- Agreed escalation process implemented in respect of non-progress of the job planning review process and related documentation to the Divisional Management Teams and Chief Medical Officer to enable corrective action to be taken. Divisions to provide action plan against all out of date job plans identified on RAG Report
- The Chief Medical Officer to confirm actions agreed with the DMD's following to agree actions to achieve the Trust target.
- Divisions have been alerted to the critical position of non-achievement of the agreed target completion date and a further request for action plans to demonstrate the target will be met.
- Due to staffing shortage within the Human Resource Department, the weekly chaser emails issued to the divisions where known job plan meetings have been undertaken and documentation has not been received in HR for validation has not yet been implemented however this is now being implemented as a priority with additional temporary resource allocated to job plan input.

Risks to Delivery

If job plans are not reviewed and validated annually there is no provision to assess individual and specialty activity affecting capacity planning and service delivery. The Trust may also be liable for individual claims for additional remunerated programmed activities which cannot be substantiated if there has been no robust process.

The table below demonstrates percentage movements for the month of February 2016 in comparison to January 2016.

	Division					TRUST TOTAL
	Clinical Support	Medicine	Surgery	TACO	W&C	
% Consultants with current job plan	↓ 3% to 40%	↑ 5% to 43%	↑ 5% to 34%	↓ 19% to 51%	↓ 3% to 91%	↓ 3% to 49%
% SAS Doctors with current job plan	⟷ 0%	⟷ 13%	↓ 14% to 0%	↓ 33% to 20%	⟷ 20%	↓ 15% to 12%
% eligible doctors with current job plan	↓ 4% to 37%	↑ 4% to 39%	⟷ 26%	↓ 21% to 45%	↓ 3% to 82%	↓ 6% to 42%

Corrective Action Statements:

Quality and Safety

Key Performance Indicator Names;

- MRSA bacteraemia (QPS 12.4)
- Mortality – HSMR monthly and rolling 12 months (HED tool) (QPS9.8)
- Mortality - SHMI monthly and rolling 12 months (inc. Deaths 30 days post discharge) (QPS9.1)
- Falls resulting in serious harm (in month) (QPS6.6)
- The total number of Serious Incidents open longer than 60 day (QPS3.1)
- % of Category 2 complaints responded within 25 days (WAHT) (QEX1.14)
- Safety Thermometer (QPS10.1)
- % of approved risks overdue for review (QR1.0) and % of approved with overdue actions (QR1.2)
- Hip Fractures – Time to Theatre within 36 hours – all patients (QEF3.1)
- VTE Risk Assessment (QPS11.1)
- Friends and Family (QEX2)

Forecast Key	
Forecast to achieve	
Potential risk target will not be achieved	
Forecast not to achieve	

Key Performance Indicator: MRSA Bacteremia (QPS12.4)

Headlines

The MRSA Blood Stream Infection KPI is set at a zero target each year. This is the first case since 2nd March 2015 and the last case prior to that was 14th July 2013.

Corrective Actions

Potential factors influencing achievement of this KPI are poor blood culture sampling technique leading to contamination of specimen, inappropriate sampling e.g. not clinically indicated increases the risk of a positive case, patient acquisition through poor insertion or on-going management of medical devices, unavoidable acquisition due to patient health status and potential for colonisation with key alert organisms such as MRSA. Current practices to mitigate risk of acquisition include;

- All patients known to be colonised or infected with MRSA are alerted on the PAS system with a warning to staff to facilitate enhanced practices. This includes; isolation of patient, if appropriate and use of a body wash to reduce the level of MRSA and other organisms on the skin. This in turn reduces the risk of infection from the patient's own skin flora.
- Education and competency assessment of all medical, nursing and allied health professionals involved in the practices of insertion and management of medical devices,
- Education and competency assessment of all staff involved in the process of obtaining sampling of patient e.g. blood sampling workshop for all FY1 and FY2 doctors entering the Trust,
- Review of all positive blood culture results to ascertain cause for acquisition and likelihood of contamination versus actual infection,
- Re-training for all staff assessed as having taken a contaminated blood culture,
- Provision of insertion packs e.g. blood culture sampling kits, cannulation packs for device insertion, urinary catheter insertion packs. In effect these promote best practice and ensure the appropriate equipment is available for optimum practice and adherence to policy,
- MRSA screening of all non - elective admissions and use of topical decolonisation agents e.g. Octenisan to reduce likelihood of patient own endogenous infection from own skin flora.

A post infection review has identified a number of learning points that are being followed up although it was difficult to pin down the precise reason for acquisition of the bacteraemia.

Risks to Delivery

Potential poor clinical outcome for patient if acquires an MRSA Blood Stream Infection and increased mortality in patients
Additional cost of treating MRSA Blood Stream Infection, increased length of stay
Reputational damage to the Trust if do not achieve zero tolerance.

Month	MRSA Bacteremia	Target
Jan-15	0	0
Feb-15	0	0
Mar-15	1	0
Apr-15	0	0
May-15	0	0
Jun-15	0	0
Jul-15	0	0
Aug-15	0	0
Sep-15	0	0
Oct-15	0	0
Nov-15	0	0
Dec-15	0	0
Jan-16	0	0
Feb-16	1	0

SRO:COO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	1	⬆	Forecast next reported month	
Last reported month performance	0	⮕	Forecast month after	
YTD performance	1	–	Forecast month after	
Revised date to meet the standard			Forecast year end	

Key Performance Indicator: HSMR monthly (QPS9.8) and rolling 12 months (HED tool) (QPS9.81)

Headlines

The HSMR for the Trust is 105.08 for the period of April – November 2015. This value, although higher than the average of 100, is within expected variability. The monthly figures demonstrate neither improvement nor deterioration however the data from the latest 3 months should be viewed with caution as it is based on an incomplete dataset due to patients admitted during these months still having active management. The impact of data refresh is to increase the HSMR value as long stay patients tend to have a higher overall mortality but not a higher predicted mortality. Using 12 month rolling figures can smooth out this sometimes distracting variability. Although the value using this methodology is within 3 SD of expected for the last 3 months in a row, for the first time in over 15 months the trend is slightly upwards.
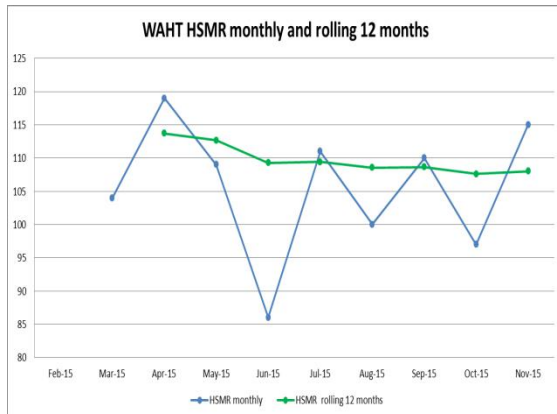
Corrective Actions

The heat map of contributing diagnostic groups indicates adverse trends in Acute Gastrointestinal Haemorrhage, Chronic Skin Ulcers and Syncope. Deep dive reviews of deaths occurring in these areas have been requested of the appropriate specialist teams - to be completed by the end of December 2015. It is anticipated that an overview report will be brought to Safe Patient Group in February 2016. Another diagnostic group that is showing and adverse trend over the 12 months to August 2015 is 'Other Circulatory Diseases'. This group includes surgical patients with a primary diagnosis related to arterio-occlusive disease (9 deaths) and medical patients with non-specific hypotension or non-specific arteritis. Requests for review of the care of the patients and diagnostic/coding accuracy have been requested of the relevant divisions.

Risks to Delivery

Failure to identify and address suboptimal care puts patient safety at risk. Errors in care lead to prolonged stay impacting on the Trusts ability to manage its emergency and elective workload. A continued high HSMR and poor compliance with completion of mortality reviews damages the Trusts reputation and risks regulatory action from the CQC.

![Worcestershire NHS Acute Hospitals NHS Trust]

This graph and chart relate to the rolling 12 months (QPS9.81)

WAHT HSMR monthly and rolling 12 months

SRO:CMO	Current Reporting Month: Nov 2015			
	Performance – rolling 12 months	Direction of travel	Plan/ Forecast	Status/ RAG
Target	TBC	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	108.1	→	Forecast next reported month	🟧
Last reported month performance	107.8	→	Forecast month after	🟥
YTD performance	-	-	Forecast month after	🟥
Revised date to meet the standard	Not provided		Forecast year end	🟥

Key Performance Indicator: SHMI – inc. deaths 30 days post discharge – monthly (QPS9.0) and rolling 12 months (QPS9.1)

Headlines

The monthly (projected) SHMI for April – October 2015 is 103.35. This compares with a value of 103.90 for the same period 2014. The outcome for 2014/15 was 111.48, which was higher (worse) than 3 standard deviations from expected indicating the Trust as a significant outlier for this measure.
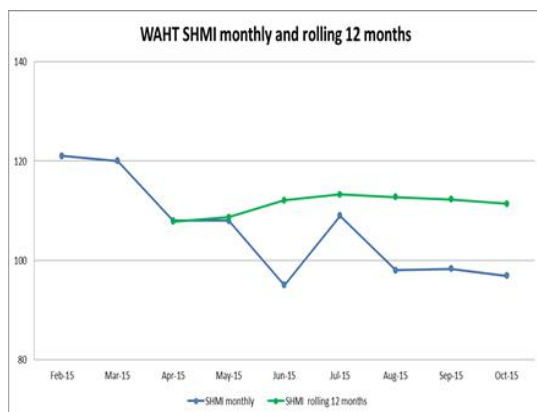
Corrective Actions

Deep dive reviews of the care of patients as per the HSMR corrective actions and establishing routine mortality reviews will help identify correctable issues with care. In addition as the SHMI incorporates deaths occurring within 30 days of discharge, work has begun to link mortality reviews occurring in Worcestershire Health and Care Trust and establish mortality reviews for patients discharged to their normal place of residence. These initiatives should identify any avoidable factors compromising the quality of care delivered to these groups of patients and thus facilitate improvement.

Risks to Delivery

Failure to identify and address suboptimal care puts patient safety at risk. Errors in care lead to prolonged stay impacting on the Trusts ability to manage its emergency and elective workload. A continued high HSMR and SHMI damages the Trusts reputation and risks regulatory action from the CQC.

This graph and chart relate to the rolling 12 months (QPS9.1)

WAHT SHMI monthly and rolling 12 months

SRO:CMO	Current Reporting Month: Oct 2015			
	Performance – rolling 12 months	Direction of travel	Plan/ Forecast	Status/ RAG
Target	TBC	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	111	⬇	Forecast next reported month	
Last reported month performance	112	⬇	Forecast month after	
YTD performance	-	–	Forecast month after	
Revised date to meet the standard	Not provided		Forecast year end	

Key Performance Indicator: The total falls resulting in serious harm (in month) (QPS6.6)
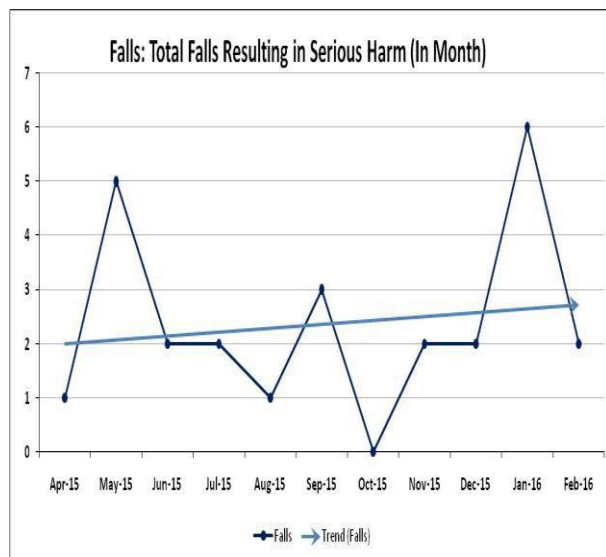
Headlines

There were 2 serious harm falls reported in February 2016. The injuries sustained a left fractured neck of femur (Alex MAU) and a subdural bleed (MAU WRH). The fall sustaining a subdural bleed was a witnessed fall and the fractured neck of femur was an un-witnessed fall. There have been 26 falls reported to date which have resulted in serious harm. If we compare our serious harm falls per 1000 bed days to the national figures compiled last year in the Falls and Frailty Audit by the Royal College of Physicians then the national average is 0.19 compared to the WAHT average of 0.09 per 1000 bed days.

Corrective Actions

There are on-going falls prevention and reduction training strategies in place. We have now completed a number of care contact time audits and given advice and support to staff on areas which have had high numbers of falls. MAU at the Alex have had 8 falls resulting in harm this financial year and there are current plans to reconfigure the bed base and staff which should improve patient care. Following review the target for falls with serious harm will be less than 24 for 2016/17.

Risks to Delivery

The overall trend for serious harm falls is up compared to last year and we need to be mindful that the increase in length of stay and mortality are increased by serious harm falls. This also directly affects the patient experience.

Falls: Total Falls Resulting in Serious Harm (In Month)

SRO:CNO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	2	⬇	Forecast next reported month	
Last reported month performance	6	⬆	Forecast month after	N/A
YTD performance	26	-	Forecast month after	N/A
Revised date to meet the standard	Not applicable		Forecast year end	

Key Performance Indicator: The total number of serious incidents (SIs), open longer than 60 days and are awaiting closure by WAHT (QPS3.3)
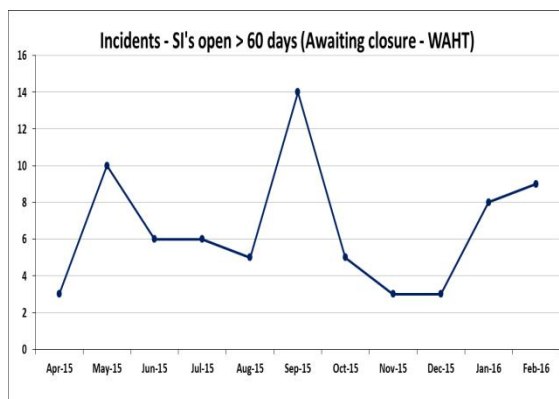
Headlines

9 SI investigations were open beyond 60 days at the end of February, an increase from January. This is a snapshot position. Six reports were pending amendments prior to executive sign-off; reports had not been received for 3 overdue SIs. A further 7 incidents will reach their due date in March.

Corrective Actions

The weekly Trust Operational Governance Meeting reviews SI reports and progress with investigations. Divisional Management Teams have been requested by the CNO and CMO to complete all overdue SI investigation reports and those which will become overdue during the Easter holiday period. These are to be provided to the two remaining March meetings. Improved attendance by the DMT at the Operational Governance Meeting has been requested. The approval of reports with minor amendments has delayed closure in some instances and this practice will be reviewed. Divisional review meetings continue to monitor progress of SI investigations and share any immediate learning within their area of responsibility. The new Divisional Governance Report will be reviewed at performance meetings: it includes the SI investigation performance and allows for challenge on performance where required. Training for additional lead investigators has been agreed and will be arranged.

Risks to Delivery

Performance in SI investigations is monitored nationally and locally with the potential to attract a contract query from the CCGs or attention from the TDA. The CQC inspection report highlighted issues with the incident reporting and investigation process and learning from these events.

Incidents - SI's open > 60 days (Awaiting closure - WAHT)

SRO:CNO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	9	↑	Forecast next reported month	Not applicable
Last reported month performance	8	↑	Forecast month after	Not applicable
YTD performance	-	-	Forecast month after	Not applicable
Revised date to meet the standard	Not applicable		Forecast year end	Not applicable

Key Performance Indicator: % of Category 2 complaints responded within 25 days (WAHT) (QEX1.14)

Headlines

Overall performance against the target of 90% of category 2 complaints being responded to within 25 working days rose to 81% by the end of December 2015 and is now 68% ytd. On-going work continues with the Divisions including regular meetings and updates and a number of briefing sessions to launch the new complaints investigation template which went live in January 2016.
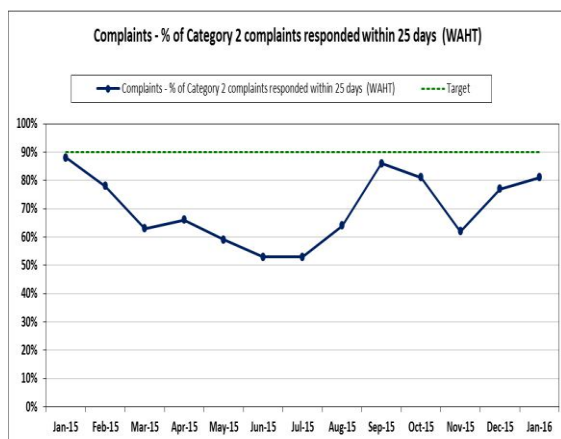
Corrective Actions

The Complaints Action Plan is included in the Patient Care Improvement Plan. This is monitored via the Patient and Carer Experience Committee and the Associate Director Patient Experience (ADPE) regularly reports progress to the Quality Governance Committee (Last attendance February 16). Actions taken to progress this are as follows:

- New investigation template now used for all complaints since 1.2.16
- Briefing sessions held for staff
- Datix Complaints Report now live and being used by Divisions
- Patient Relations Manager continuing to hold letter writing sessions with staff
- Regular meetings with Divisions re complaints
- All 22 day outstanding complaints escalated to DDNs
- All 23 day outstanding complaints escalated to ADPE
- All 24 day outstanding complaints escalated to DCNO
- New Complaints & PALS Newsletter implemented in February 2016 to share themes, trends, performance and learning
- New Complaints Policy being drafted
- TDA Complaints Framework template completed to inform improvement / policy development.

We dealt with 232 PALS in January and 263 in February. The most enquiries we have ever had in a month. With 2322 PALS contacts to the end of January 2016, we have already significantly exceeded the total of 1833 for 2014-15. Given we only have one PALS Officer for the whole Trust this does have capacity implications which are being reviewed as part of the wider workforce review.

Risks to Delivery

 If we do not adequately understand & learn from complaints and patient feedback we will be unable to deliver and demonstrate excellent patient experience.

Worcestershire NHS
Acute Hospitals NHS Trust

Complaints - % of Category 2 complaints responded within 25 days (WAHT)

SRO:CNO	Current Reporting Month: Jan 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>90%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	81%	⬆	Forecast next reported month	
Last reported month performance	77%	⬆	Forecast month after	
YTD performance	70%	-	Forecast month after	
Revised date to meet the standard	September 2016		Forecast year end	

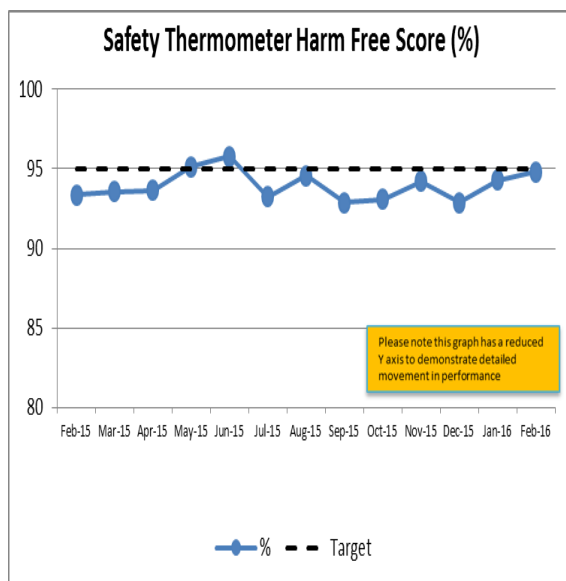**Key Performance Indicator: Safety Thermometer (QPS10.1)**

Headlines

The target score set for harm free care is 95%. The Trusts overall harm free care score for February 2016 was 94.82% against a national benchmark for acute trusts of 93.55%. The Trust has achieved a score of 95% for 2 months out of 9 this financial year. Overall performance in the remaining six months has been between 92.8% and 94.82%. The main reason for not achieving 95% has been the scores for all pressure ulcers and the presence of catheters and urinary tract infections. A portion of these are acquired prior to admission to our hospitals and our beyond our control. The number of new pressure ulcers for February was 0.28% of all reported, and the number of new catheters and urinary tract infections was 0.84% of all reported. Of all new harms, those that occur within our Trust were 1.4% for the month of February 2016.

Corrective Actions

All pressure ulcers are reviewed by the Trust Tissue Viability Team and accountability meetings held with relevant staff. Where pressure ulcers have occurred whilst in our care, action plans are developed and monitored by Matrons supported by the Tissue Viability Team. Ward areas have tissue viability link nurses who support learning from incidents and provide educational support to ward teams. The prevalence of catheter associated urinary tract infection (UTI) remains a focus for the Trust. The use of catheters must be documented including documenting the rationale for insertion and documentation of on-going care (which can follow the patient across the health economy) to help improve catheter management and reduce infection. A Harm Free Group was established in February 2016 to bring together all current groups looking at 'harms' such as falls, pressure ulcers, venous thrombosis and infection, as these are often interconnected and the group will look at prevention of all harms using a connected and holistic approach. The next meeting is in April 2016.

Risks to Delivery

The risks for not meeting the target of 95% need to be broken down into the specific areas that are being flagged. The number of pressure ulcers, catheter acquired urinary tract infections, falls and VTE's need to be looked at as to whether they occurred within the Trust or not (ie new harm), Also, Safety Thermometer should not be used as a bench mark with other trusts – NHS Safety Thermometer advise that we look at the trends within our own organisation. Both CQC and TDA will expect to see actions plans for the areas where there are issues which are within our control.

Safety Thermometer Harm Free Score (%)

Please note this graph has a reduced Y axis to demonstrate detailed movement in performance

SRO:CNO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>95%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	94.82%	⬆	Forecast next reported month	
Last reported month performance	94.28%	⬆	Forecast month after	
YTD performance	-	–	Forecast month after	
Revised date to meet the standard	Not provided		Forecast year end	

Key Performance Indicator: % of approved risks overdue for review (QR1.0) and % of approved risks with overdue actions (QR1.2)

Headlines

Reasons a risk or action is not completed on time include:

- Unrealistic timeframe set or inadequate action planning
- Cancelled meetings, or risk register not added to agenda
- Risk register not being reviewed in detail at meetings, or staff not held accountable for overdue actions

Overall this month, the trust achieved the target for QR1.0 (% of approved risks overdue for review) but did not meet QR1.2 (% of approved risks with overdue actions). The three Divisions with the highest percentage of approved risks with overdue actions is as follows: Women's and Childrens - 45% (17 of 38), Estates and Facilities 44% (12 of 27) and Surgery 38% (12 of 32).
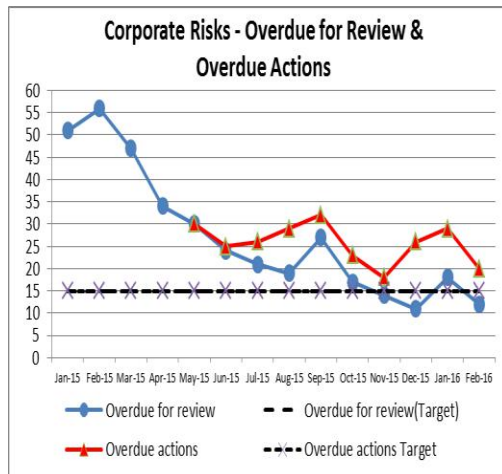
Corrective Actions

The original forecast for achieving target was February 2016, however this has not been achieved for QR1.2. The revised forecast for achieving this is April 2016. In February the Trust Risk Officer started to attend Directorate meetings where performance is not meeting target, and liaising with the Divisional Quality Leads and the relevant DMT's. It has been noted that despite these efforts, if the chair or attendees do not challenge overdue dates, performance will not improve. The Trust Risk Officer is meeting with relevant chairs and meeting facilitators to ensure risks have robust review. Women and Children have commenced an in-depth review of risks at their directorate meeting. Estates and Facilities have commenced a department heads meeting process for review of risks (and incidents). Further action: Implement alongside Ward Performance Dashboard phase three in March 2016

Risks to Delivery

The following could all impact on the delivery of the target:

- Divisions and Corporate services not giving sufficient time or attention to overdue risks & actions
- Cancelled meetings or risk register not added to agenda/papers
- Risk owners not sufficiently engaged or state they do not have time to update the risk

Corporate Risks - Overdue for Review & Overdue Actions

SRO:CNO	Current Reporting Month: Feb 2016			
	Overdue for review	Overdue actions	Plan/ Forecast	Status/ RAG Overdue Actions
Target	<15%	–<15%	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	12%	20%	Forecast next reported month	
Last reported month performance	18%	29%	Forecast month after	
YTD performance	–	–	Forecast month after	
Revised date to meet the standard	April 2016		Forecast year end	

Key Performance Indicator: Hip Fractures – Time to theatre within 36 hours – all patients (QEF3.1)

Headlines

Performance has previously been discussed at the Trust Quality Governance Committee Meeting on the 12 November 2015. It was recognised that there has been unacceptable performance and variation month on month. February performance has shown an increase of 17% from 59% in January to 76%. The latest 2015 NHFD West Midlands Data (2014) shows performance for 2015 WRH was 70% and AGH was 72%, which is an improvement on our 2014 performance, however we need to continue to push for better outcomes. The national average for 2014 was 72%.
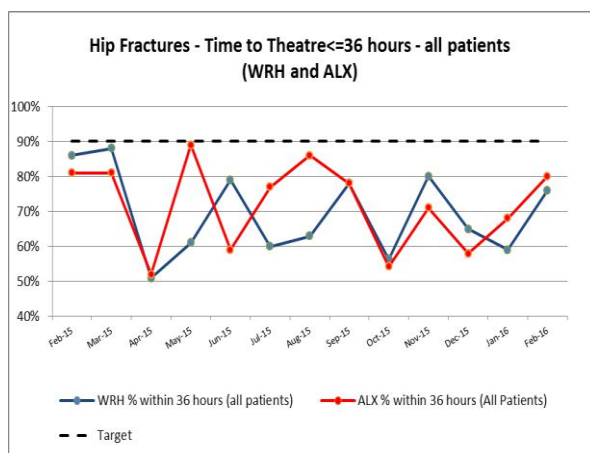
Corrective Actions

1) Prioritisation of #NoF cases to be done first on the PM Trauma Theatre Sessions; this to be driven by the Trauma Nurse Practitioners & Clinical Teams.
2) Hip Fracture Escalation Policy disseminated to the T&O Clinical Teams to support the following:- - #NoFs first on the list; other cases to be prioritised - Hip Fracture Escalation Policy to be enforced - delaying fracture care needs to be challenged - 36 hour breach time to be added onto Bluespier (support required from IT to implement).
3) Trauma Nurse Practitioners & Clinical Teams are reviewing and escalating daily trauma issues.
4) Trauma Nurse Practitioners submit a daily #NoF Report on the achievement of the 36 hour target; report submitted to the COO & Surgical Division.
5) #NoF performance reviewed and discussed at the Monthly T&O Directorate Meetings; this will be a monthly standard agenda item for discussion.
6) Business Case to be submitted for additional weekend Trauma Theatre Sessions for both The Alexandra & Worcester Sites. The document "Case for Change – Weekend Trauma Sessions" was resubmitted on the 3 March 2016.

Risks to Delivery

Weekday Theatre 3 & Theatre 4 PM Sessions are required to support #NOF workload.
Currently no dedicated weekend Trauma Theatre Sessions at the Alexandra Site and only weekend AM dedicated Theatre Sessions at the Worcester Site.
There appears to be a significant number of patients being prescribed new generation anticoagulants, which is delaying surgery as we cannot reverse these in the same way as Warfarin.
Guidance is required from haematology and anaesthetics on this matter as more and more patients seem to be switching from Warfarin to e.g. Apixaban for AF in the community.

Hip Fractures - Time to Theatre<=36 hours - all patients (WRH and ALX)

SRO:COO	Current Reporting Month: Feb 2016			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	90%	–	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	76.0%	↑	Forecast next reported month	
Last reported month performance	59.0%	↓	Forecast month after	
YTD performance	66.6%	–	Forecast month after	
Revised date to meet the standard	Not provided		Forecast year end	

The graph below shows how the Worcestershire Royal Hospital and the Alexandra Hospital are performing against the West Midlands average.

2014 WM Average #NOF<36 Hours
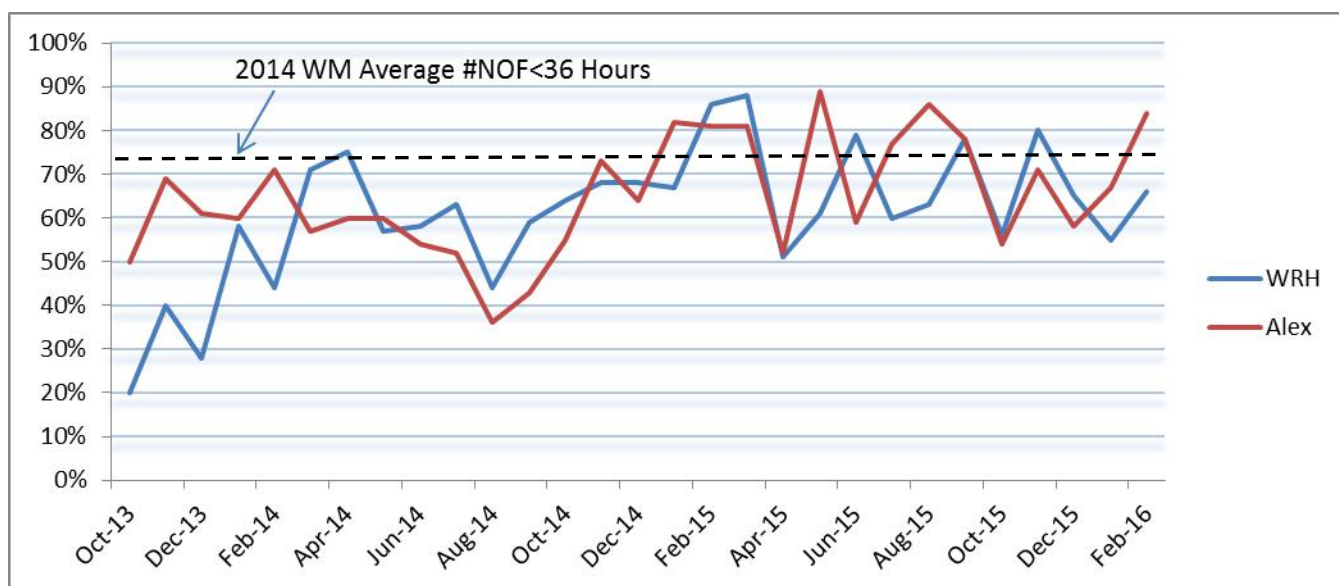
Key Performance Indicator: VTE Risk Assessment (QPS11.1)

Headlines

Previous performance has been achieving target until November 2015, however performance has been declining since then with February 2016 performance being RAG rated red at 93.2% . A review of identified a change in the layout of the proforma as the only significant change to process. On re-examination the change was deemed to be minor and not expected to impact on performance. An audit of health records identified instances where VTE assessments were recorded and therapy prescribed, but not recorded in appropriate proforma or electronically.
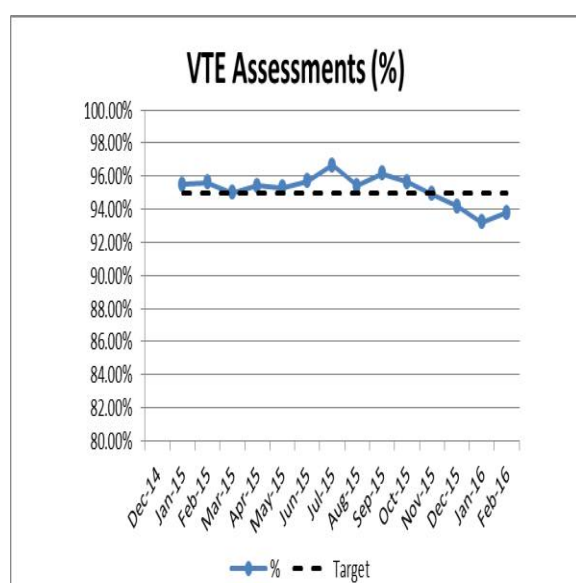
Corrective Actions

The clinical lead for VTE attended the Safe Patient Group in February 2016 to report to the group and discuss the challenges in performing and recording the VTE assessments. The process was described as requiring appropriate clinical review and completion of the VTE and subsequent recording of completion of the VTE assessment electronically within Oasis. It was agreed that information would be disseminated to clinicians by the Thrombosis Committee reinforcing the benefits and necessity of performing VTE assessments . In addition to this communication, a safety notice was published Trust wide explicitly stating that VTE assessments save lives:

- VTE assessments save lives – but we're not meeting the 95% target
- Make sure your patients have had a VTE assessment
- If you notice that a patient has not had their VTE assessment – ensure this is completed

Risks to Delivery

Failing to achieve this KPI will result in a contract query with CCG. Not performing VTE assessments prevents the provision of appropriate therapeutic interventions which reduce an individual's risk of developing a VTE with the possibility of subsequent morbidity or mortality. Not recording VTE assessments, which have been completed appropriately, results in avoidable adverse reporting.

VTE Assessments (%)

SRO:CNO	Current Reporting Month: Feb 2016			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	93.8%	⬆	Forecast next reported month	(red)
Last reported month performance	93.2%	⬇	Forecast month after	(amber)
YTD performance	-	-	Forecast month after	(amber)
Revised date to meet the standard	Not available		Forecast year end	(red)

Key Performance Indicator: Friends and Family (QEX2)

Headlines

With the exception of Maternity, all of the response rates are below target although with the exception of the A&E at AGH, the response rate improved in February 2016 compared with January 2016. Scores have decreased in all areas when compared to January, however all remain above the target of 71 with the exception of WRH A&E.

Please note that the methodology for reporting has been reviewed in February 2016 in line with national guidance. Hence the Data Quality kitemark has changed to Green.

Corrective Actions

FFT returns and scores have continued to prove challenging in both A&E departments. The ADPE and new Patient Experience Lead met with staff at AGH on the 4th March and are following up a number of actions to raise the profile of FFT within both A&E departments including ensuring reception staff understand FFT and help encourage completions, use of TV screens which includes a FFT film and new FFT boxes and posters in the waiting areas and cubicles. We have identified areas that need posters and boxes and are liaising with Estates and 'ServicePoint' to try and expedite these. A proposal to expand SMS texting to both A&E and Maternity services has been agreed in principle and a review is scheduled with Finance to ensure the budget is identified.

The informatics team have been working closely with Patient Experience on developing a clearer and more user friendly way of presenting FFT data by ward and area which has now gone live. Initial feedback is positive and further ideas for improvements are welcome. Further work will be taking place during March to ensure that the data is available by Ward and A&E separately, rather than combined as shown currently in the Trust dashboard.

A national week long campaign to raise awareness of the FFT commences on the 14th March and we will use this to spend further time in A&E and continue to embed this with staff.

Risks to Delivery

- Failure to ensure our response rates meets agreed targets impacts upon our contract.
- It impacts on our reputation at a time of increased scrutiny
- It decreases patient confidence. However recent CQC report highlights that while our response rates are low our recommendations are higher than the national average.

SRO:CNO	**Current Reporting Month: Feb 2016**			
	A&E – score (both sites)	**Wards – score**	**Plan/ Forecast**	**Status/ RAG For A&E score only**
Target	71	71	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	61.6	74.4	Forecast next reported month	
Last reported month performance	72.4	78.6	Forecast month after	
YTD performance	–	–	Forecast month after	
Revised date to meet the standard	**A&E – September 2016 Wards – March 2016**		Forecast year end	

Friends and Family Response Rates

	January	**February**	**Target**	**YTD %**	**RAG**
Wards	11.42%	13.74%	30%	15.7%	
A&E WRH	12.38%	15.98%	20%	17.93%	
A&E ALX	11.17%	7.66%	20%	12.44%	
Maternity	31.22%	31.13%	30%	30.48%	

Friends and Family Score

	January	**February**	**Target**	**YTD**	**RAG**
Wards	78.62	74.42	71	76.09	
A&E WRH	66.53	52.21	71	61.78	
A&E ALX	90.12	86.61	71	85.24	
Maternity	87.02	80.49	71	84.94	

Corrective Action Statements:

Finance

Key Performance Indicator Names;
- Elective Income (FCP2.2)
- Surplus / Deficit
- Temporary Staff expenditure (excluding WLI expenditure)

PLEASE REFER TO THE DETAIL INCLUDED IN THE MONTH 11 FINANCIAL PERFORMANCE REPORT

Forecast Key	
Forecast to achieve	■
Potential risk target will not be achieved	■
Forecast not to achieve	■

Worcestershire NHS
Acute Hospitals NHS Trust

Report to Trust Board

Title	Financial Performance – Month 11 2015/16
Sponsoring Director	**Rob Cooper – Interim Director of Finance & Information**
Author	**Haq Khan – Deputy Director of Finance**
	Rob Pickup - Assistant Director of Finance
	Katie Osmond - Assistant Director of Finance
Action Required	The Trust Board is requested to note that the
	• Contract agreement for 14/15 and 15/16 needs to be formally signed off with local commissioners and NHSE.
	• Expenditure needs to be contained within the forecast values including the closure of capacity as per the £10m savings plan despite the continuing very high levels of emergency demand.
Previously considered by	Finance & Performance Committee

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	✓
Develop and sustain our business	

Related Board Assurance Framework Entries	2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service.
	2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability
Legal Implications or Regulatory requirements	The Trust must ensure plans are in place to achieve the Trust's financial forecasts.
	The Trust has a statutory duty to breakeven over a 3 year period.
Glossary	*Commissioning for Quality and Innovation (CQUINs)* – payments ensure that a proportion of providers' income (currently up to 2.5%) is conditional on quality and innovation and is linked to service improvement. The schemes that qualify for CQUIN payments reflect both national and local priorities.
	Earnings before interest, taxation, depreciation and amortisation (EBITDA) – is a measure of a trust's surplus from normal operations, providing an indication of the organisation's ability to reinvest and meet any interest associated with loans it may have. It is calculated as revenue less operating expenses less depreciation less amortisation.
	Liquidity – is a measure of how long an organisation could continue if it collected no more cash from debtors. In Monitor's Risk Assessment Framework, it is measured by the number of days' worth of operating costs held in cash or cash-equivalent forms and is a key component of the continuity of services risk rating.

Title of report	Financial Performance – Month 11 2015/16
Name of director	Rob Cooper

	Quality, innovation, productivity and prevention (QIPP) – is a programme designed to identify savings that can be reinvested in the health service and improve quality of care. Responsibility for its achievement lies with CCGs; QIPP plans must therefore be built into planning (and performance management) processes.
	Marginal rate emergency tariff (MRET) – is an adjustment made to the amount a provider of emergency services is reimbursed. It aims to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid 70% of the national price for each patient admitted as an emergency over and above a set threshold.
	Introduced in 2003, *payment by results (PBR)* was the system for reimbursing healthcare providers in England for the costs of providing treatment. Based on the linking of a preset price to a defined measure of output of activity, it has been superseded by the national tariff.

Key Messages

- At a deficit of £4.8m the month 11 position is £0.4m better than the preceding month; the YTD deficit has moved to £55.1m. Expenditure has remained on target to achieve the forecast year end position, with the non recurrent movements to non pay and PDC returning to forecast levels. The management of expenditure within forecast levels is highly dependent on the closure of capacity; significantly Ward 9 and Avon 5 have shut and the Silver Unit relocated mid-march with the residual capacity in Aconbury East closing by the end of March despite emergency demand remaining at very high levels. Income has improved in month by £0.5m (excluding non PbR drugs), although this is not accounting for any year end agreement, the impact of which will be shown in March. The Trust remains on target to hit the £59.9m forecast deficit position though not without some risk.

- The bridge diagram details the variance and distinguishes four key themes which continue to drive the Trust's off plan year to date position:
    1. Income, fines and penalties (£5m adverse variance includes specialised services gain share and excludes additional capacity income). Fines continue for RTT as although the Trust has been achieving this as a whole, fines are being levied by commissioner and by specialty.
    2. Impact of medically fit for discharge (£4m).
    3. Additional premium staffing including the extra staff in A&E (£11.8m).
    4. Non-pay overspends and other operating income (£3.9m).

- The Trust is continuing to be fined for RTT performance despite hitting the target as a Trust. Fines are being levied on an individual commissioner and specialty level.

- Significant discussions have been held to settle 14/15 and 15/16 with Worcestershire CCGs and it is likely that a settlement will be reached. An agreement has been reached with NHSE Specialised Services for 15/16. For 2016/17 negotiations with local CCGs are continuing and have focused on a potential 'cap and collar' arrangement. A joint letter has recently been sent to NHSE and NHSI seeking extra funds to be released to support a 'cap and collar' arrangement but no response has been received yet. Negotiations with NHSE Specialised Services and Public Health and Oral Surgery are ongoing for 2016/17 but it is believed that an agreement will be reached with only a handful of differences.

Title of report	Financial Performance – Month 11 2015/16
Name of director	Rob Cooper

- The TDA and Monitor set out a list of priorities for the remainder of 2015/16. These were included in Appendix 4 of the letter sent out on January 15th, 2016 and list the areas highlighted below for review and action. The majority of these have already been enacted by the Trust either in this year or previous years. A third return was submitted on the 15 March highlighting progress against these headings maintaining the £5.2m improvement to forecast. The areas highlighted were:

    - Loan capital to revenue transfers
    - Accurate monthly capital forecasting
    - Accurate provision reporting
    - Workforce
    - Agency staffing
    - Reviewing in-year priorities
    - Balance sheet review
    - Bad debt provisions
    - VAT changes
    - Annual leave
    - Asset valuations
    - Asset lives review

- The QIPP savings after month 11 represent 57% of the total required to meet the original target of £15.6m. The year to date performance of £9.2m is ahead of the plan (£0.4m), including slippage factor, although the forecast does not indicate an increase to meet the original target. In month saving performance is levelling out.

- The Internal QIPP forecast has maintained at £10.3m against the target of £15.6m. £1.9m of this shortfall is forecast to be delivered through the Financial Recovery Plan (FRP) although this remains £7.9m short of the £9.7m originally planned. This takes total savings in year to £12.2m. Further detail on this is included in the QIPP/FRP paper.

- Throughout 2015/16 the Trust has required significant levels of working capital in order to meet its financial commitments. The revised forecast of £59.9m helped this requirement. This has resulted in further TDA scrutiny and follows the CEO and DoF meeting with the Department of Health in November to discuss cash requirements. Currently, the Trust has an Interim Revenue Support Facility Loan of £38.172m, which represents the Trust's Stretch Control Target for 2015/16 of £28.716m plus the Working Capital identified as being required by the Trust in its 2015/16 ITFF application (£9.456m). The Revenue Support facility figure is broadly comparable with funding equivalent to 40 days worth of operating expenditure.

- The Trust has accessed a Revolving Working Capital Facility Loan in the last quarter of the financial year. During March the Trust has drawn £14.0m cash support in addition to £5.1m in January and £4.9m in February. A decision on the permanent solution to the Trust's cash funding remains outstanding.

- At the end of February a decision on the level of cash support to be received from the DH was outstanding. Thus the Trust held a higher level of cash at the end of February (£7.4m held compared to a plan of £1.9m) in order to guarantee that the Trust had sufficient funds in place to ensure that the bi-annual statutory payment of PDC Dividend and Loan Principal Repayments (including interest charges) could be made.

Title of report	Financial Performance – Month 11 2015/16
Name of director	Rob Cooper

Worcestershire **NHS**
Acute Hospitals NHS Trust

Enc G3

Finance Report
Month 11

Rob Cooper

Interim Director of Finance

6th April 2016

Worcestershire **NHS**
Acute Hospitals NHS Trust

At a deficit of £4.8m the month 11 position is £0.4m better than the preceding month; the YTD deficit has moved to £55.1m. Expenditure has remained on target to achieve the forecast year end position, with the non recurrent movements to non pay and PDC returning to forecast levels. Income has improved in month by £0.5m (excluding non PbR drugs), although this is not accounting for any year end agreement, the impact of which will be shown in March. The Trust remains on target to hit the £59.9m forecast deficit position.

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1. Income, fines and penalties (£5m adverse variance includes specialised services gain share and excludes additional capacity income). Fines continue for RTT as although the Trust has been achieving this as a whole, fines are being levied by commissioner and by specialty.
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YEAR TO DATE VARIANCE TO PLAN

2
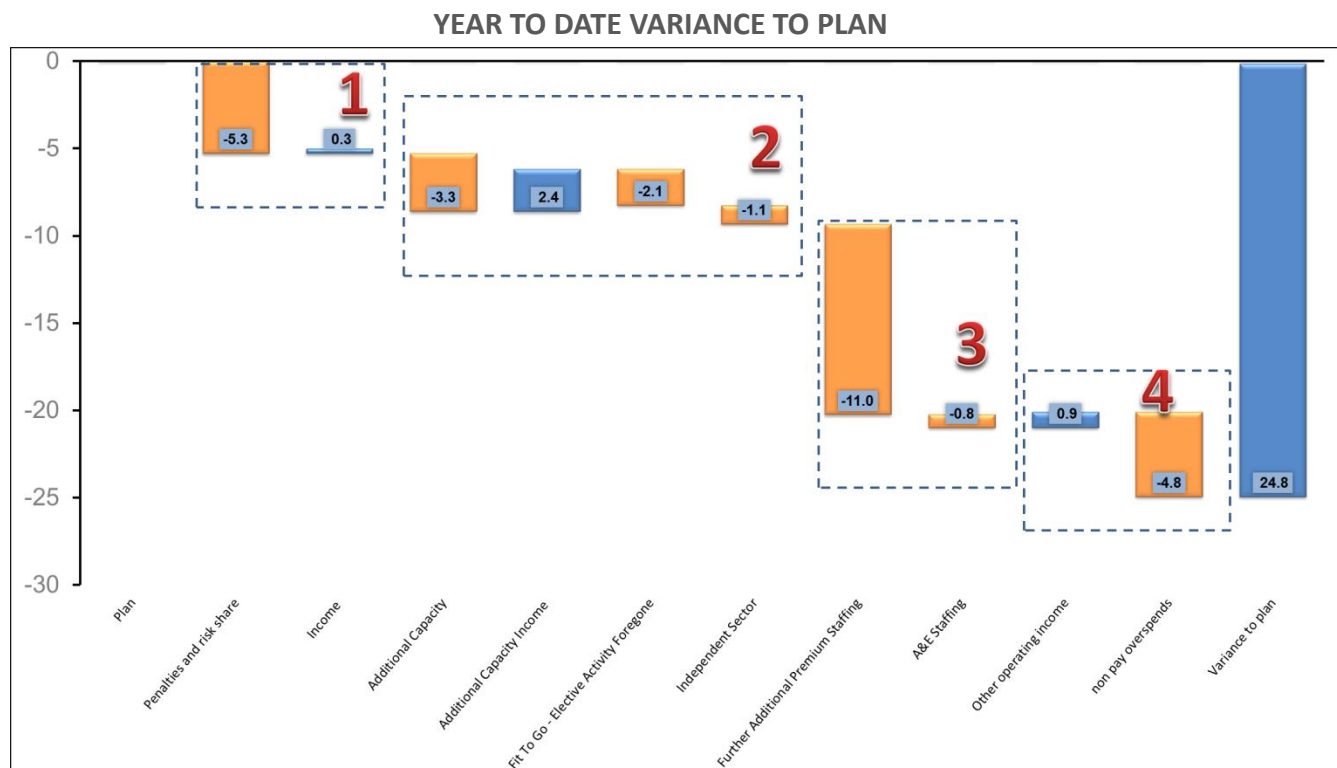
Forecast Outturn Position & Winter costs

The Trust forecast financial position remains at £59.9m. This is a £5.2m improvement from the M9 FOT. This movement is due to improving pay and non pay positions, increased income from commissioners and increases to operating income. The movements in the forecast are shown in the table below with other areas remaining consistent with the previous forecast. At month 11 the Trust is on or ahead of forecast for pay, non pay and other operating income.

	£m's	£m's
Month 9 FOT		(65.10)
Movements		
Pay & Non Pay savings (inc FRP)	1.60	
Additional Healthcare income	1.80	
Other Operating income	1.75	
Bad Debt Provision	0.05	5.20
Revised FOT		(59.90)

Winter Costs	M7-M11 £000's
MDU	180
Silver additional Beds	63
Ward 9	137
Avon 5	181
Red cross	34
Physio & OT	8
Site Coordinators	19
Total	**620**

Key Movements

Pay and Non Pay Savings – Improved expenditure position from increased controls and the impact of bringing forward some of the £10m FRP where possible. Increased controls include greater non pay restraint, stopping WLIs and greater adherence to agency caps.

Additional Healthcare Income - Due to continued discussions with commissioners and the increased likelihood of reaching a year end settlement.

Bad Debt Provision – Reduced requirement to hold bad debt provision as probability of non payments by debtors has reduced.

Other Operating Income - Increased funding from Health Education England for continued costs in the provision of training.

Additional capacity opened across both the WRH and Alex site. Ward 9 and Avon 5 have shut with Silver expected to be closed by the end of March despite emergency demand remaining at very high levels. February spend on this additional capacity was £138k. This is a reduction of £78k from month 10 as a result of the capacity closures.

QIPP & Cash

The QIPP savings after month 11 represent 57% of the total required to meet the original target of £15.6m. The year to date performance of £9.2m is ahead of the plan (£0.4m), including slippage factor, although the forecast does not indicate an increase to meet the original target.   In month saving performance is levelling out.

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The Trust's material aged debt with a profile over 90 days against NHS organisations has improved significantly and is now worth £1.4m. This is more than offset by the Trust's creditor position with the same group and profile, which now stands at £3.75m. Disputes with Worcestershire Health & Care Trust (WHCT) constitute the largest elements of aged NHS debt and credit, £0.8m & £0.6m respectively; disputes with Gloucestershire NHS Foundation Trust amount to £0.35m debtor and £0.7m creditor. Negotiations to resolve both of the disputes are on-going. A significant improvement in the aged debtor and creditor position with WHCT occurred in February 2016, and a further improvement is expected in March 2016. The majority of The WHCT values will be resolved by the end of March.

Risks & Mitigations

The following risks have been identified and categorised in relation to delivery of the 2015/16 financial and operational plan.

RISK

- **Demand & Delayed Discharges and Patient Safety.** Increasing levels of emergency pressures and staffing issues may require the Trust to implement further emergency service changes to maintain patient safety. The current situation is generating additional costs and lost income; further changes may intensify these effects. These costs remain in the system at month 11, adversely affecting the Trust's position. This is currently worse than forecast in the Trust plan.

MITIGATION

- Working closely with SRG to agree robust plans for managing demand and delayed discharges including robust winter plans.
- Systematic, rigorous and frequent reviews of all patients classified as MFFD to facilitate prompt discharges.
- Improving capacity utilisation including improvements in utilisation of Kidderminster and Redditch sites.

RISK

- **CCG QIPP.** Financial plan has been set assuming £2.75m impact of CCG QIPPs as agreed by the Trust review panel.

MITIGATION

- Working closely with CCGs to support the development of effective but realistic QIPP schemes.

RISK

- **Risks from 14/15 position.** As previously reported to the Board, items not fully agreed in the 14/15 position (£1.8m) may impact the 15/16 position once negotiations are concluded. Locally agreed deadline for reaching a settlement has passed without agreement.

MITIGATION

- Continue to negotiate with the CCGs to attempt to minimise the impact of 14/15 issues.
- The plans to agree a contract outturn position would include the impact of 14/15 risks.

RISK

- **Liquidity**. The Trust has received £14.0m cash in March. This allows the Trust to meet commitments but is £7.5m short of what is required to service a £59.9m deficit as planned.
- A decision on the permanent solution to the Trust's cash funding remains outstanding.

MITIGATION

- Managing working capital effectively.
- Cash received for March.
- Seek clarity on a permanent solution to the Trust's cash funding.
- Seek clarity on meeting the in year cash shortfall of £7.5m.

RISK

- **Contract penalties.** The Trust's position at Month 11 now includes £5.3m in penalties and risk share arrangements. The original plan assumed that contract penalties applied would be reinvested in the Trust, although agreement was only received for this in respect of RTT penalties. Continued penalties will have a detrimental impact on the Trust's plans and challenge its ability to absorb them within the available financial envelope. The risk share agreement remains unsigned. The locally agreed deadline was passed without reaching an agreement on the risk share. The impact of this has been included in the forecast outturn position.
- The Trust is continuing to be fined for RTT performance despite hitting the target as a Trust. Fines are being levied on an individual commissioner and specialty level.

MITIGATION

- The plans to agree a contract outturn position would include the impact of contract penalties.

Risks & Mitigations

RISK
- **Medics recruitment.** Continued recruitment difficulties result in high levels of agency expenditure. This would impact future years and the sustainability of the Trust.

MITIGATION
- Developing effective medical workforce plans to support recruitment is essential.
- External specialist expertise engaged to support recruitment to shortage specialties.
- Robust management of temporary staffing costs.

RISK
- **Delivery of CIPs.** The £15.6m target represents a significant challenge as it relates to 3.8% of total spend and elements of this are not influenceable. Delivering the required level of savings will require more radical approaches than have previously been taken and must deliver at a greater pace. At month 11, the forecast value of schemes stands at £10.3m.

MITIGATION
- Confirm and challenge meetings have been arranged to close the gap and improve delivery.
- Additional savings plans and FRP.
- Plans have been developed for £10m FRP in 16/17, which have some impact in 15/16.

RISK
- **Education Funding.** Current Education funding schedules show a £0.6m reduction in the level of funding to be received, despite similar levels of Trainees. This has reduced from a £1m issue.
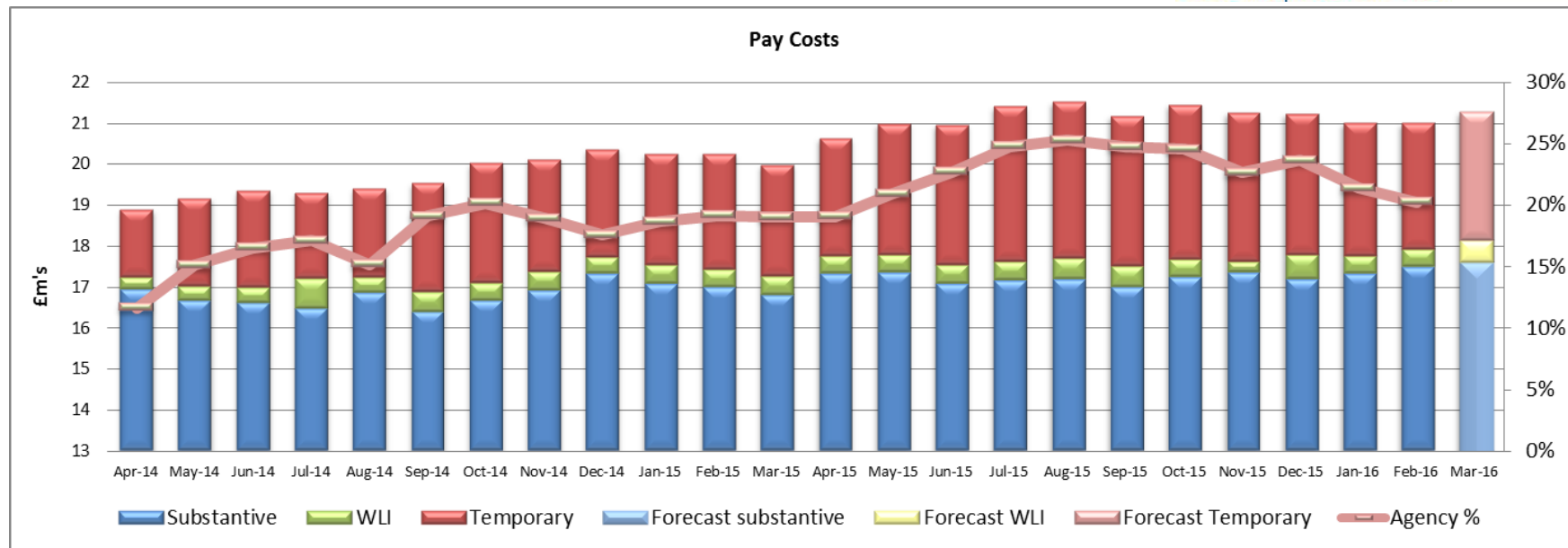
MITIGATION
- Discussions are taking place with the new team in place at Health Education West Midlands (HEWM).
- Reconciliations of the level of trainees has taken place by the Trust to show the consistency of returns between years that have been provided to HEWM.
- The impact of the £0.6m reduction has been included in the forecast outturn position.

Conclusions & Recommendations

Worcestershire **NHS**
Acute Hospitals NHS Trust

- The Trust forecast financial position remains at £59.9m. This is a £5.2m improvement from the M9 FOT. This movement follows emergency discussions requested by the TDA as the Trust's deficit forecast increased in month 9. The previous deterioration was mainly due to a reduction in forecast income, most notably the £2m impact from the removal of the Risk Share with Commissioners. The subsequent improvement relies on improvements across income (£3.5m), pay and non pay (£1.7m).

- The Trust is continuing to be fined for RTT performance despite hitting the target as a Trust. Fines are being levied on an individual commissioner and specialty level.

- The Trust is off plan driven by the consequences of operational problems. This needs to be resolved as promptly as possible. This involves focusing on flow and exploiting our planned elective capacity. Actions are being taken to exercise increased grip on the management of MFFD patients and improve utilisation of theatre capacity at Kidderminster and Redditch.

- Significant discussions have been taken to settle 14/15 and 15/16 with Worcestershire CCGs and it is likely that a settlement will be reached. An agreement has been reached with NHSE Specialised Services for 15/16. For 2016/17 negotiations with local CCGs are continuing and have focused on a potential 'block' arrangement. A joint letter has recently been sent to NHSE and NHSI seeking extra funds to be released to support a block arrangement but no response has been received yet. Negotiations with NHSE Specialised Services and Public Health and Oral Surgery are ongoing for 2016/17 but it is believed that an agreement will be reached with only a handful of differences.

Conclusions & Recommendations

Worcestershire **NHS**
Acute Hospitals NHS Trust

- Additional capacity at WRH and Alex needs to be contained to the agreed plans. Ward 9 and Avon 5 capacity has closed.

- The TDA and Monitor set out a list of priorities for the remainder of 2015/16. These were included in appendix 4 of the letter sent out on January 15th, 2016 and list the areas highlighted below for review and action. The majority of these have already been enacted by the Trust either in this year or previous years. A third return was submitted on the 15th of March highlighting progress against these headings maintaining the £5.2m improvement to forecast. The areas highlighted were:

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  - Agency staffing
  - Reviewing in-year priorities
  - Balance sheet review
  - Bad debt provisions
  - VAT changes
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  - Asset valuations
  - Asset lives review

Appendices

Pay

Worcestershire **NHS**
Acute Hospitals NHS Trust

Pay Costs

Medics & Nursing Pay

Worcestershire **NHS**
Acute Hospitals NHS Trust

Medics Pay Costs

Legend: Substantive, WLI, Temporary, Forecast - Substantive, Forecast - WLI, Forecast - Temporary, Agency %
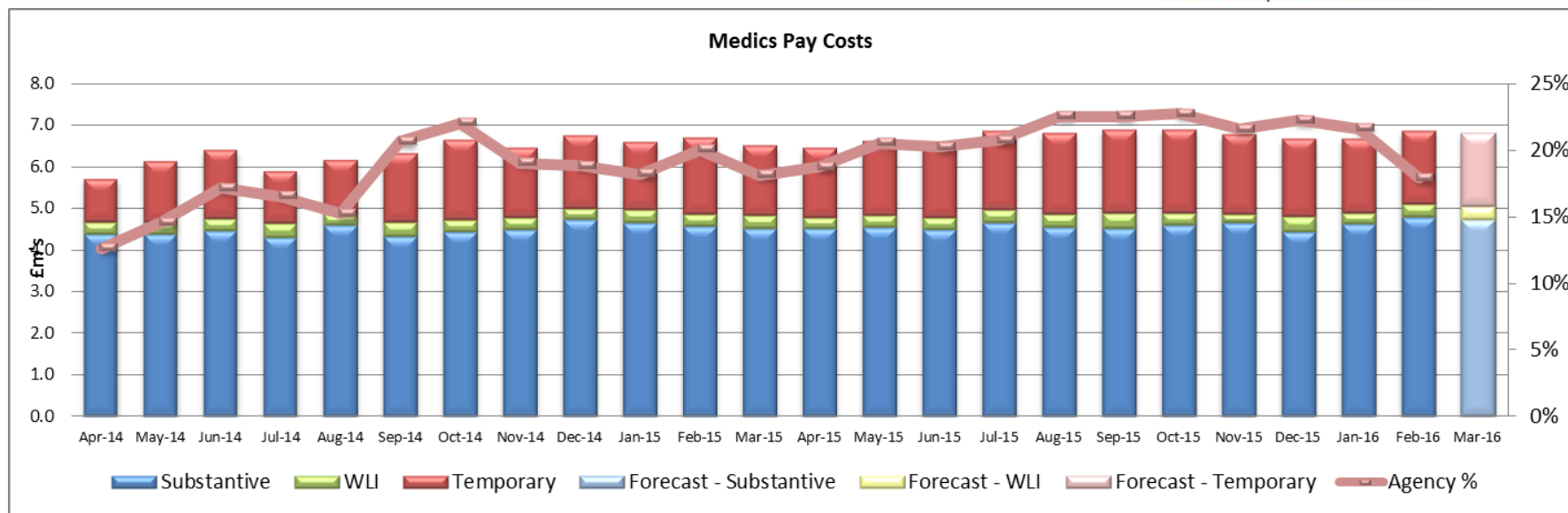
Note. Month 4 contained a YTD change from a net position to a gross position for Consultants sub-contracted to other Trusts.

Nursing Pay Costs

Legend: Substantive, WLI, Temporary, Forecast - Substantive, Forecast - WLI, Forecast - Temporary, Agency %
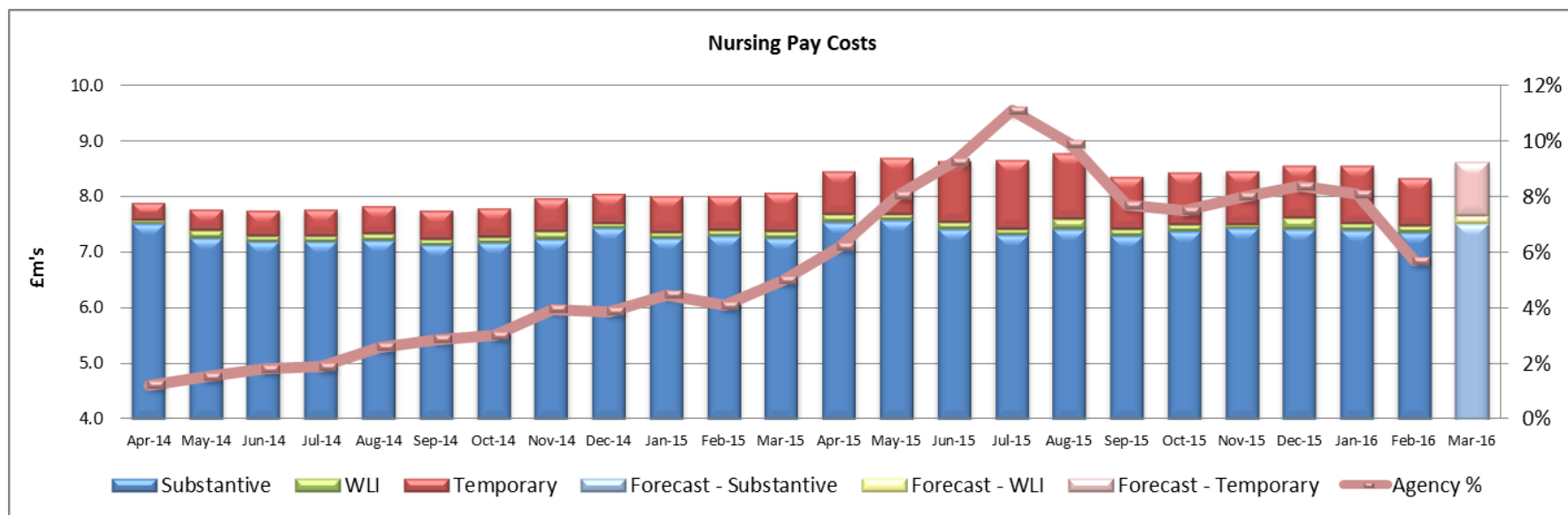
Non Pay
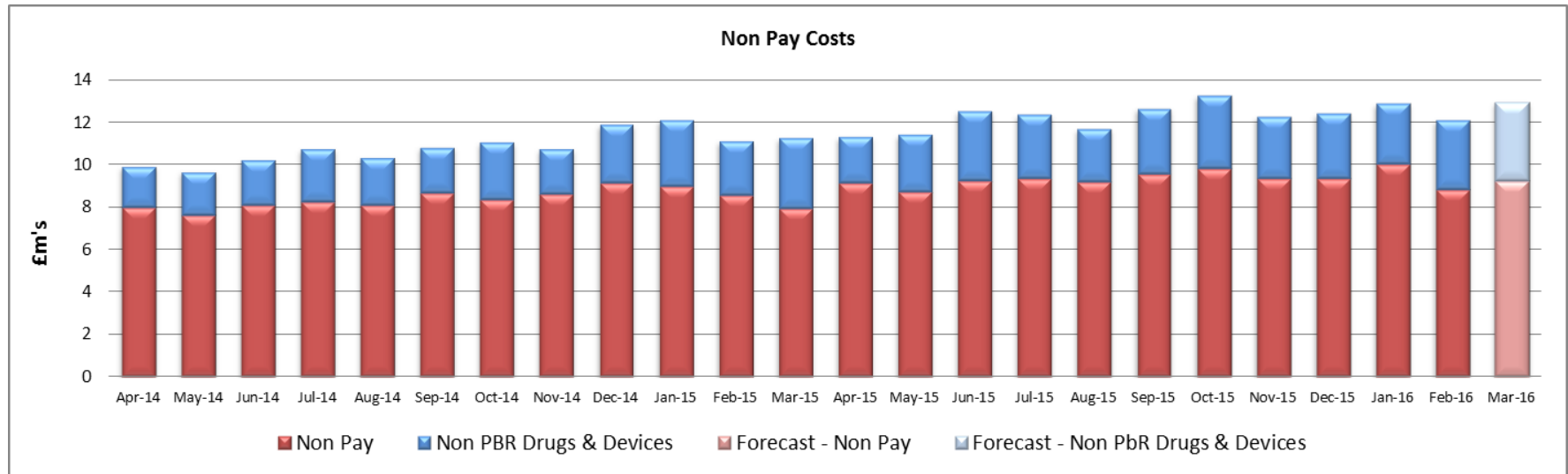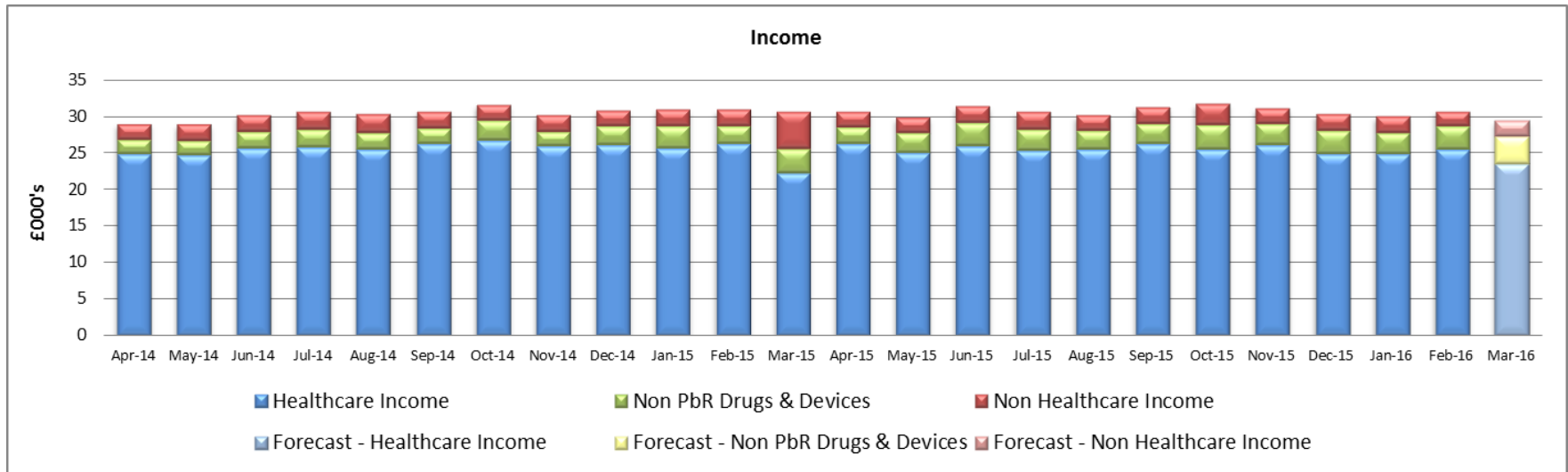
Income

Healthcare income was £0.5m under plan in February and is now £4.7m under plan YTD. There were no significant one-offs in the month and therefore the underlying position was £0.5m under plan.

Against forecast the position is £0.3m adverse in February. Primarily being driven by an underperformance on Daycases £0.4m and Outpatients £0.4m, counteracted with a strong performance in Emergency care £0.5m.

Activity performance in February was adverse versus plan. Inpatients were 1% and Outpatients activity 3% under plan in-month. Emergency care was 12% over and both Electives and Day cases were under plan, 1% and 11% respectively. New attendances were significantly down in-month with a 10% under performance against plan.

Although 87 more theatre sessions were undertaken in February compared to January, actual utilisation was lower as the Trust planned to do more sessions in February compared to January. Medical Fit For Discharge days fell from 3,966 to 3,320 in February compared with January. At WRH there was a notable fall in Medical Fit For Discharge days of 492 bed days in February compared to January.

14

Income

	In Month				YTD				Full Year	
	Plan £'000	Actual £'000	Var £'000	% £'000	Plan £'000	Actual £'000	Var £'000	% £'000	Initial Plan £'000	Current Plan £'000
Elective	2,145	2,114	(31)	(1%)	25,967	23,905	(2,062)	(8%)	28,151	28,419
Daycase	2,980	2,654	(326)	(11%)	30,812	30,786	(25)	(%)	34,119	33,907
Non Elective - Emerg	6,516	7,288	772	12%	76,243	79,445	3,202	4%	82,860	82,896
Non Elective - Emerg Threshold	0	(39)	(39)		0	(327)	(327)		0	0
Non Elective - Other	143	117	(26)	(18%)	1,623	1,400	(223)	(14%)	1,764	2,345
Total Inpatients	**11,783**	**12,134**	**350**	**3%**	**134,645**	**135,210**	**565**	**%**	**146,895**	**147,567**
Outpatients New	1,742	1,560	(183)	(10%)	18,121	17,598	(522)	(3%)	19,849	19,921
Outpatients F Up	1,571	1,564	(8)	(%)	16,727	17,347	620	4%	18,436	18,368
Outpatients Procedure	646	670	24	4%	6,901	7,678	777	11%	7,454	7,553
Total Outpatients	**3,959**	**3,793**	**(166)**	**(4%)**	**41,749**	**42,623**	**874**	**2%**	**45,739**	**45,843**
ED Attendances	1,194	1,258	64	5%	13,776	14,092	315	2%	15,254	15,071
Community MIU	146	157	12	8%	1,602	1,852	250	16%	1,747	1,747
Total ED/MIU	**1,339**	**1,415**	**76**	**6%**	**15,378**	**15,943**	**565**	**4%**	**17,001**	**16,818**
Maternity - Delivery	898	931	33	4%	10,545	11,043	498	5%	11,027	11,395
Maternity Ante Natal	729	646	(83)	(11%)	8,287	7,723	(564)	(7%)	8,879	8,954
Maternity Post Natal	114	125	10	9%	1,480	1,435	(46)	(3%)	1,578	1,603
Total Maternity	**1,741**	**1,701**	**(40)**	**(2%)**	**20,314**	**20,203**	**(111)**	**(1%)**	**21,483**	**21,951**
Paed - Daycase/Elective	19	25	6	30%	222	230	8	4%	245	245
Paed - Non Elective	406	454	48	12%	5,064	5,172	108	2%	5,738	4,898
Paed - Outpatient	240	225	(15)	(6%)	2,335	2,365	30	1%	2,571	2,559
Paed - H@H, Drugs, CQUIN	121	97	(24)	(20%)	1,571	1,509	(62)	(4%)	2,041	1,692
Paed - Neonatal Cot Days	287	363	76	27%	3,129	3,876	747	24%	3,357	3,417
Total Paediatrics	**1,073**	**1,163**	**91**	**8%**	**12,321**	**13,153**	**832**	**7%**	**13,951**	**12,811**
Chemotherapy Delivery	**276**	**311**	**35**	**13%**	**3,030**	**3,378**	**348**	**11%**	**3,287**	**3,354**
Drugs PBR Excluded	2,221	2,221	0	%	20,040	20,040	0	%	20,134	22,234
Critical Care ITU/HDU	862	874	12	1%	9,418	9,045	(373)	(4%)	9,439	10,280
Other Contract Income	4,402	4,252	(149)	(3%)	50,348	48,361	(1,988)	(4%)	50,600	54,851
Financial Sanctions	0	(388)	(388)		0	(3,630)	(3,630)		0	0
Risk Share	0	(353)	(353)		0	(1,225)	(1,225)		0	0
Total Other Contract Income	**7,484**	**6,607**	**(878)**	**(12%)**	**79,807**	**72,592**	**(7,215)**	**(9%)**	**80,173**	**87,365**
Non Contract Income	753	817	63	8%	8,753	8,230	(523)	(6%)	7,678	9,422
Income CIP	0	0	0		0	0	0		3,879	(0)
Phasing Adj	692	692	0	%	788	788	0	%	0	0
	29,101	**28,633**	**(469)**	**(2%)**	**316,786**	**312,121**	**(4,665)**	**(1%)**	**340,087**	**345,132**

- Cost & Volume marginal rates for under/over performance have been applied

Activity

	In Month				YTD				Full Year	
	Plan	Actual	Var	%	Plan	Actual	Var	%	Initial Plan	Current Plan
Elective	793	711	(82)	(10%)	9,639	8,560	(1,079)	(11%)	10,465	10,543
Daycase	4,533	4,221	(312)	(7%)	46,871	48,002	1,131	2%	52,312	51,587
Non Elective - Emerg	3,211	3,529	318	10%	37,910	38,271	361	1%	41,623	41,206
Non Elective - Other	59	49	(10)	(18%)	682	528	(154)	(23%)	742	742
Total Inpatients	**8,596**	**8,510**	**(86)**	**(1%)**	**95,102**	**95,361**	**259**	**%**	**105,143**	**104,079**
Outpatients New	12,090	10,833	(1,257)	(10%)	126,904	123,601	(3,303)	(3%)	138,972	139,321
Outpatients F Up	19,922	20,127	205	1%	213,124	221,412	8,288	4%	234,822	233,672
Outpatients Procedure	3,820	3,941	121	3%	41,474	44,493	3,019	7%	45,422	45,368
Total Outpatients	**35,831**	**34,901**	**(930)**	**(3%)**	**381,502**	**389,506**	**8,004**	**2%**	**419,216**	**418,361**
ED Attendances	11,380	11,637	257	2%	131,025	132,370	1,345	1%	145,414	143,371
Community MIU	2,510	2,710	200	8%	27,615	31,924	4,309	16%	30,125	30,125
Total ED/MIU	**13,890**	**14,347**	**457**	**3%**	**158,640**	**164,294**	**5,654**	**4%**	**175,539**	**173,496**
Maternity - Delivery	434	442	8	2%	5,306	5,267	(39)	(1%)	5,720	5,720
Maternity - Non Delivery	241	200	(41)	(17%)	2,888	2,171	(717)	(25%)	3,119	3,119
Maternity - Outpatient	3,460	3,811	351	10%	39,149	40,114	965	2%	42,653	42,653
Maternity Ante Natal	514	455	(59)	(12%)	5,874	5,432	(442)	(8%)	6,344	6,344
Maternity Post Natal	394	462	68	17%	5,165	5,254	89	2%	5,591	5,591
Total Maternity	**5,044**	**5,370**	**326**	**6%**	**58,383**	**58,238**	**(145)**	**(%)**	**63,427**	**63,426**
Paed - Daycase/Elective	29	37	8	27%	327	349	22	7%	361	360
Paed - Non Elective	455	627	172	38%	5,734	6,674	940	16%	6,546	6,248
Paed - Outpatient	1,357	1,403	46	3%	13,311	14,539	1,228	9%	14,701	14,615
Paed - H@H, Drugs, CQUIN	0	0	0		0	0	0		0	0
Paed - Neonatal Cot Days	590	701	111	19%	6,416	7,628	1,212	19%	6,859	7,006
Total Paediatrics	**2,431**	**2,768**	**337**	**14%**	**25,788**	**29,190**	**3,402**	**13%**	**28,466**	**28,230**
Chemotherapy Delivery	**729**	**950**	**221**	**30%**	**8,117**	**10,172**	**2,055**	**25%**	**8,806**	**8,967**
Drugs PBR Excluded	0	0								
Critical Care ITU/HDU	805	843	38	5%	8,802	8,585	(217)	(2%)	8,923	9,606
Other Contract Income	0	0								
Total Other Contract Income	**805**	**843**	**38**	**5%**	**8,802**	**8,585**	**(217)**	**(2%)**	**8,923**	**9,606**
Non Contract Income										
Phasing Adj										

Elective, Day Cases & Outpatients New

Worcestershire **NHS**
Acute Hospitals NHS Trust

Daycase activity

Forecast based upon activity up to 29th Mar
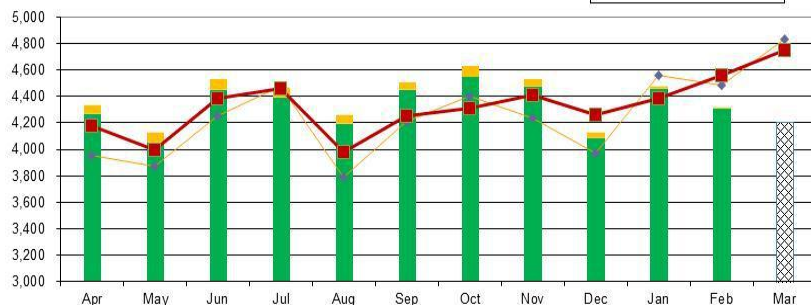
Ave. Income per admission												
FY Plan	£695											
Monthly Actual	£641	£632	£650	£641	£636	£651	£649	£637	£657	£634	£625	

Legend: 2015/16 Actual - Private | Forecast | 2015/16 Actual | 2014/15 Actual | 2015/16 Plan

Outpatient New Activity

Forecast based upon activity up to 29th Mar
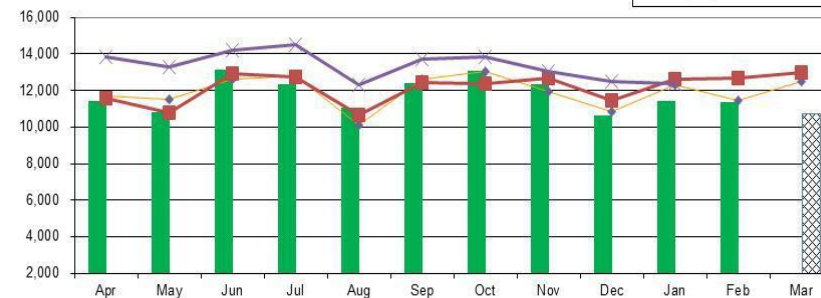
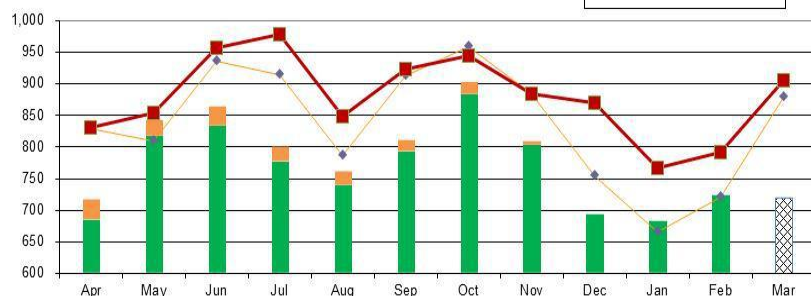| Ave. Income per admission												
FY Plan	£143											
Monthly Actual	£144	£145	£145	£145	£143	£146	£146	£147	£146	£147	£147	

Legend: 2015/16 Actual | Forecast | 2014/15 Actual | 2015/16 Plan | Referrals

Elective activity

Forecast based upon activity up to 29th Mar

Ave. Income per admission												
FY Plan	£2,708											
Monthly Actual	£2,641	£2,664	£2,794	£2,689	£2,820	£2,807	£2,844	£2,844	£2,784	£2,851	£2,930	

Legend: 2014/15 Actual - Private | Forecast | 2015/16 Actual | 2014/15 Actual | 2015/16 Plan

Activity performed within Trust and sent Private				
	Daycase		Elective IP	
	Trust	Private	Trust	Private
Apr	4,268	72	685	31
May	4,052	77	817	25
Jun	4,456	80	833	30
Jul	4,391	79	776	24
Aug	4,199	59	740	20
Sep	4,453	56	793	18
Oct	4,554	80	882	20
Nov	4,474	65	803	5
Dec	4,090	39	693	0
Jan	4,462	17	682	0
Feb	4,309	1	723	0
Mar	0	0	0	0
YTD	47708	625	8427	173

Internal QIPP

Worcestershire **NHS**
Acute Hospitals NHS Trust

Total Trust Performance 2015/16 at M11
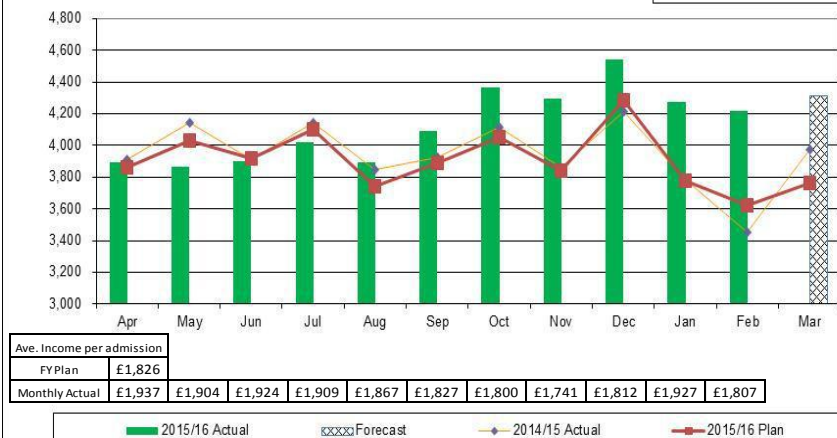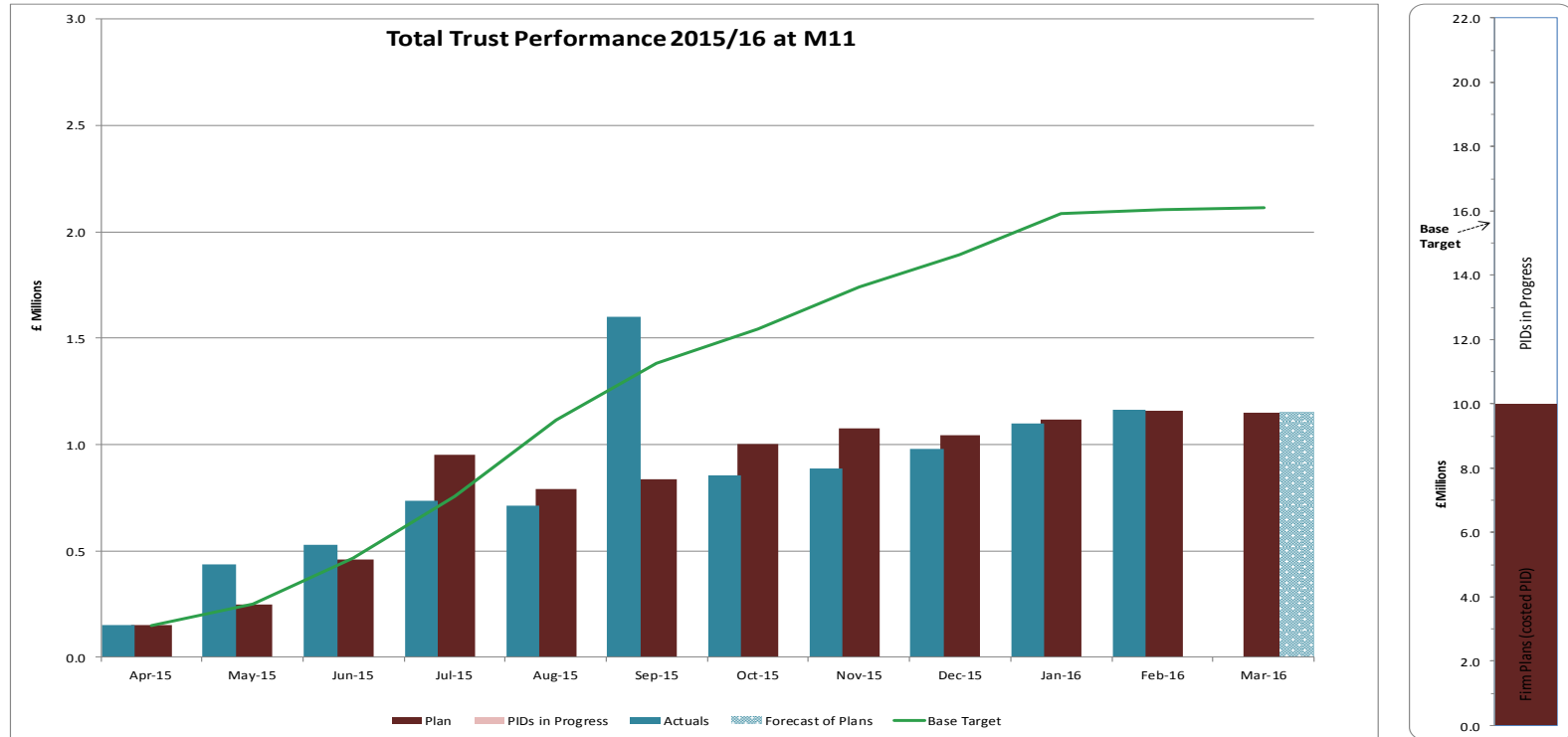
Division	Base Target	In year Plan	PIDs in Progress	YTD Plan (M11)	YTD Actual (M11)	Variance YTD Actual to Plan	Full Year Forecast	% Forecast v Base Target
Medicine	5,029	2,504	0	2,178	2,518	340	2,860	57%
Surgery	2,136	1,690	0	1,532	1,363	-169	1,568	73%
Women & Children	1,418	527	0	483	1,127	644	1,226	86%
TACO	2,183	1,725	0	1,547	1,296	-252	1,474	68%
Clinical Support	1,770	1,383	0	1,149	1,581	432	1,712	97%
Asset Mgmt & IT	1,641	1,763	0	1,579	1,001	-578	1,168	71%
Corporate	1,423	395	0	366	270	-96	297	21%
Trustwide	0	0	0	-115	0	115	0	0%
Total	**15,600**	**9,986**	**-**	**8,720**	**9,157**	**437**	**10,306**	**66%**

Balance Sheet

Worcestershire **NHS**
Acute Hospitals NHS Trust

| Balance at 31st January 2016 | Balance at 29th February 2016 | Movement in Month | Balance Sheet | Full Year | | | |
				Annual Plan	Forecast 31st March 2016	Variance from Plan	Balance at 31st March 2015
£000s	£000s	£000s	**ASSETS, NON CURRENT**	£000s	£000s	£000s	£000s
185,734	185,617	(117)	Property, Plant and Equipment and intangible assets, Net	296,943	270,796	(26,147)	182,933
84,204	84,820	616	Property, plant & equipment (PFI)	0	0	0	85,624
2,451	2,775	324	Other Assets, Non-Current	1,267	1,267	0	2,059
272,389	**273,212**	**823**	**Assets, Non-Current, Total**	**298,210**	**272,063**	**(26,147)**	**270,616**
			ASSETS, CURRENT				
8,305	8,309	5	Inventories	6,107	5,728	(379)	6,107
32,739	29,228	(3,511)	Debtors	21,831	30,594	8,763	29,174
1,965	7,431	5,466	Cash and Cash Equivalents	1,907	1,907	0	2,107
43,009	**44,968**	**1,959**	**Assets, Current, Total**	**29,845**	**38,229**	**8,384**	**37,388**
315,398	**318,181**	**2,782**	**ASSETS, TOTAL**	**328,055**	**310,292**	**(17,763)**	**308,004**
			LIABILITIES, CURRENT				
1,970	**1,970**	**0**	PFI leases, Current	1,936	1,936	0	1,970
101,608	**103,766**	**2,157**	Creditors < 1 Year	39,599	53,952	14,353	47,946
103,578	**105,736**	**2,157**	**Liabilities, Current, Total**	**41,535**	**55,888**	**14,353**	**49,916**
(60,570)	**(60,768)**	**(198)**	**Net Current Assets/(Liabilities)**	**(11,690)**	**(17,659)**	**(5,969)**	**(12,527)**
			LIABILITIES, NON CURRENT				
42,687	47,748	5,061	Creditors > 1 Year	44,061	95,570	51,509	36,168
72,349	72,185	(164)	PFI leases, Non-Current	72,055	70,273	(1,782)	73,991
0	0	0	Other Liabilities, Non-Current	0	0	0	0
115,036	**119,933**	**4,897**	**Liabilities, Non-Current, Total**	**116,116**	**165,843**	**49,727**	**110,159**
96,784	**92,512**	**(4,272)**	**TOTAL ASSETS EMPLOYED**	**170,404**	**88,561**	**(81,843)**	**147,930**
£000s	£000s		**FINANCED BY :- PUBLIC EQUITY**	£000s	£000s	£000s	£000s
183,996	184,536	540	Public Dividend Capital	224,992	184,564	(40,428)	183,996
60,539	60,539	0	Revaluation reserve	76,240	60,539	(15,701)	60,539
(861)	(861)	0	Other reserves	(861)	(861)	0	(861)
(146,890)	(151,702)	(4,812)	I&E Reserve	(129,967)	(155,681)	(25,714)	(95,744)
96,784	**92,512**	**(4,272)**	**TOTAL PUBLIC EQUITY**	**170,404**	**88,561**	**(81,843)**	**147,930**

Report to Trust Board

Title	Financial Plan 2016/17 - Update
Sponsoring Director	**Rob Cooper – Interim Director of Finance**
Author	**Haq Khan – Deputy Director of Finance** **Rob Pickup - Assistant Director of Finance**

Action Required	1. Approve the submission of the 2016/17 financial plan on 11 April 2016 on the basis set out in this paper noting the assumption around the £13.1m STF.
	
	2. Support the progress on the financial plan, including the £24.3m of savings target and contracts.
	
	3. Review the risks and:
	   a. consider whether these are complete and are adequately reflected in the financial plan
	   b. seek assurance that appropriate mitigations are in place
	
	4. Agree the basis for budget setting for 2016/17.

Previously considered by	*Finance & Performance Committee*

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	✔
Develop and sustain our business	

Related Board Assurance Framework Entries	2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability. 2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service. 3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances and patient experience.
Legal Implications or Regulatory requirements	The Trust must ensure plans are in place to achieve the Trust's financial forecasts. The Trust has a statutory duty to breakeven over a 3year period.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

Worcestershire **NHS**
Acute Hospitals NHS Trust

Key Messages

- The Trust is on course to maintain its £38.3m plan for 2016/17 subject to accessing the £13.1m Sustainability and Transformation Fund (STF), ahead of the 11th April submission.

- Work is continuing on agreeing an alternative contract model with local commissioners, which would see a contract value set with a very tight cap and collar arrangement in place, to minimise financial risk for all parties. Failure to agree this would mean resorting back to a Payments by Results (PbR) contract which may result in mediation. Contract negotiations with other commissioners are progressing well and are not expected to require the dispute resolution process.

- The Trust has identified plans and is on course to deliver £9.6m of the '£10m Financial Recovery Plan (FRP)'; first tranche of the savings target for 2016/17. Work is on-going around the second tranche of £14.3m to deliver the full £24.3m required.

- The capital plan is over committed by £1.1m and will need to be managed through in-year slippage. Further capital loans have been flagged to support the reconfiguration (£3m), address backlog maintenance (£2m) and support recurrent savings and site rationalisation (£1.2m).

- Further cash support of £52.9m will be required in 2016/17.

- The Board needs to assure itself that risks have either been appropriately reflected in the financial plan or have robust mitigation plans.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

Worcestershire **NHS**
Acute Hospitals NHS Trust

REPORT TO TRUST BOARD

1. Purpose of the Report

The report sets out progress with financial plans for 2016/17 particularly:
- 2016/17 contracting process
- 2016/17 planned position
- Cost Improvement Plans (CIP)/saving 2016/17 progress
- Budget setting
- Capital Programme
- Cash
- Next steps

2. 2016/17 contracting process

The Trust has been working closely with its Commissioners to agree activity baselines and demand assumptions for 2016/17 contracts. The national deadline for contract signature is 31st March 2016, with a dispute resolution process in place for anyone not able to meet that deadline.

At the same time as agreeing the contract, all organisations are working together as part of the National Sustainability and Transformation Programme (STP). In light of this STP joint working, the Trust and Worcestershire CCGs are endeavouring to develop an alternative contract model for 2016/17. This, if agreed, would see a contract value set with a very tight cap and collar arrangement in place, to minimise financial risk for all parties. The model relies upon the parties working jointly on shared QIPP schemes to significantly reduce demand for services by the end of 2016/17, allowing the Worcestershire health economy as a whole to reduce its cost base by removing capacity.

A Partnership Agreement is in place which sets out the key heads of terms between the respective organisations. It does not however replace the need for a traditional NHS Standard Contract to be in place and work is ongoing to develop and agree all of the required schedules for the main contract. At the time of writing, there is some uncertainty around Commissioner access to the required non recurrent funding, and some remaining areas of detail to negotiate. If we are unsuccessful in negotiating a mutually agreed position on this alternative model then we would need to revert to a traditional PbR contract.

Given the timescale, it is likely that if we are unable to agree contract terms on the alternative model, that we would need to enter the nationally set dispute resolution process as set out in the timetable below.

For our other commissioners, the Trust is continuing negotiations with Prescribed Services and the NHS England Area Team for screening and oral surgery activity. It is not anticipated that any form of external dispute resolution will be required for these contracts.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

We have shared contract offers with Associate Commissioners for 2016/17 and are negotiating the detail with them. The majority of these commissioners form part of our main contract with Worcestershire CCGs and so whilst agreement may be reached ahead of the national deadline, signature will only be achieved once the Worcestershire contract is signed.

It is important to note that given the lateness of publication this year of the final tariff, the updated contract and the national CQUIN guidance the deadline of contract signature by 31st March becomes increasingly challenging for all contracts.

Contract Agreement / Dispute Resolution timetable:

Milestone	Description	Date
Milestone 1	National contract stocktake	23 March
Milestone 2	Post national contract stocktake, local decision whether or not to enter mediation	by close of business, 23 March
Milestone 3	National deadline for signing of contracts	31 March
Milestone 4	Final date for avoiding arbitration and submission of appropriate documentation	25 April
Milestone 5	Arbitration Panel and/or hearing.	Between 26 April and 10 May
Milestone 6	Written Arbitration findings issued to both parties.	by two working days after Panel date
Milestone 7	Contract and schedule revisions reflecting arbitration findings completed and signed by both parties.	by 13 May 2015

3. **2016/17 planned financial position and budget setting process**

The planned financial position remains at a deficit of £38.3m as submitted in the initial financial plan (8th Feb), pending a resolution to the 2016/17 contract position. The position includes the £13.1m general element of the STF. A condition of this is not breaching agency caps and hitting the given control total (£9.3m deficit). Currently the Trust is not in a position to achieve either of these and clarity is being sought as to the status of the £13.1m STF and its inclusion in Trust plans. Should this need to be removed the planned position would be a £51.4m deficit.

Further work is continuing ahead of the 11th April submission in refining the savings programme and subsequent alignment of the monthly profile.

Financial plans have been based on:

- Budgets based on quarter 4 forecast run-rate. Adjusted for:
  - Non recurrent items
  - Agreed service changes
  - Trust CIP & Financial Recovery Plans (FRP)

- Inflation has been based on tariff and planning guidance and contained within the assumptions made to date.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

- Reserves and contingencies have been held for a general 0.5% contingency, income risk around contract agreement and a reduction in deanery posts.

- Growth has been assumed at 2%, with a higher rate for Drugs. This has been assumed at no margin. Should final agreement of this be different this will not impact the bottom line position.

- CIP targets will be deducted from budgets

- No impact of winter costs above those planned for 2015/16 have been included within the position.

- Service developments have been included based on agreed business cases with a net cost of £0.2m. With regard to the financial position these business cases will be reviewed again by the Executive Team.

- No in year impact of Commissioner QIPPs have been included in plans. The Trust is working with Commissioners on a shared QIPP programme for 2016/17. The key work streams and leads have been identified and project plans are being developed. As this work progresses we will assess the potential in year impact of these on the Trust.

The table below shows the impact of the assumptions in arriving at the 2016/17 planned deficit of £38.3m in the scenario where the Trust receives the £13.1m STF.

2016/17 Financial Position	£m	£m
FOT		(59.9)
Reprovide 15/16	(1.3)	
Impact of Q4 Run Rate	(5.6)	
		(66.8)
NR Income 14/15 outstanding issues	2.0	
NR Income 15/16 adjustment & contract risk	1.0	
		(63.8)
Service developments (net)	(0.2)	
		(64.0)
Tariff Increase	4.8	
Cost Pressures and inflation	(13.8)	
		(73.1)
0.5% contingency	(2.2)	
Deanery Contingency	(0.5)	
		(75.7)
£14.3m CIP	14.3	
£10m FRP	10.0	
Total Without S&T Fund		**(51.4)**
S&T Fund	13.1	
Total With S&T Fund		**(38.3)**

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

4.   Budget Setting

Budget setting has been carried out in accordance with the principles outlined in the 'Budget Setting Policy 2016/17', with the exception of:

- Income potentially being set via an alternative contract model noted in section 2. This has not yet been agreed.

- CIP process is being implemented. There has been good progress with the identification of the £24.3m, which would be the highest level of savings ever identified by the Trust. The Finance & Performance Committee has received regular updates on £10m of this target which is broadly on course to deliver from 1 April 2016 and the process for agreeing divisional targets and plans for the £14.3m has been set out. Workforce plans are not yet available but are being developed.

4.1   Budget Sign Off

The aim is to obtain final formal divisional sign off for activity plans and budgets by mid-April. The expectation is that workforce plans and capacity modelling will need further work in-year to support the delivery of the savings target. Sign off will entail senior budget holders personally signing budget statements. In addition, presentations covering budget holder's responsibilities will take place in April/May.

5.   Capital Programme

In order to ensure that the Trust can maintain its estate, IT and equipment to required standards, the capital planning strategy will continue to be to use depreciation as the sinking fund for asset renewal and replacement. The strategy for financing new investments will continue to be to borrow but only where there is a clear return on investment. The planned deficit position means the Trust cannot generate sufficient cash to repay the principals on existing loans let alone service additional borrowing making it increasingly difficult to obtain loan funding for investments. That said the Trust Development Authority (TDA) has been made aware of the £19m capital requirement for Phase 1 of the reconfiguration business case which will provide up to 80 additional beds on the Worcestershire Royal Hospital (WRH) site along with women and children's centre plus car parking. There is also a requirement to invest in endoscopy and elective women's care on the other sites. The cost will be split across the next 2 financial years.

The capital expenditure plan for 2015/16 has been closely monitored and approved at Capital Prioritisation Group. (CPG) The plan for 15/16 resulted in deferring ICT schemes to ensure essential backlog maintenance work could be undertaken; this in in turn will put pressure on the resources available for new schemes in 2016/17. The expectation is that the Trust's internally generated resource will be principally committed to essential works and equipment replacement.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

Bids for equipment replacements were requested from the Divisions, linked to their divisional priorities for 2016/17. All Divisional bids for ICT and Property & Works were jointly submitted with the Divisions and capital workstream leads and again linked to the divisional priorities. Any schemes that have been deferred from 15/16 that are still deemed to be a priority will be the first call on the capital plan for 16/17.

The draft capital plan for 16/17 shows an over commitment against the plan by £1.1m, however this may change once depreciation is finalised. The over commitment will be managed through slippage and regular reviews of the position with the workstream leads and finance to ensure the Trust meets its Capital Resourcing Limit (CRL). There is no contingency built into the capital programme.

Before the plans are resubmitted to the TDA, the Trust will be reviewing the affordability of the capital programme in light of the overall financial position and recovery plan and the sources of funding.

The key points to note from the draft capital plan set out in the table below are:

- The only agreed capital loan within the draft plan for 16/17 relates to the Emergency Department (ED) at WRH, estimated to be £1.386m.
- Almost £7m of the capital programme is subject to successful loan applications. If the business cases and loans are not agreed then these schemes cannot proceed. The risk associated with backlog maintenance will need to be kept under review.
- The draft plan includes £3m for the anticipated capital loan in 16/17 to support the implementation of the service reconfiguration. Working to a total capital requirement of £35m for implementation of ASR over a three year period.
- Further schemes are being reviewed to include invest to save schemes with a potential for at least a 1 to 1 return including the closure of Aconbury East and A Block at Kidderminster and the expansion of car parking on the WRH site.   These are estimated at £1.2m in 16/17 funded via further capital loans subject to business cases.
- The draft plan also includes an estimated £2.8m for a distressed capital loan application for Property and Works (P&W) backlog maintenance, subject to a business case being presented. P&W schemes in 16/17 relate only to essential backlog maintenance and Statutory/Mandatory works. This is to enable the Trust to prioritise the essential maintenance works required countywide. The schemes have been reviewed further to phase the plans over a 3 year programme.
- It is proposed that TAU is supported from the capital programme in 16/17, at an estimated cost of £170k. Further Clinical Developments and Strategic scheme bids amounting to circa £6m are not included in the capital programme. These will be reviewed by Executive Team and will need to be funded through further loan applications if deemed to be necessary.
- Receipts from the Sale of Land at Redditch have been included at an estimated Net Book Value of £325k which was deferred from 15/16. There is potential to release further surplus land for sale which is being reviewed by the Director of Asset Management and ICT but not included above as yet.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

- Equipment replacement is planned to be £700k. It is assumed that equipment will be leased where better value for money can be achieved.
- The ICT plan is estimated at £2.5m which includes the expenditure to finalise the Data Centre scheme (£1.8m). There is an opportunity for a further bid for some digital roadmap funding, which the Director of Asset Management and ICT is reviewing.

Capital Plan	2016/17 Plan £000's	16/17 Proposed Schemes £000's	16/17 Variance to Plan £000's
Funding			
Depreciation	8,165		
Capital Loan ED	1,386		
Anticipated Capital Loan - ASR	3,000		
Anticipated Capital Loan - Invest to Save	1,200		
Distressed Capital Bid - Backlog Maintenance	2,756		
CRL	**16,507**		
Capital Loan Principal Repayments	(2,756)		
Total Available Capital Funding	**13,751**		

Expenditure			
Expenditure			
ED Expansion	1,386	1,386	0
TAU	170	170	0
Anticipated Capital loan - ASR	3,000	3,000	0
Sub Total Developments	**4,556**	**4,556**	**0**
Property & Works	2,364	2,503	(139)
Anticipated Capital Loan - Invest to Save	1,200	1,200	0
Distressed Capital Bid - Backlog Maintenance	2,756	2,756	0
Sub Total P&W	**6,320**	**6,459**	**(139)**
Equipment	700	700	0
Sub Total Equipment	**700**	**700**	**0**
ICT	700	1,661	(961)
Data Centre	1,800	1,800	0
Sub Total ICT	**2,500**	**3,461**	**(961)**
Total Expenditure	**14,076**	**15,176**	**(1,100)**
Alex Land Disposals	(325)	(325)	0
Sub Total Donations/Receipts	**(325)**	**(325)**	**0**
Total Net Expenditure	**13,751**	**14,851**	**(1,100)**

Following a review by the Executive Team the Capital Programme will go back to the Capital Prioritisation Group for endorsement. It will then be presented to Finance & Performance Committee and Trust Board for approval. A final capital plan will be submitted to the TDA as part of the Operational Planning requirements on the 11th April 2016.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

6.   Cash

Throughout 2015/16 the Trust has required significant levels of working capital in order to meet its financial commitments. The Trust has received cash support of £61.9m to cover the £59.9m forecast deficit, loan principal repayments, the capital element of the unitary payment and the working capital movement. The cash support has been received through interim revenue support facility loans and revolving working capital loans. This leaves the Trust with a £7.5m shortfall in cash funding in comparison to April 2015. Consequently, the Trust has only paid half of the invoices (by value) within 30 days on average year to date but this has been on a deteriorating trend.

The total cash requirement for 2016/17 is £52.9m based on:
*   Planned deficit £38.3m
*   15/16 cash shortfall £7.5m
*   Loan principal repayments £5.1m
*   Capital element of the unitary payment £2.0m

This level of cash support will return the Trust's cash position to April 2015 levels. Even at this level the Trust will only be able to pay 70% of suppliers within 30 days.

The TDA has set out the cash support application process for April 2016 requiring submissions by 30th March. The application process for future months beyond April is still under discussion centrally. Updates will be provided through the monthly finance report as the Trust is informed of future arrangements.

The Trust has submitted a cash support application of £11.4m for April. This comprises the April forecast deficit position of £3.7m, the 2015/16 cash shortfall of £7.5m and the in-month capital element of the unitary payment of £0.2m.

7.   Assumptions / Risks

A number of underpinning key assumptions / risks could significantly impact the Trust's plans. These include:

*   **Achievement of Savings Schemes –** At £24.3m this would be the highest level of savings achieved by the Trust. Any slippage in the achievement of this will cause an equal movement in the Trust's deficit position.

*   **Winter** – No impact above those planned for 2015/16 has been included within the position. Any increase in stranded patients or a reduction in the amount of elective activity would have a detrimental impact to the plan depending on the contractual arrangements.

*   **CCG Affordability –** The proposed alternative contract model relies upon the CCGs being able to access their non recurrent resources from NHS England. If this is not possible then there could be an affordability issue in agreeing the contract.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

- **Cost of Transformation –** Additional costs around external and interim costs the Trust may be required to fund.

- **Delays in Reconfiguration –** This would constrict the potential progress on some of the key drivers of the deficit, particularly around the ability to recruit to medical posts.

- **Lack of Progress on System Flow –** The Trust needs to continue to improve flow and reduce the numbers of medical fit for discharge patients; a number of the actions will require support form health economy partners. Should flow not be restored to the local health economy, this would detrimentally impact the Trust's financial position.

- **Impact of Commissioner QIPPs –** The Trust is working with Commissioners on a shared QIPP programme for 2016/17. The key work streams and leads have been identified and project plans are being developed. As this work progresses we will assess the potential in year impact of these on the Trust. If the alternative contract model is agreed, the Trust will be protected from fiscal lag and from costs that cannot be easily removed in the short term. In the event the contract reverts to a PbR approach, the Trust will need to fully understand the potential timing of QIPP delivery and align its cost reduction to mitigate against fiscal lag stranded costs.

- **Deanery Posts –** Deanery posts not filled or decommissioned over and above those the Trust has already been notified of.

8.   **Next Steps**

- Formal divisional sign off of activity plans and income and expenditure budgets by mid-April. Divisions have budget envelopes including their CIP targets with draft plans for implementation.

- Agree contracts with commissioners and take to Board for agreement. The aim is to complete by the end of April unless mediation is triggered in which case the timetable set out in Section 2 would apply.

- Finalise and implement the plans for the £14.3m CIP target by the end of April.

- Agree workforce plans for recruitment to medical and nursing vacancies. This is being overseen by the Workforce Assurance Group.

- The detailed capital plan to be reviewed by Executive Team before being endorsed by Capital Prioritisation Group and Finance & Performance Committee and presented to the next Board meeting for approval.

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

9.   Action Required

1. Approve the submission of the 2016/17 financial plan on 11 April 2016 on the basis set out in this paper noting the assumption around the £13.1m STF.

2. Support the progress on the financial plan, including the £24.3m of savings target and contracts.

3. Review the risks and:
    a. consider whether these are complete and are adequately reflected in the financial plan
    b. seek assurance that appropriate mitigations are in place

4. Agree the basis for budget setting for 2016/17.

Rob Cooper
Interim Director of Finance

Title of report	Financial Plan 2016/17 - Update
Name of director	Rob Cooper

Date of meeting: 6 April 2016   **Enc H1**

Report to Trust Board (in public)

Title	Audit and Assurance Committee report
Sponsoring Director	**Bryan McGinity** **Chair – Audit and Assurance Committee**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Board is requested to: • Receive assurance in relation to the external Audit report • Receive assurance in relation to the management of core financial systems • Note the actions being taken in respect of the waiting list initiative audit • Receive assurance in relation to the management of risk • Note the report
Previously considered by	N/A

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	
Related Board Assurance Framework Entries	The Committee reviews and provides assurance on the overall management of the BAF risks.
Legal Implications or Regulatory requirements	
Glossary	

Key Messages
This is the routine report from the Audit and Assurance Committee to the Trust Board and covers the meeting held on 16 March 2016.

Title of report	Audit and Assurance Committee
Name of director	Bryan McGinity

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 3 FEBRUARY 2016

1.   Situation

The Audit and Assurance Committee met on 16 March 2016. This report details the business undertaken at that meeting.

2.   Background

The Audit and Assurance Committee provides assurance on systems and processes in place at the Trust. It is a key assurance committee.

3.   Assessment

3.1   **External Audit**

The External Auditors expressed concern about the ability to progress the final accounts' audit due to the absence of a permanent Chief Accountant. Mitigations had been put in place which included weekly telephone conference calls and a dummy run of the running of the accounts. The members expressed concern about the length of time it has taken to recruit to the post which has had a substantial impact on the final accounts process.

It was noted that there was a change to the audit reporting of the value for money conclusion.

The annual benchmarking annual report was presented which showed that the Trust Annual Report for 2014/15 was fit for purpose. It was noted that the Annual Report guidance had significantly changed the reporting requirements for the Report for 2015/16.

3.2   **Internal audit**

The Committee received the audit into core financial systems which received significant assurance. The audit into waiting list initiative payments received limited assurance. The Interim Chief Operating Officer outlined his response to the audit and members received assurance about the progress being made.

The Internal Audit plan for 2016/17 was approved with the addition of an audit into endoscopy and the consideration of an audit into procurement.

3.3   **Risk Management Strategy**

The Committee were assured with the progress of the risk Management Strategy and were informed that the Strategy would be reviewed in the first quarter of 2016.

Title of report	Audit and Assurance Committee
Name of director	Bryan McGinity

3.4   **PWC governance report**
Following a review from the TDA, the action plan will be developed. Each committee will review its actions and a further report will be given in May.

4   Recommendation
The Board is recommended to:
- Receive assurance in relation to the external Audit report
- Receive assurance in relation to the management of core financial systems
- Note the actions being taken in respect of the waiting list initiative audit
- Receive assurance in relation to the management of risk
- Note the report

Bryan McGinity
Chair – Audit and Assurance

Title of report	Audit and Assurance Committee
Name of director	Bryan McGinity

Worcestershire **NHS**
Acute Hospitals NHS Trust

Date of meeting: 6 April 2016   **Enc H2**

Report to Trust Board in public

Title	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR)**
Sponsoring Director	Mari Gay, Interim Chief Nursing Officer
Author	Justin King, Trust Risk Officer
Action Required	Trust Board is asked to: • Note the changes to the BAF & CRR • Review risk ratings, controls, assurance and mitigating actions and consider if these are reasonable
Previously considered by	TMC / EMT

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	√
Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	√

Related Board Assurance Framework Entries	This paper relates to all BAF risks
Legal Implications or Regulatory requirements	NHS guidance states that Trusts are expected to have a Board Assurance Framework. This is monitored through the TDA and Monitor for Foundation Trusts. The approval of a BAF is a requirement for the Trust and forms part of the internal and external assurance requirements.
Glossary	BAF – Board Assurance Framework TMC – Trust Management Committee EMT – Executive Management Team

Key Messages
This paper provides Trust Board with the quarterly update of the full BAF and full Corporate Risk Register.

Title of report	Board Assurance Framework (BAF)
Name of director	Chief Nursing Officer

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – APRIL 2016

1. Situation

Trust Board is provided with the BAF Risk Register and Corporate Risk Register for assurance.

2. Background

NHS Trusts are required to have a Board Assurance Framework (BAF). Trust Board review the BAF Risk Register and Corporate Risk Register in full quarterly.

3. Assessment

3.1 Board Assurance Framework (BAF)

The risks recorded on the 2015/16 BAF Risk Register have been reviewed by the responsible Executive Directors, and action plans updated.

A revised committee reporting process is attached at page 4. This has been approved by EMT.

A new risk has been added, as noted on the BAF index: *3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances.*

The risk rating of the following risk has been increased to high following the Annual Staff Survey and Trust Risk Survey: *2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity*.

3.2 Corporate Risk Register (CRR)

There are 36 risks recorded on the Corporate Risk Register, with 15 at a rating of high. The index sheet provided shows the executive lead and monitoring committee of each.

Since last reviewed by Trust Board in January 2016, two risks have been added to the Corporate Risk Register:

2856 Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury

2899 Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, poor clinical outcomes (migrated from BAF)

4 Action required

Trust Board is asked to:
- Note the changes to the BAF & CRR
- Review risk ratings, controls, assurance and mitigating actions and consider if these are reasonable
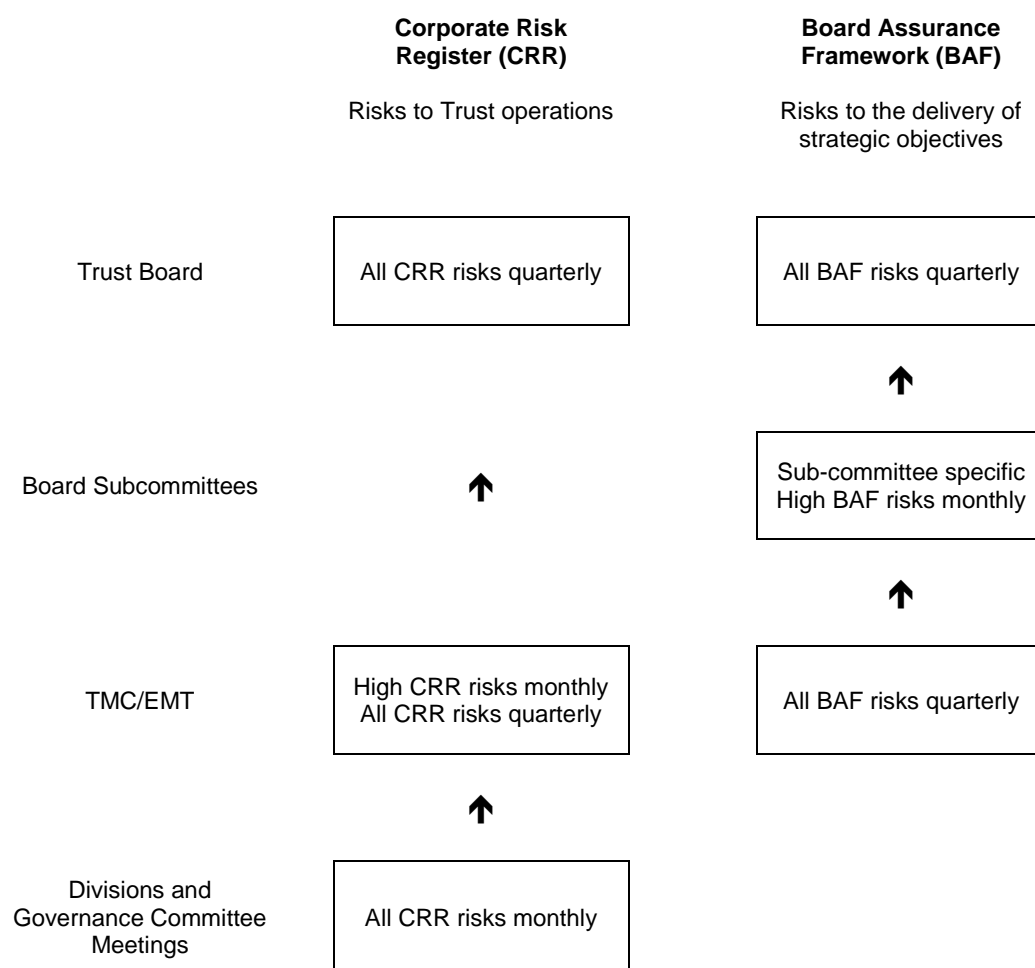
Mari Gay
Interim Chief Nursing Officer

Title of report	Board Assurance Framework (BAF)
Name of director	Chief Nursing Officer

Reporting process for BAF and Corporate Risk Register

	Corporate Risk Register (CRR)	**Board Assurance Framework (BAF)**
	Risks to Trust operations	Risks to the delivery of strategic objectives
Trust Board	All CRR risks quarterly	All BAF risks quarterly
Board Subcommittees	↑	Sub-committee specific High BAF risks monthly
TMC/EMT	High CRR risks monthly All CRR risks quarterly	All BAF risks quarterly
Divisions and Governance Committee Meetings	All CRR risks monthly	

Title of report	Board Assurance Framework (BAF)
Name of director	Chief Nursing Officer

Worcestershire **NHS**
Acute Hospitals NHS Trust

Board Assurance Framework:

Risk Register 2015/16

<u>All Risks</u>

Trust Board

March 2016

Principles of the Approach:

This document is intended to be dynamic. Each potential risk is given a score (risk level) that is derived from consideration of the <u>consequences for the achievement of the objective(s)</u> (or impact) and the <u>probability of the risk arising</u> (likelihood). The scoring has taken account of the controls and assurances that are in place to mitigate the risk.

Where gaps are identified in controls or assurances, a corresponding action plan is included. A second 'anticipated risk score' is then calculated, which reflects the level of risk posed to the achievement of the relevant objective once the appropriate action has been completed. (Where the action is split into several stages, a single score is awarded for all stages).

As actions are completed, additional controls and assurances resulting from those actions will be registered in the appropriate sections. The gaps will be removed and where possible, the risk level reduced (in terms of probability and/or impact) accordingly. Risks on the assurance framework will not be removed if the risk level is reduced, but will remain so as to provide continued assurance to the Board that controls and assurances are in place.

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
OBJECTIVES **Achievement of organisational / strategic objectives**	Negligible effect upon the achievement of the objective	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty / cost	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty / cost	Significant effect on the objective making it extremely difficult / costly to achieve	Catastrophic effect on the objective making it unachievable.
CLINICAL **Impact on the safety of patients (physical/ psychological harm)**	Incident prevented / near miss. Incident not prevented but **NO HARM** was caused	Any patient safety incident that required extra observation or **MINOR** treatment and cased minimal harm to one or more patients e.g. first aid, additional therapy or additional medication	Any patient safety incident that resulted in a **MODERATE** increase in treatment and that caused significant but not permanent harm to one or more patients Moderate increase in treatment is defined as: a return to surgery; an unplanned readmission; a prolonged episode of care; extra time in hospital or as an outpatient; cancelling of treatment; transfer to another area such as intensive care - as a result of the incident.	Any patient safety incident that appears to have resulted in permanent (**SEVERE**) harm to one or more patients Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as: permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.	Any patient safety incident that directly resulted in the **DEATH** of one or more patients The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) - Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) - Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Service actively causing patient harm Gross failure of patient safety if findings not acted on Non coronial Inquest/ ombudsman inquiry Gross failure to meet national standards
OPERATIONAL Service/business interruption Environmental impact	Loss/interruption of >1 hour No impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Impact on staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury requiring minor intervention Requiring time off work but less than 7 days	Moderate injury requiring professional intervention Requiring time off work for 7 -14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident causing death Multiple permanent injuries or irreversible health effects
FINANCIAL	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
INFORMATION GOVERNANCE	Minor breach of confidentiality. Up to 10 individuals affected (scale 0)	Information up to 100 individuals (scale 1&2) Local media coverage	Serious breach of confidentiality e.g. Information for 101 – 1000 individuals (scale 3) Local media coverage ICO fine up to £50k	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1001 – 100 000 people affected ICO fine of £50k to £250k	Loss of all systems / data Very sensitive information Information about 100,001 + individuals ICO fine of £250k to £500k National media attention
REPUTATION	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence	Local media coverage Long-term reduction in public confidence	National media coverage requiring significant action	National media coverage impacting on our ability to function
COMPLIANCE Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Critical report	Multiple breaches in statutory duty Prosecution Severely critical report

SECTION 2 - LIKELIHOOD OF OCCURRENCE

Score	Operational scale Time until next event	Project and strategic planning scale Probability within planning period
1 - Rare	Will only occur in exceptional circumstances	Less than 1%
2 - Unlikely	Next event expected within a year	25%
3 - Possible	Next event expected within a month	50%
4 - Likely	Next event expected within a week	75%
5 - Almost certain	Next event expected to occur within a day	More than 99%

SECTION 3 - RISK SCORING MATRIX

		CONSEQUENCE				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

SECTION 4 - ACTION AND REPORTING REQUIREMENTS

Score	Risk	Action	Reporting Requirements
1-6	Risk is within tolerance	Within risk appetite / tolerance Managed through normal control measures at the level it was identified	Within tolerance so no reporting Record on risk register at the level the risk was identified
8-10		Within risk appetite / tolerance Review control measures at the level it was identified	Within tolerance so no reporting Record on risk register at the level the risk was identified
12-15	Risk Exceeds tolerance	Exceeds risk appetite / tolerance Actions to be developed, implemented and monitored at the level the risk was identified	Record on Risk Register at the level the risk was identified Report to next level of management
16-25		Exceeds risk appetite / tolerance **Immediate action required** Treatment plans to be developed, implemented and monitored at the level the risk was identified	Record on Risk Register at the level the risk was identified Report to next level of management With Executive Director approval - enter onto Corporate Risk Register

BAF risks mapped to Strategic Goals

	1. Deliver safe, high quality, compassionate patient care	2. Design healthcare around the needs of our patients, with our partners	3. Invest and realise the full potential of our staff to provide compassionate and personalised care	4. Ensure the Trust is financially viable and makes the best use of resources for our patients	5. Develop and sustain our business
Strategic Goal					
Assurance Committee	**Quality Governance Committee**	**Quality Governance Committee**	**Workforce Assurance Group**	**Finance and Performance Committee**	**Strategy and Transformation Committee**
NED	Bill Tunnicliffe	Bill Tunnicliffe	John Burbeck	John Burbeck	Andrew Sleigh
ED	Chief Medical Officer	Chief Nursing Officer	Director Human Resources	Andrew Sleigh Director of Finance	Director of Strategy & Planning
Risks	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed (COO) **20**	3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care **16**	2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity (DoC) **20**	2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability **20**	2665 If we do not achieve wider service redesign in a timely way we will have inadequate numbers of clinical staff to deliver quality care (CMO) **20**
	2902 If the Trust does not successfully improve clinical care, we will fail to reduce avoidable harm to expected levels **16**	2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience **12**	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels **16**	2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service **16**	2905 Failure to transform our services, resulting in inability to deliver required improvement **12**
			2894 Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems **15**	3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances (COO) **16**	3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected (DoC) **12**
			Remuneration Committee Chairman Chief Executive		
			2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services **20**		

BAF Risk Report

Risk	**2665 If we do not redesign services in a timely way we will have inadequate numbers of clinical staff to deliver quality care**
Date opened	22/04/2014
Strategic goal	Develop and sustain our business
Strategic objective(s)	Provide excellent patient experience
Initial Risk Level	Major Almost certain 20 High

Director/Committee	Chief Medical Officer / Trust Management Committee
Description/Impact	If we do not redesign services (county wide reconfiguration)in a timely way we will have inadequate numbers of clinical staff to ensure safe, high quality care that is sustainable. As a result, the Trust will be unable to finalise its longer term strategy and may have a resultant deterioration in its financial position affecting its ability to be a standalone provider. Increased costs from high reliance on temporary staff affecting financial position of the Trust. The Trust may be unable to implement the large-scale changes required to services - further deterioration of clinical safety and quality, low staff morale. Loss of clinical staff to other providers. Reputation damage.
Key Controls	Specialty specific risk mitigation plans set out in line with the schedules and thresholds for action by Division Escalation of risks to TMC Future of Acute Hospital Services in Worcestershire (FOAHSW) Project established Sustainability sub-committee of Programme Board Project management contractors employed to support delivery
Sources of Assurance	Management Assurance-Divisional reports to the Safe Patient Group Management Assurance-Safe Patient Group report to the Quality Governance Committee Internal reports to the Board-Standing Board agenda item on reconfiguration. Management Assurance-FOAHSW Programme Board Independent Assurance-Health Gateway Report Independent Assurance-NHS England

Performance Monitoring	The Corporate Risk Register contains FoAHSW staffing sustainability risks for the Medicine, Surgery and Women and Children divisions. These risks have a suite of key staffing and clinical quality performance metrics with associated performance thresholds. These are reported to Trust Management Committee monthly. Annual Plan Objectives Monitoring Template FoAHSW Project Board reports
Gaps in Control	Timetable for reconfiguration is subject to: consensus of the Clinical Senate, NHSE assurance tests, affordability for all partners, capacity constraints (for more detail see Acute Services Review Project Risk Register) Contingency plan to include appropriate agreed mitigations Public consultation will require consideration and potential subsequent review of plan Commissioners required to submit separate business case to NHSE - uncertainty of outcome The consequences of emergency relocation of services may create unanticipated risks
Gaps in Assurance	Lack of certainty in proposed timeline and achievement of reconfiguration

Current Risk Level   Major   Almost certain   20   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop and gain endorsement for model of reconfiguration	Andy Phillips Interim Chief Medical Officer	16/05/2016	November 2015: Option not unanimously endorsed by FoAHSW Programme Board on 23rd October. Option to be refined at an extraordinary Quality and Sustainability Sub-committee. December 2015 update: FoAHSW Programme Board have endorsed the QSS model of paediatric care in the county. Due date updated to reflect the time required to go to the clinical senate and then NHS England for endorsement. Feb 2016 update: Three CCG governance bodies and WAHT Trust Board have approved model. Request submitted to review at clinical senate.	
ASR Project developing detailed business case(s) for interim and permanent solutions.	Chris Tidman Acting Chief Executive	18/07/2016	Due date updated as a result of delays in endorsement for the model.	
Planned consultation and engagement during the public consultation on reconfiguration	Andy Phillips Interim Chief Medical Officer	18/07/2016	Public consultation contingent on endorsement. Due date changed again to reflect time required for consultation.	
Development and Board sign off of the contingency plan (quality thresholds exceeded).	Mark Wake Chief Medical Officer	31/01/2015	Trust Board has agreed interim measures. Acute Surgery implemented. High risk obstetrics and paediatric surgery under discussion.	12/12/2014

BAF Risk Report

Work underway within General Surgery, gynecology and Obstetrics and paediatrics regarding interim plans to ensure safety of service provision and staffing levels	Andy Phillips Interim Chief Medical Officer	30/09/2015	TDA supporting assistance from other trusts with medical rotas. Continuous monitoring and interim plans have been established. Continued recruitment processes in place Weekly review of staffing levels and trigger points for safe staffing levels in place	21/09/2015
Develop trigger points for escalation in services affected by reconfiguration delays.	Andy Phillips Interim Chief Medical Officer	31/12/2015	Trigger points established for W&C specialities and endorsed by Trust Board and partners. Developed for Surgery. Performance monitoring tool established.	15/12/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	Timetable and delivery plan delayed. November 2015: Emergency action taken on the 5th November to temporarily move maternity and neonatal services from Alexandra Hospital to the Worcestershire Royal Hospital. Outpatient, day assessment and community midwifery services continue as normal. Model for reconfiguration not unanimously endorsed by FoAHSW Programme Board on 23rd October 2015. The Quality and Sustainability Subcommittee agreed to create a single item task and finish group to propose a model for paediatric care in the county. On 12th November 2015 the group met and agreed an option which will be refined and endorsed at an extraordinary Quality and Sustainability Subcommittee. December 2015 update: Back on road to public consultation pending appropriate scrutiny and endorsement by Clinical Senate and NHS England. February 2016 update: When Clinical Senate endorsement achieved, model will progress to NHSE.

Next Review Date	06/04/2016

BAF Risk Report

Risk	**2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service**
Date opened	22/04/2014
Strategic goal	Ensure the Trust is financially viable and makes the best use of resources for our patients
Strategic objective(s)	Use resources wisely
Initial Risk Level	Major Likely **16** High

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	Description: If plans for improving cash position do not materialise the Trust will not be able to pay creditors which ultimately could impact on supplies to support service delivery. Impact: Inability to meet cash requirements with resultant impact onto Continuity of Service (COS). Reduced capacity and capability to achieve change Reputational damage and confidence in Board. Will trigger further action by TDA. Suppliers ceasing provision of products and services impacting operations and patient care Interest payments increase over time
Key Controls	Further working capital loan or PDC requested. Daily cashflow forecasts Close management of working capital to prioritise creditors Delivery of financial plan
Sources of Assurance	Management Assurance-Monthly monitoring of cash position by F&P Committee. Internal Audit-Financial Management Arrangements & Reporting Audit Internal Audit-Core Financial Transaction Processing Internal Audit

Performance Monitoring	Financial reports to Finance & Performance and Trust Board
Gaps in Control	Confirmation of capital availability to meet needs of Trust.
Gaps in Assurance	Still lack of clarity on the actual availability of cash from the DH

Current Risk Level   Major   Likely   **16**   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Deliver revised forecast in order to obtain further cash draw downs	Rob Cooper Director of Finance	15/04/2016		
Public Dividend Capital (PDC) /Loan application to be made to Independent Trust Financing Facility alongside Long Term Financial Model in August, with Trust Development Authority support	Chris Tidman Acting Chief Executive	31/10/2014	Revenue cash injection application approved as PDC (£26.5m)and the Trust has been recently advised of terms and condiitons which have been reported to FPC.	22/12/2014
Bidding for any National funds available	Chris Tidman Acting Chief Executive	28/02/2015	The Trust has been successful in the Integrated Digital Care Fund Bid but the value has been reduced to £1.3m of which £0.8m will be received this year. The Trust has been unsuccessful in the other bid against the Nurse Tech Fund.	28/02/2015
Submit application for £4.95m distressed capital to improve IT infrastructure resilience.	Chris Tidman Acting Chief Executive	28/02/2015	The bid was successful and the Trust was initially informed that this will be PDC but we have now been told that this will be a loan.	28/02/2015
Apply for further revenue cash support of £17.2m for 14/15 to counter impact of increased deficit.	Chris Tidman Acting Chief Executive	31/03/2015	Application was approved by the by the ITFF, now awaiting DH formal confirmation. In the meantime the Trust has drawn down a temporary loan of £8m.	14/05/2015
Seek cash injection for 2015/16	Colin Gentile Director of Finance	31/10/2015	Temporary funding of £19m has been agreed to meet the cash requirements for the first 6 months of 2015/16. The application for permanent funding is dependent on the development of a financial recovery plan. This means the trust will need to extend the current temporary facility. It is likely the Trust will require additional access to cash as its defecit is larger than planned. 16/11/2015 Recieved 30 days working capital. Currently applying for 40 day facility	31/10/2015

BAF Risk Report

Submit two applications for distressed capital, August and September/October 2015	Colin Gentile Director of Finance	30/10/2015	ITFF bid for £5m capital to support ED expansion, discharge lounge and car park submitted August 2015. The second bid will be subject to TDA new guidance which is likely to make access to further capital difficult. Update 16/11/2015: Recieved £4m for ED expansion and discharge lounge	16/11/2015
Conduct a review of the Trust's risk appetite to reduce expenditure and ensure compliance with the agency caps	Rob Cooper Director of Finance	15/02/2016	Plans agreed to close surge capacity and reduce agency expenditure.	15/02/2016

Target Risk Level	Major	Possible	12	Moderate

Progress	

Next Review Date   06/04/2016

BAF Risk Report

Risk	**2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels**
Date opened	19/05/2014
Strategic goal	Invest and realise the full potential of our staff to provide personalised and compassionate care
Strategic objective(s)	Develop and support staff

Initial Risk Level   Major   Almost certain   **20**   High

Director/Committee	Director of Human Resources / Workforce Assurance Group
Description/Impact	If we do not attract/retain key clinical staff we will be unable to ensure safe and adequate staffing levels. There will be increased dependency on temporary staffing which affects the safety, quality and consistency of care to patients. Health Education West Midlands is reviewing the workforce plan for commissioning
Key Controls	Workforce metrics reviewed monthly at Trust Board Divisions produce resource plans for the workforce within their service
Sources of Assurance	Review-Internal-Family and Friends staff surveys Internal reports to the Board-CNO Board report on safe staffing reporting on NICE guidance compliance Internal reports to the Board-WAG report on workforce recruitment and medical staffing management - report via TMC to the Board Internal Audit-Temporary Staff Booking Process Audit

Performance Monitoring	Vacancies as Proportion of Funded Establishment (WVR1.23) Clinical Staff Turnover % (Clinical, WT1.1)
Gaps in Control	Understanding retention issues, eg formal exit interview processes Formal marketing plan Uncertainty around reconfiguration timetable Deanery control of doctor training places
Gaps in Assurance	

Current Risk Level   Major   Likely   **16**   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Create Workforce Development Plan and implement new roles. Maximising internal Bank recruitment	Denise Harnin Director of HR & OD	15/03/2016 new date May 2016	WAG and NMWAG looking at: temporary staffing, role development, consultant job planning, recruitment processes, workforce reporting, operational management templates. Strategy implementation expected by December 2015, due date updated to reflect this. Update Dec 2015: Strategy discussed at WAG 21st Dec 2015. Baseline complete. Organising a facilitated workshop with divisions to review forward plan. Alternative practitioner models to be picked up in this work. Propose update due date to March 2016. March 2016 update: Workforce Development plan in progress, propose new due date May 2016.	
Marketing plan for recruitment by division	Denise Harnin Director of HR & OD	30/09/2014	Surgery - open day held. Corporate resources to support recruitment being provided	25/11/2014
CMO discussing Deanery withdrawing training numbers - implications for Worcestershire	Mark Wake Chief Medical Officer	31/12/2014	Action complete	31/12/2014
Ensure future medical contracts are trust-wide appointments	Andy Phillips Interim Chief Medical Officer	31/07/2015	All medical appointments are made on the basis of county-wide working.	31/07/2015
Revise internal staff engagement programme	Denise Harnin Director of HR & OD	27/11/2015	Strategy developed for next 12 months. Endorsed at Directors meeting 1/12/2015	30/11/2015
CMO to work with surrounding universities and local education and training board (LETB) on alternative practitioner models	Andy Phillips Interim Chief Medical Officer	30/11/2015	Meetings have commenced with universities and LETB. Ongoing work being picked up as part of the workforce strategy.	31/12/2015

BAF Risk Report

Medicine Division to review workforce strategy	Andy Phillips Interim Chief Medical Officer	15/04/2016	Re-opened following discussion at WAG September 2015. Update Dec 2015: The re-established MWAG will progress this work. To be included in revised terms of reference. Propose new target date March 2016. February 2016 update: propose new target date April 2016. March 2016 update: action closed as this is captured within the workforce development plan.	24/03/2016
Improve communication and engagement of staff to develop them as ambassadors for the trust	Denise Harnin Director of HR & OD	13/05/2016	Director of HR and Director of Communications developing an engagement strategy. March 2016 update: action closed as engagement strategy covered in risk 2893	24/03/2016

Target Risk Level	Moderate	Blank	12	Moderate

Progress	Update November 2015: Monitor and the NHS Trust Development Authority (TDA) have implemented a cap on the amount of money that trusts can pay per hour for agency staff working for the NHS, taking effect from 23rd November 2015. The impact of this change will be known from the first report on 25th November 2015. Caps can be exceeded in individual cases on safety grounds, but within a process overseen by Trust Board and reported to the TDA. If the TDA consider that the trust is not applying the rules in a timely manner, they may use formal powers. The Trust continues to focus on improving recruitment, graduate intake and increasing internal bank.

Next Review Date   06/04/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2790 As a result of high occupancy levels, patient care may be compromised**
Date opened	02/02/2015
Strategic goal	Develop and sustain our business
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Major · Almost certain · **20** · High

Director/Committee	Chief Operating Officer / Urgent Care Oversight Team (UrCOT)
Description/Impact	If the trust experiences high occupancy levels and there is a lack of downstream flow in the local health economy then patient access performance will be compromised. These pressures can detrimentally affect safety, quality and patient experience. Impact: Over-crowding in ED Increased quality and safety risk due to sub-optimal location of patient, multiple tranfers between wards/departments/sites, lack of privacy and dignity for patients, increased length of stay. Financial (£4.8m FYE)and reputational impact of non-delivery of targets.
Key Controls	Bed management team and processes to place patient in optimal bed Waiting list management Weekly meetings of the Urgent Care Oversight Team in ED to coordinate patient flow Monitoring electronic white boards (EWBS) on a daily basis Working in partnership to deliver the Patient Care Improvement Plan (PCIP) System wide capacity plan Monitoring of patients >10 days LOS on a weekly basis Full capacity protocol
Sources of Assurance	Internal reports to the Board-Monitoring demand and utilisation of capacity / improvement via divisional performance reporting Management Assurance-Monthly quality and safety monitoring via divisional quality forums Internal Audit-Waiting List Initiative (WLI) Expenditure Audit Management Assurance-Divisional monitoring waiting lists Management Assurance-Divisions monitoring outliers daily Internal Audit-Divisional Governance Structures Audit

Performance Monitoring	CEM target initial clinical assessment within 15 minutes of ambulance arrival in A&E % of patients waiting less than 4hrs in A&E (CAE1) Backlog > 18 weeks (PW4) Cancer targets (CCAN1-9) Delayed Transfers of Care SitRep (Days) (PIN3) Acute bed days occupied by patients 'Fit to Go'
Gaps in Control	Discharge planning and delivery process needs improvement More physical capacity needed in ED and discharge lounge needed More senior clinical decision making particularly out of hours is needed The Trust lacks clarity and control of the management of new referrals to the waiting list
Gaps in Assurance	Further information and assurance being sought through the CCG 18 week RTT Working Group, CCG Contract Monitoring Board and Systems Resilience Group (SRG) System wide capacity plan not available at this time

Current Risk Level · Major · Almost certain · **20** · High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Improve patient flow with actions outlined in the PCIP, such as ambulatory emergency care, redesign bed model, improve discharge processes	Rab McEwan Chief Operating Officer	15/06/2016	The actions within the Patient Care Improvement Plan (PCIP) are tracked at UrCOT.	
It is proposed that a Local Health Economy Action Plan is to be developed and monitored through Systems Resilience Group	Rab McEwan Chief Operating Officer	28/02/2015	This was signed off at last SRG.	30/06/2015
Ensure compliance with College of Emergency Medicine guidance that initial assessment is carried out by clinical staff within 15 minutes of arrival	Robin Snead Divisional Director of Operations	30/06/2015	Systems in place to monitor and deliver this target.	30/06/2015

Date Generated: 24/03/2016

BAF Risk Report

Patient pathways review by Transformation Team. Assertive recycling of theatre lists. KTC realignment plan	Rab McEwan Chief Operating Officer	28/02/2015	Patient pathway review undertaken. KTC realignment plan approved by Trust Board Dec 2014. Now being implemented.	31/08/2015
Trust action plan include: recruitment to consultant gaps, ringfencing of cancer beds, restructuring Cancer Board, weekly cancer Patient tracking List meeting chaired by D.Ops	Rab McEwan Chief Operating Officer	28/02/2015	Cancer bed ringfencing established, weekly cancer patient tracking list meetings established. Cancer Board restructured and will commence in new structure in April 2015. Two week wait target achieved in Feb 2015 and on track to achieve target for YTD. 62 day target yet to be achieved.	31/08/2015
CCGs to agree plans with the Trust for management and reduction of GP referrals.	Rab McEwan Chief Operating Officer	31/08/2015	Agreed key specialities with significant backlogs- CCG to request GPs to refer to alternative providers. Trust has developed speciality level action plans to achieve 92% incomplete standard by September 2015. Complete.	31/08/2015
Commission a Discharge to Assess Pathway via Nursing Homes using Operational Resilience Funding	Rab McEwan Chief Operating Officer	31/10/2015		31/08/2015
Launch Breaking the Cycle initiative	Rab McEwan Chief Operating Officer	31/10/2015	Initiative launched. Early signs of improvement in key performance measures and underlying processes such as early discharges.	30/10/2015
Acute Trust to plan additional activity through existing theatre capacity	Rab McEwan Chief Operating Officer	31/12/2015	Winter plan to maximise elective activity of AGH and KTC with no down time for maintenance.	31/12/2015
Implement the Winter Plan which includes actions to increase bed capacity and cohort outliers	Rab McEwan Chief Operating Officer	29/02/2016	Winter plan implemented though elements were not funded by CCG so full capacity not commissioned.	31/12/2015
Weekly review of DTOC's led by SWCCG to speed up discharge	Rab McEwan Chief Operating Officer	29/02/2016	Weekly reviews completed and ongoing.	10/02/2016

Target Risk Level	Minor	Unlikely	4	Very Low

Progress	Capacity remains an issue. There are system wide issues with the three pathways - this will be discussed at SRG. System wide action plan still in development. CCG GP referral management plan still to be agreed. We continue to work with CCG Commissioners in the delivery of the 18 week pathway.

Next Review Date   06/04/2016

BAF Risk Report

Risk	**2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability**
Date opened	14/05/2015
Strategic goal	Develop and sustain our business
Strategic objective(s)	Use resources wisely

Initial Risk Level Catastrophic   Likely   `20`   High

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	If the Trust does not secure sufficient income, the financial position will be placed at further risk and could affect its long term sustainability. The risks around marginal rates and fines mean the Trust needs to deliver contracted performance levels whilst remaining within contracted levels of activity. If expenses are not sufficiently contained and reduced there will be a serious impact on the financial position of the Trust and this will affect its long term sustainability. Possibility of charges from 2014/2015 carrying over into 2015/2016. Impact: - Inability to meet planned deficit at year end or meet cash requirements will have a resultant impact onto Continuity of Service (COS) - Liquidity Problems - Reputational damage and confidence in Board - Will trigger further action by TDA - Risk of lack of investment in the environment/facilities/equipment supporting patient care
Key Controls	Finance and Performance Committee Executive accountability Financial reporting to highlight key issues and facilitate corrective action Divisional management structures & divisional performance management monthly Robust QIPP plans signed off and divisional QIPP Confirm and Challenge meetings Monthly review of plan delivery by PMO with divisions and escalation of issues to weekly meeting with COO Monthly QIPP report to Finance & Performance Committee Expenditure controls Executive accountability Contract Management Board (CMB) and weekly contract negotiation meetings Monthly income and activity reconciliations with CCGs System Resilience Group
Sources of Assurance	Management Assurance-Monthly review via Finance and Performance Committee and Trust Board Management Assurance-Turnaround Board with 3/4 year recovery plan and supporting progress reports Internal Audit-PWC Opportunities Report Management Assurance-Monthly monitoring of cost improvement programme delivery by divisions reported to F&P Independent Assurance-Value for Money Audit Internal Audit-Financial Management Arrangements & Reporting Audit

Performance Monitoring	Report to Turnaround Board - performance against the Financial Recovery Plan Financial reports to Finance & Performance Committee and Trust Board
Gaps in Control	Staff capacity and capability to deliver turnaround The performance management system requires strengthening Finalised project plans for all material elements of the QIPP programme Ability to realise savings in the face of operational pressures including safety issues and delayed discharges
Gaps in Assurance	Turnaround plan to be finalised in order to create assurance processes Three year recovery plan not yet completed Current financial position

Current Risk Level Catastrophic   Likely   `20`   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done

BAF Risk Report

Develop robust medical workforce plans to support recruitment as well as managing temporary costs	Denise Harnin Director of HR & OD	15/02/2016 new date Oct 2016	December 2015 update: Agency cap process in place. Weekly return being provided to TDA. HR working with divisions on plans to reduce and eliminate agency usage. Being recorded in the NHSP and HCL systems to improve transparency. Action plan required by TDA to address agency usage above cap. Propose new due date of mid-February 2016. February 2016 update: Recruitment strategies to be completed in consultation with divisions by end February 2016. Workforce plans first draft to be developed by 1st March. Centralising medical locum coordinators to be completed by March 2016. Planning to implement an all staff bank. Propose new due date end March 2016. Update March 2016: Draft Workforce plan presented to WAG. To be endorsed by WAG April 2016. Centralised medical locum coordinators to be established on 4th April 2016. All staff bank will take approximately six months to establish. In light of this, proposed new due date October 2016.	
Reduce cost of additional premium rate capacity	Rab McEwan Chief Operating Officer	15/04/2016	Costs have reduced and a further target reduction of £10m agreed. Due date updated to reflect new target.	
Develop a recovery plan in conjunction with external advisors and Trust Board	Sarah Smith Director of Strategy, Planning and Improvement	31/07/2016	Align recovery plan with STP development plans.	
Establish a turnaround Board	Chris Tidman Acting Chief Executive	30/06/2015	ToRs approved by Board. Board established.	22/06/2015
Engagement of a financial turnaround specialist to support the development of the plan	Chris Tidman Acting Chief Executive	30/06/2015	Interim Director Finance has relevant experience.	30/06/2015
Strengthen financial controls over discretionary expenditure	Colin Gentile Director of Finance	01/10/2015	Financial controls strengthened	01/10/2015
Develop a 3 year recovery plan in conjunction with external advisors and Trust Board, considering a range of radical options and workforce reductions	Sarah Smith Director of Strategy, Planning and Improvement	30/09/2015	Outline recovery plan developed 15/08/15. Presented to Trust Board in October 2015. The Turnaround Plan is set out in financial terms and themes, but not down to the detail of schemes.	30/10/2015
Divisions to finalise plans for delivering CIPs	Rab McEwan Chief Operating Officer	30/09/2015	CIPS to cover original gap developed and planned CIP delivery has improved.	30/10/2015
Performance management processes to be strengthened	Sarah Smith Director of Strategy, Planning and Improvement	31/10/2015	Monthly divisional performance meetings have commenced with the Chief Operating Officer.	31/10/2015
Finance and Procurement Teams are creating revised instructions and controls to further eliminate discretionary expenditure for the remainder of the year	Colin Gentile Director of Finance	30/11/2015	Revised instructions signed off at Finance and Performance Committee November 2015.	30/11/2015
Resolve outstanding queries with specialised commissioners	Colin Gentile Director of Finance	30/11/2015	Contract signed May 2015. Two of the three issues to be resolved during Q1 have been agreed. The third issue is the subject of a discussion with NHS England Commissioning Team in September 2015. The due date has been amended to reflect this. Update October 2015: The Trust received a response from the specialised commissioners on 20th October on the third issue, asking for further information for one element and disputing another. The Trust has responded to the query and is drafting a response to the disputed element. In the event that this cannot be resolved locally it will be escalated for dispute resolution. Revised completion / resolution date of 30 November 2015 – if not resolved by then it will be escalated. Update 1st December 2015: Outstanding queries all resolved.	30/11/2015

BAF Risk Report

Develop detailed schemes to achieve the outline recovery plan	Rob Cooper Director of Finance	03/02/2016	Schemes developed to achieve £4.3m recurrent savings. Further schemes required to achieve the minimum of £10m required. To be completed by end Jan 2016 Update Feb 2016: Schemes developed to a value of £9.9m, to be presented to Finance & Performance Committee on 26/2/16.	18/02/2016
Divisions to develop further CIPs for remaining gap	Rab McEwan Chief Operating Officer	03/02/2016	There is work being undertaken on finding CIPs for the remaining gap, focused on agency staff expenditure. This will be completed by end Jan 2016. Update Feb 2016: Superseded by schemes developed to date. Need to maintain delivery of existing CIP schemes.	22/02/2016

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	

Next Review Date   06/04/2016

BAF Risk Report

Risk	**2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity and missed opportunities**
Date opened	18/05/2015
Strategic goal	Invest and realise the full potential of our staff to provide personalised and compassionate care
Strategic objective(s)	Develop and support staff

Initial Risk Level	Moderate	Likely	12	Moderate

Director/Committee	Director of Human Resources / Workforce Assurance Group
Description/Impact	Employees need to be able to raise concerns, offer suggestions for improvement and be involved in decision making across the trust. Engagement during times of change is vital to inform decision making and to ensure buy-in of employees in the process. This ensures realisation of potential for innovation for safer more effective and efficient services. A growing body of evidence links staff engagement to employee wellbeing, patient satisfaction and clinical outcomes.
Key Controls	Staff communications such as CEO brief and Daily Brief Chief Executive feedback breakfast sessions Trust Board Surgeries 'How was it for you' sessions with Chief Nursing Officer Staff surveys- annual National Staff Survey, quarterly Friends and Family scores to provide an engagement score Intranet resources for staff Whistleblowers policy and reporting process Divisional staff engagement plans wirtten Chief Executive feedback breakfast sessions The Big Conversation engaging staff in changes and improvements
Sources of Assurance	Management Assurance-Workforce Assurance Group reporting

Performance Monitoring	Friends and Family test conducted quarterly and reported trust-wide and to Divisions highlighting an overall engagement score Staff absenteeism and turnover data reviewed at TMC and Trust Board Staff exit questionnaires
Gaps in Control	Lower than national average for staff scores to questions "I am involved in deciding on changes introduced that affect my work area / team / department", "My immediate manager asks for my opinion before making decisions that affect my work", "Senior managers here try to involve staff in important decisions", and "Senior managers act on staff feedback" Consistent high turnover and failure to attract the numbers of new recruits required.
Gaps in Assurance	

Current Risk Level	Major	Almost certain	20	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop new infrastructure for delivery of engagement plan	Lisa Thomson Director of Communications	15/07/2016		
Review whistle blowing policy	Denise Harnin Director of HR & OD	31/10/2015	Whistleblowing was ratified and agreed at October 2015 JNCC.	13/11/2015
Develop internal staff opinion survey	Denise Harnin Director of HR & OD	15/03/2016	This action is part of the staff engagement plan. Update Dec 2015: This action is awaiting completion of engagement strategy before commencement. Propose new due date mid-March 2016. Updated Jan 2016: Online staff survey (survey monkey) tested with nursing focused on nursing bank Additional questions included in the quarterly staff FFT surveys to enable an engagement score to be calculated and reported	31/12/2015
Trust engagement plan to be reviewed	Lisa Thomson Director of Communications	15/03/2016	Trust Engagement Plan now being mananaged by Director of Communications. Updated to reflect change in responsibility. Propose new due date mid-March 2016. Update Jan 2016: Draft plan developed to be discussed at WAG and Executive. Update being taken to the Board in March. Includes the development of a staff engagement group. Update March 2016: Staff engagement plan presented to Trust Board 23/03/2016. This work will be picked up by staff engagement group.	24/03/2016

BAF Risk Report

Target Risk Level	Moderate	Unlikely	6	Very Low

Progress	Annual staff survey underway. Awaiting results for an updated staff engagment score.

Next Review Date   06/04/2016

BAF Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**2894 Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems**
Date opened	18/05/2015
Strategic goal	Invest and realise the full potential of our staff to provide personalised and compassionate care
Strategic objective(s)	Develop and support staff
Initial Risk Level	Moderate Almost certain 15 Moderate

Director/Committee	Director of Human Resources / Workforce Assurance Group
Description/Impact	Trust leadership and managers need to be visible and approachable throughout the organisation. They need to coach and support employees helping remove barriers that get in the way of teams doing their jobs. Trust leadership and management need to support a culture, particularly with clinical teams, of partnership working based on trust, engagement and involvement.
Key Controls	A range of accredited leadership development programmes including ILM A range of accredited coaching programmes with coaches available for staff to access and a coaching skills programme Clinical Leadership programme in place
Sources of Assurance	Internal Audit-Job planning audit

Performance Monitoring	Annual staff survey includes numerous questions relating to management and leadership. It is reported to Workforce Advisory Group and Trust Board.
Gaps in Control	Lower than national average for staff scores to questions: "My immediate manager encourages those who work for her/him to work as a team", "My immediate manager can be counted on to help me with a difficult task at work", "I know who the senior managers are here", "Communication between senior management and staff is effective", "Senior managers where I work are committed to patient care"
Gaps in Assurance	

Current Risk Level   Moderate   Almost certain   15   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop aspirant leaders development programme	Denise Harnin Director of HR & OD	15/03/2016	Aspiring ward manager programme in place for Band 6 nurses. Further development of leadership programmes including Band 7 staff by end Dec 2015. Due date updated follow meeting with Lisa Miruszenko. Update Dec 2015: Programme drafted and with DCNO. Initial plan will be completed by mid-March 2016. March 2016 update: programme drafted. Improvement Director scoping nursing leadership requirements.	
Implement Organisational Development Strategy	Denise Harnin Director of HR & OD	31/12/2016		
Development of clinical leadership programme	Denise Harnin Director of HR & OD	30/09/2015	Clinical leadership programme in place, LET C funded, with nine staff accepted onto programme.	24/09/2015
Create HR strategy for learning and development, including leadership for senior management	Denise Harnin Director of HR & OD	15/02/2016	Overdue, due date updated to align with OD Strategy Development (December 2015). Update Dec 2015: Organisational Development strategy developed and presently with Executives for review. Propose new date mid-February 2016. Update March 2016: Organisation Development Strategy re-written and presented to WAG 21/03/2016 and at Trust Board Development day 23/03/2016. Action closed.	24/03/2016

Target Risk Level   Moderate   Possible   9   Low

Progress	Staff survey underway, awaiting further results regarding support and reliability of management. Update Jan 2016: A bid is being developed to access special measures money to take this forward.

Next Review Date   06/04/2016

BAF Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience**
Date opened	18/05/2015
Strategic goal	Design healthcare around the needs of our patients, with our partners
Strategic objective(s)	Provide excellent patient experience
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Nursing Officer / Patient & Carer Experience Group
Description/Impact	One of the most important aspects of monitoring complaints is to ensure that the Trust learns from complaints received and takes action to ensure that the situation that led to the complaint is not repeated. If we do not adequately understand & learn from complaints and patient feedback we will be unable to deliver and demonstrate excellent patient experience.
Key Controls	Complaints & PALS policy and procedure Ace With Pace customer service training Training for Healthcare Assistants in patient experience Patient experience incorporated into preceptorship for newly qualitfied nurses Patient and Public Forum ward visits and action plans Established system for recording compliments Patient experience dashboard provided routinely to divisions 'How was it for you' sessions with Chief Nursing Officer Ace With Pace customer service training
Sources of Assurance	Internal reports to the Board-Patient and Public Forum ward visits and action plans Care Quality Commission-Care Quality Commission (CQC) inspection Review-External-Parliamentary and Health Service Ombudsman Management Assurance-Quality Review Visits and mock inspections Management Assurance-Divisional Quality Governance Teams

Performance Monitoring	Numerous performance indicators, including: - Complaints numbers, response times & themes - Friends and Family test - National inpatients survey - CQC survey - Hospedia - Carer Feedback Survey - Cleanliness polls - PPF action plans - PALS reports - NHS Choices/Patient Opinion
Gaps in Control	Patient experience data spread across numerous surveys and reports and therefore themes may be difficult to identify No standardised method of disseminating learnings from feedback, innovations or good practices Improvements from complaints not tracked centrally
Gaps in Assurance	Planned actions provided by divisions in response to complaints sometimes unclear or unsubstantiated

Current Risk Level   Moderate   Likely   12   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop a Quality Newsletter to disseminate learnings	Chris Rawlings Head of Clinical Governance & Risk Management	30/06/2015	First newsletter disseminated.	30/06/2015
Develop Patient Experience reports and dashboards to bring together various sources of data, identify themes and target areas	Tessa Mitchell Associate Director of Patient Experience	31/07/2015	Patient Experience Dashboard implemented. Measures to be incorporated into Trust Dashboard.	31/07/2015
Develop method for recording improvements from complaints	Tessa Mitchell Associate Director of Patient Experience	31/10/2015	TDA patient experience assessment framework completed June 2015. CQC inspection identified need for improved Datix usage across Trust. 5/11/2015 Internal Audit has also highlighted this gap. New complaints template implemented Trustwide in January 2016 with briefings for staff. Quarterly audits by Divisions will commence in March 16. A new DATIX complaints report is now live and accessible by Divisions.	31/10/2015

BAF Risk Report

Deliver Trust component of Learning Disabilities Strategy	Rani Virk Lead Nurse for Quality & Patient Experience	31/12/2015	Regular attendance at Worcestershire Learning DIsabilities Partnership Board. Lead Nurse for Quality & Patient Experience working with Learning Disabilities team. Positive confirm and challenge visit in July 2015.	31/12/2015
Implement new complaints investigation template across Trust following pilot	Tessa Mitchell Associate Director of Patient Experience	15/02/2016	rolled out Trust wide in January with staff briefing	02/02/2016
Meet with NED's to review presentation of patient experience data	Tessa Mitchell Associate Director of Patient Experience	26/02/2016	PE Event held 1.2.16 to review current position and data and set priorities to improve patient experience moving forward.	02/02/2016
Improve presentation and triangulation of data - collaboration between Patient Experience and Information Teams	Tessa Mitchell Associate Director of Patient Experience	31/01/2016	New FFT script has been completed and going live in February. New Complaints DATIX Report now available to all via DATIX reports system. Further development and tweaking taking place. Regular meetings with Informatics and PE managers.	02/02/2016
Develop method for disseminating learnings from complaints and patient experience data	Tessa Mitchell Associate Director of Patient Experience	15/03/2016	Reviewing areas for improvement and ensuring these are captured in action plans. Update Dec 2015: Actions to be taken following complaints being added to Datix. New Datix report template set up by Information Team. update Jan 2016: New Monthly Complaints update to go on weekly Brief from February. Looking at format used by other hospitals. PE Event 1.2.16 helped set scene and establish priorities going forward. New PE Lead starts in March. Regular Complaints & PALS and Patient Experience Newsletters introduced Feb 16. These promote info, activities and share learning.	03/03/2016

Target Risk Level	Major	Unlikely	8	Low

| Progress | The establishment of the Patient Relations team brought together Complaints, PALS and patient experience staff under one Associate Director in January 2015.

The objectives of the 2013-17 Patient, Public and Carer Experience Strategy aim for clearer accountability, focussed support to our Divisions and to reflect our commitment to ensuring that public, patient and carer voices remain central to our healthcare services.

Significant improvements have been made to our complaint handling processes during the last year and the revised template will fill many of the process gaps identified in our recent internal audit.

Liaison with informatics are improving data presentation and understanding. Ward Dash Boards will greatly assist.

Update Jan 2016: Trust Board downgraded risk to moderate |
|---|---|

Next Review Date   06/04/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2902 If the Trust does not achieve safety targets, it will fail to improve clinical care and reduce avoidable harm to expected levels**
Date opened	21/05/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Major　　　Likely　　　16　　　High

Director/Committee	Chief Medical Officer / Safe Patient Group
Description/Impact	The Trust is committed to developing and sustaining safe services. It is creating a Sign up to Safety campaign which includes work to: - Reduce harm from medicines incidents - Improve outcomes and experience for patients with #NOF - Improve mortality review processes If these and other safety priorities are not successfully implemented, patients may experience preventable harm, resulting in morbidity and mortality, increased length of stay, complaints and legal claims.
Key Controls	Policies and procedures for patient safety, eg Incident Reporting and Investigation Policies Corporate Clinical Governance Team and Divisional Quality Teams to support implementation Routine monitoring and assurance processes for safety and quality indicators Clinical Governance committee structure and review and challenge of metrics, for review of patient safety issues Incident reporting and monitoring system Communication of safety issues via induction, divisional meetings, daily brief, safety newsletter Mortality review process established Single weekly Operational Governance meeting to coordinate patient safety forums Corporate Clinical Governance Team and Divisional Quality Teams to support implementation
Sources of Assurance	Management Assurance-Quality Review Visits Management Assurance-Quality Governance Committee Structure and reports on key subjects from committees Internal Audit-Internal audit of Risk Management and Serious Incident processes Care Quality Commission-CQC inspections Management Assurance-Progress against various safety initiatives captured in Patient Care Improvement Plan (PCIP)
Performance Monitoring	Numerous safety indicators reported in Trust Board Performance Dashboard monthly: - Incidents & Never Events by category (QSIN1-6) - Mortality (QSM1) - Safety Thermometer (QSST1) - VTE (QSVT1) - Hip Fractures – Time to Theatre within 36 hours (QEF3.1) - Infection Control (QSIC1-5) Review of Divisional Quality KPIs Divisional performance reviews
Gaps in Control	Trust-wide mechanisms for feedback of the outcome of incident investigations to individuals Mortality review process requires embedding Patient Safety work needs to be more proactive
Gaps in Assurance	Consistent review of safety and quality performance review down to directorate and department level

Current Risk Level　　　Major　　　Likely　　　16　　　High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Launch safety culture campaign with highlighted themes	Lisa Thomson Director of Communications	17/06/2016		
Actions regarding improvement in patient safety and mortality review are contained within the Trust Improvement Programme (prev. PCIP)	Chris Rawlings Head of Clinical Governance & Risk Management	31/12/2016		
Improve feedback mechanisms on quality matters to staff - Quality newsletter	Chris Rawlings Head of Clinical Governance & Risk Management	30/06/2015	First newsletter produced and published- Quarterly publication scheduled. Datix system now sending automated emails at closure of incidents.	02/07/2015
Embed Signup to Safety plan actions into the Patient Care Improvement Plan (PCIP)	Sarah Smith Director of Strategy, Planning and Improvement	15/01/2016	This has been completed	01/12/2015

BAF Risk Report

Create a signup to safety implementation plan with associated resources	Steve Graystone AMD Patient Safety	30/09/2015	Signup to Safety plan andorsed at Safe Patient Group 4th December 2015.	11/12/2015
Review performance management framework	Sarah Smith Director of Strategy, Planning and Improvement	31/01/2016	Review of Integrated Performance Report underway by Information Team. Due date updated to 31 December 2015. December 2015 update: Review of performance management framework being presented to Trust Board January 2016. February 2016 update: Now working to new framework	31/01/2016
CMO and CNO to identify how Signup to Safety will be implemented in context of Governance Review and new responsibilities	Andy Phillips Interim Chief Medical Officer	15/02/2016	Incorporated into existing PCIP work streams and as necessarypatient safety workstreams.	12/02/2016

Target Risk Level	Major	Possible	12	Moderate

Progress	The second draft of the Sign up to Safety Plan has been produced and is being mapped to the PCIP to identify factors already included and any gaps. December 2015 - Additional actions related to this risk are recorded in the PCIP so are not duplicated here. The mortality review process has improved and returns increasing following changes that provide patient health records to consultants earlier. The new weekly Governance Operational Meeting will commence on 15th january and include mortality 3x per month. Sign-up-to-safety plan is included within the PCIP Communication strategy for feedback of learning will be developed during January. Brainstorming meeting on sharing / feedback from learning held in February.

Next Review Date   06/04/2016

BAF Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2904 If there is inadequate culture and staff development for improvement, the Trust will not be able to continuously improve**
Date opened	26/05/2015
Strategic goal	Develop and sustain our business
Strategic objective(s)	Get better every day
Initial Risk Level	Major Possible `12` Moderate

Director/Committee	Director of Human Resources / Trust Management Committee
Description/Impact	If there is insufficient culture and capability for improvement, the Trust will not be able to continuously improve. Key clinical and non-clinical staff need to be supported with training and tools to enable innovation and improvement. In order to achieve the objective Get better every day, the Trust needs to create a 'can-do' culture.
Key Controls	Training delivered by Transformation team to project teams, including: 5S, Improvement Methodology and Six Sigma, Change Agent, Measurement for Improvement by Transformation team Training in principles of customer service and communication by Organisation Development Suite of training in aspects of quality and safety by Clinical Governance
Sources of Assurance	Management Assurance-Transformation project reporting processes Management Assurance-Complaints and patient feedback reporting Management Assurance-Quality and safety reporting via clinical governance structures and processes

Performance Monitoring	Trust performance monitoring dashboard Annual Staff Survey regarding culture, and management responsiveness to change and improvement
Gaps in Control	Interventions to improve the culture of improvement
Gaps in Assurance	

Current Risk Level   Major   Possible   `12`   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Implement OD and engagement improvement plan	Denise Harnin Director of HR & OD	31/12/2016		
Review current suite of training to ensure it includes general improvement methodology and behaviours for improvement	Sarah Smith Director of Strategy, Planning and Improvement	31/07/2015	Ann Hill has produced a section on the Organisational Development Plan which was endorsed by WAG in August.	31/08/2015
Development of the three year Organisational Development Program to support staff by providing the right conditions for innovation and creative thinking	Denise Harnin Director of HR & OD	15/03/2016	Draft presented to TMC. Update Dec 2015: Draft Programme with Executives for review. Propose new due date mid-March 2016. Update Feb 2016: the ODP is captured in the PCIP Update Mar 2016: the Organisational Development and engagement plan agreed by the Improvement Board in March 2016. Action closed	24/03/2016

Target Risk Level   Major   Unlikely   `8`   Low

Progress	

Next Review Date   06/04/2016

BAF Risk Report

Risk	**2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services**
Date opened	09/06/2015
Strategic goal	Invest and realise the full potential of our staff to provide personalised and compassionate care
Strategic objective(s)	Develop and support staff
Initial Risk Level	Major Likely **16** High

Director/Committee	Chief Executive / Remuneration Committee
Description/Impact	Worcestershire Acute Hospitals NHS Trust has entered a challenging period in its history, requiring a financial and operational turnaround, the plans for which last at least three years. This is against a background of substantial capacity issues in the county, recruitment difficulties and uncertainty over the Future of Acute Hospitals in Worcestershire reconfiguration. Continuing to have a strong and stable Board is essential to meet these challenges. At present the Trust Board consist of six Non-Executive Directors (NEDs) including the chair, one Associate NED, five voting Executive Directors including the Chief Executive, and two non-voting Executive Directors. The terms of office of all the NEDs are due to expire in 2016. Of particular concern is the fact that the Chair leaves the Trust in March 2016, with four other NED Terms ending in December 2016. This creates a business continuity risk for the governance of the organisation. Furthermore since April 2015, four of the voting Executive Directors are on leave or have resigned, leaving interims in these posts (see also risk 2932) and an Acting Chief Executive. This places an extra pressure on the NED members of the Board to maintain continuity. The requirements of Non-Executive Directors in terms of knowledge skills and experience are high, especially in this context. There is a particular need to ensure the appointment of individuals with a full range of abilities including financial experience, strategy, and communications along with an understanding of the pressures on NHS Trusts. The number of candidates meeting these requirements and with links to the area may be challenging. This could potentially lead to either delays in recruitment and subsequent challenge achieving quorum, or appointment of individual(s) who have less experience in the role. There is a risk that the newly appointed NEDs may take some time to acclimatise and gather an understanding of the organisation before reaching the level of effectiveness required. Other Trusts have approached this issue by staggering the expiry dates of Board Members' terms of office, reducing disruption and ensuring the Board is strong and corporate memory and continuity are maintained. The Trust has proposed this to the TDA who are responsible for the appointments, however this has not been accepted. The TDA have stated that they will now only appoint for two year periods. Furthermore, as a result of the absence of several Executive Directors, four Executive posts are interim. Therefore business continuity may be affected, resulting from handover issues, and loss of corporate memory. There is a risk that this and further absences could impair the Trust's ability to operate services.
Key Controls	All posts currently filled with suitably qualified acting or interim staff Clear deputizing arrangements in operation, and or swift action to bring in interim support where required PA support ensuring inboxes monitored and directed to interim/acting staff Named roles covered by temporary arrangements to ensure statutory responsibilities are covered, eg key roles of responsible officer covered by CMO, Caldicott Guardian and Controlled Drugs Officer covered by AMD Continuity provided by Trust operational and governance committees through minutes, action logs, project plans etc. Staff notified of changes via Chief Executive's Team Brief and daily notices, meetings etc. Non-Executive Director induction process & Trust Board Development Days NED position descriptions and selection criteria and appraisals conducted by Chairman
Sources of Assurance	Management Assurance-Acting Chief Executive ensuring and reviewing business continuity through the Exective Management Team (EMT) Management Assurance-Confirmed at Trust Board through TDA self-certification

Performance Monitoring	Achievement of financial turnaround. Achievement of various performance targets.
Gaps in Control	Potential for gaps where not covered by above controls If further absences occur this could significantly worsen the situation Trust Board appointment process governed by the TDA
Gaps in Assurance	The Trust is not presently aware of the TDA's plans for NED appointment in 2016

Current Risk Level	Major Almost certain **20** High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Constant review of interim posts is taking place between the CEO and Chair	Chris Tidman Acting Chief Executive	15/04/2016	Chief Nursing Officer and Director of Finance posts advertised.	
Develop a NED recruitment programme	John Burbeck Interim board chair	15/07/2016		

BAF Risk Report

Appoint interim Finance Director	Chris Tidman Acting Chief Executive	31/07/2015	Interim Finance Director appointed	30/06/2015
Develop channels of communication with staff regarding leadership arrangements	Chris Tidman Acting Chief Executive	31/07/2015	Work underway with the Communications team to ensure all changes/updates are communicated with staff. Review modes of communication such as Team Brief, Daily Brief, intranet pages, noticeboards etc. The Big Conversation initiative has been launched in the trust.	30/09/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	

Next Review Date   06/04/2016

BAF Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care**
Date opened	12/10/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care

Initial Risk Level   Major   Likely   16   High

Director/Committee	Chief Nursing Officer / Trust Management Committee
Description/Impact	The report from the July 2015 announced CIH inspection was released in December 2015. The report rated the Trust as Inadequate overall, and the Trust has subsequently been placed in special measures. If the Trust does not respond to the concerns highlighted by the CIH inspection 2015 and does not continue to seek assurance of compliance with fundamental standards the Trust will fail to improve patient care and receive continued scrutiny from CQC adversely affecting reputation.
Key Controls	Policies covering the Trust's quality and business activities, monitoring these and taking action to improve compliance Clinical Governance structures and processes Divisional Quality Governance meetings, reporting to QGC Quality Review Visits Clinical Audit Incident management processes and monitoring Action plan part of PCIP and reported to QGC
Sources of Assurance	Self-assessment against standards-Quality Review Visits Review-External-CQC Intelligent Monitoring Report (IMR) Internal Audit-Review of CQC related processes

Performance Monitoring	Dashboards in development which will be presented in CQC domains
Gaps in Control	Not all corporate processes are subject to an assessment of compliance with the standards Ability to review performance in context of domains
Gaps in Assurance	

Current Risk Level   Major   Likely   16   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Implement changes outlined in the review of quality	Chris Rawlings Head of Clinical Governance & Risk Management	13/05/2016	Associate Director post being advertised in December 2015. Structural changes will be implmented when this post commences. Initial review of committees completed, more detailed review of aims and objectives, chairmanship, membership and reporting commenced.	
Ensure that the "must do's" contained within the Final Report are acted on.	Lisa Miruszenko Deputy Chief Nursing Officer	30/06/2016	The PCIP has been populated with the "Must Do's" from the Final report. All "Should Do's" have been reviewed and those identified as good practice for the organisation have also been moved across into the PCIP reports. The remainder have been cascaded to the divisions who have developed action plans that are being monitored through the Divisional Quality Meetings. Progress against the PCIP, which is currently being underpinned with updated project documentation, is being monitored through the Improvement Board (Est 9th March 2016).	
Conduct mapping of existing ward performance measures against CQC domains	Heather Webb Healthcare Standards Lead	31/12/2015	This has been completed as part of the development of the ward quality dashboard.	02/11/2015
Review of quality governance structures and processes	Chris Rawlings Head of Clinical Governance & Risk Management	30/11/2015	Review undertaken and report endorsed by QGC in October 2015.	30/11/2015
Review Quality Review Visits process	Lisa Miruszenko Deputy Chief Nursing Officer	31/01/2016	Meeting to progress this action planned for 15th December 2015. Update Jan 2016: First new format Quality Review Visit scheduled for 11th February 2016 and will be conducted monthly thereafter.	01/02/2016

Target Risk Level   Major   Unlikely   8   Low

Worcestershire **NHS**
Acute Hospitals NHS Trust

Progress	Short-listing of Deputy Director post has taken place. Must do's and selected should do's are incorporated into the PCIP, which is being monitored by the Improvement Board. Quality Review Visits are being used to test assumptions and provide assurance that improvments are being sustained. Risk areas are being communicated to Quality Champions so that they can cascade good practice and other messages throughout the Trust. Hot Topics are being developed to facilitate communication of key messages throughout the Trust.

Next Review Date   06/04/2016

BAF Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected**
Date opened	18/01/2016
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services

Initial Risk Level	Moderate	Likely	12	Moderate

Director/Committee	Chief Executive /
Description/Impact	Media interest, external reports and delays in reconfiguration all have the potential to damage Trust reputation. If these and other issues are not proactively managed commissioners may look to other organisations to provide services; political interference may inhibit and slow critical decisions required to deliver the Trust's plans; and requests for funding and to be part of any national initiatives would be restricted. All of this could lead to a lack of confidence from patients and difficulties with recruitment if the Trust is seen to be a less desirable place to work or be treated. It will also adversely affect the ability to raise funds and support for fundraising activities.
Key Controls	Director of Communications & Communications Team Communications strategy for handling the publication of any reports about the Trust
Sources of Assurance	Review-External-TDA Communications team provide assurance regarding the communications strategy and approach

Performance Monitoring	Yearly stakeholder survey to be initiated. Media monitoring (including social media) to be put in place and reported
Gaps in Control	Social media under-utilised Relationships with stakeholders insufficiently formal
Gaps in Assurance	Insufficient information available regarding stakeholder views & opinions of the Trust

Current Risk Level	Moderate	Likely	12	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Create an integrated Communications Strategy	Lisa Thomson Director of Communications	15/04/2016	Staff engagement group formed. First meeting to take place in early March. National staff survey results known in March. Both of these will be used to inform the communications strategy.	
Conduct the first annual stakeholder survey	Lisa Thomson Director of Communications	16/05/2016	Survey drafted for consideration by the executive team	
Promote and develop staff and patient roles as advocates for the Trust to improve confidence amongst colleagues and the community	Lisa Thomson Director of Communications	15/06/2016	Staff engagement group formed. ToR for patient advocates under development.	
Implement Media Policy	Lisa Thomson Director of Communications	15/07/2016		
Implement Stakeholder Brief (for Commissioners, Council Leaders, MP's etc)	Lisa Thomson Director of Communications	15/02/2016	First brief distributed and programme of monthly briefs developed Brief used to communicate progress on FOASH externally. Internal weekly brief a team brief used as opportunities to update staff on progress on the FOASH programme. Update March 2016: first stakeholder brief distributed	24/03/2016
Increase utilisation of social media	Lisa Thomson Director of Communications	15/03/2016	Draft Media Policy produced and available. Submitted to WAG in February 2016 and now needs to be presented to the policy group. Update March 2016: media policy signed off, action closed.	24/03/2016

Target Risk Level	Minor	Unlikely	4	Very Low

Progress	

Next Review Date	06/04/2016

BAF Risk Report

Risk	**3193 If the Trust does not achieve patient access performance targets, there will be significant impact on finances**
Date opened	23/03/2016
Strategic goal	Ensure the Trust is financially viable and makes the best use of resources for our patients
Strategic objective(s)	Use resources wisely
Initial Risk Level	Major　　　　Likely　　　　16　　　High

Director/Committee	Chief Operating Officer / Finance and Performance Committee
Description/Impact	As part of the Sustainability and Transformation Plan (STP) process, approximately £14m of Trust income is dependent on delivery of the four main access standards, that is: - 4 hour Emergency Access Standard (EAS) - 18 week Referral to Treatment (RTT) standard - 62 days from urgent GP referral for suspected cancer to first treatment - Cancer diagnosis rates (one year survival) The amount of money provided is scaled depending on the degree to which these access targets are achieved. This will be challenged by a number of factors, including: changing terms and conditions for delivery of additional clinical activity; staffing; high occupancy levels; delayed transfer of care.
Key Controls	Weekly access meetings Additional activity through theatres Waiting list management Somerset Cancer Registry to monitor cancer waiting times & escalation reports Patient level tracker for all cancer standards Monthly review of capacity and utilisation at senior level across system Full capacity protocol Monitoring of patients >10 days LOS on a weekly basis
Sources of Assurance	Management Assurance-Plan and trajectory provided in regular reports at Finance & Performance Committee Management Assurance-Monthly performance review with divisional teams

Performance Monitoring	CAE1.1 % of patients waiting less than 4hrs in A&E PW4.0 Backlog > 18 weeks (Outpatients + Day Case + Elective Inpatients)
Gaps in Control	Demand management plan with commissioners Finalised workforce and recruitment contract for 2016 with commissioners Consultant workforce numbers
Gaps in Assurance	

Current Risk Level	Major	Likely	16	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Introduce outsourced support for imaging to enable a 24/7 service	David Burrell Divisional Director of Operations	16/05/2016		
Centralise pathology services to improve efficiency of diagnostics	David Burrell Divisional Director of Operations	15/06/2016		
Implement training and development for staff and a validation resource for RTT data	Inese Robotham Deputy COO	15/06/2016		
Urgent Care and Patient Flow Trust Improvement Programme contains the full action plan for this risk	Rab McEwan Chief Operating Officer	31/12/2016		

Target Risk Level	Moderate	Possible	9	Low

Progress	

Next Review Date	06/04/2016

Worcestershire **NHS**
Acute Hospitals NHS Trust

Corporate Risk Register Summary

March 2016

ID	Opened	Title	Executive Lead	Monitoring Committee	Rating (current)	Risk level (current)
1941	29/06/2010	Lack of available bed capacity may cause overcrowding in ED which can lead to suboptimal care & a poor patient experience	Chief Operating Officer	TMC	20	High
2664	22/04/2014	Insufficient out of hospital capacity to meet the needs of patients with on-going healthcare needs	Chief Operating Officer	TMC	20	High
2856	07/04/2015	Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury	director of Asset Mgt	TMC	20	High
3097	27/11/2015	If managers do not adhere to financial controls, there will be excess expenditure and financial recovery plan not met	Finance Director	Finance and Performance Committee	20	High
3041	16/10/2015	If the Trust does not increase efforts to save money, it may not realise the CIP target, worsening the financial position	Finance Director	Finance and Performance Committee	20	High
3078	23/11/2015	Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner	Chief Operating Officer	TMC	16	High
3079	23/11/2015	Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care	Chief Medical Officer	WAG	16	High
2908	28/05/2015	Use and release of information which is inaccurate, false or misleading resulting in reputational and legal damage	Director of Resources	Data Quality Group	16	High
2791	04/02/2015	If the Medicine Division is unable to sustain appropriate staffing levels it will be unable to provide safe patient care	Chief Operating Officer	FoAHSW QSS, TMC	16	High
2709	19/08/2014	Risk to critically ill patients having delayed admission to ITU due to lack of bed spaces (spaces occupied by wardable patients)	Chief Operating Officer	TMC	16	High
2711	29/08/2014	Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	Chief Nursing Officer	TMC, WAG	16	High
2649	11/04/2014	Workforce shortages affecting the consultant on-call rota for emergency surgery at AGH	Chief Operating Officer	FoAHSW QSS, TMC	16	High
2661	22/04/2014	Increased pressure in emergency demand may impact on the safety of patient care & failure to meet performance standards	Chief Operating Officer	TMC	16	High
2746	24/10/2014	If W&C Division are unable to sustain safe staffing levels it will be unable to provide safe patient care at all sites	Chief Medical Officer	FoAHSW QSS, TMC	16	High
2747	26/11/2014	Failure to prepare for serious new or emerging pathogens (eg Ebola, MERS) leading to exposure of public, patients and staff.	Chief Nursing Officer	EPRR, Trust Infection Prevention & Control Committee	16	High
2662	22/04/2014	Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT	Chief Operating Officer	TMC	15	Moderate
2736	13/10/2014	Lack of Section 12 approved doctors to act as Responsible Clinician prevents legal detentions under Mental Health Act	Chief Nursing Officer	TMC	15	Moderate
2396	15/01/2013	Poor quality clinical record keeping may lead to a variety of harms to patients and organisation	Chief Medical Officer	EPR Prog Board	15	Moderate
3018	15/09/2015	As a result of the care models on the Wyre Forest GP unit, medicines are not managed safely	Chief Operating Officer	Safe Patient Group	15	Moderate
3019	15/09/2015	As a result of the care models on Ward 1, medicines are not managed safely resulting in sub-optimal care	Chief Operating Officer	Safe Patient Group	15	Moderate
2994	03/08/2015	Failure to meet the NHS England Serious Incident Framework resulting in failure to learn and potential regulatory action	Chief Nursing Officer, Chief Medical Officer	Safe Patient Group	12	Moderate
2995	03/08/2015	If Patient Safety Incidents are not managed in a timely way there will be missed learning and preventable harm	Chief Nursing Officer	Safe Patient Group	12	Moderate
3044	21/10/2015	If the Trust does not manage CCG QIPPs the financial plan will not be realised	Finance Director	Finance and Performance Committee	12	Moderate
2774	15/01/2015	Failure to provide resilient IT infrastructure resulting in system unavailability which negativity impacts patient care	Director of Resources	TMC	12	Moderate
2857	07/04/2015	Failure to manage water system resulting in transmission of harmful pathogens to patients or staff	Chief Nursing Officer	Trust Infection Prevention & Control Committee	12	Moderate
2864	20/04/2015	Failure to follow pressure ulcer prevention procedures (risk assessments, position changes, correct equipment) resulting in harm	Chief Nursing Officer	Safe Patient Group	12	Moderate
2899	19/05/2015	Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, poor clinical outcomes	Chief Operating Officer	TMC	12	Moderate
2372	16/11/2012	Failure to address the causes of falls resulting in patient harm and financial penalties	Chief Nursing Officer	Safe Patient Group	12	Moderate
2462	19/04/2013	Failure to prevent MRSA bacteraemia due to lapse in care resulting in adverse patient outcomes and reputational damage	Chief Nursing Officer	Trust Infection Prevention & Control Committee	12	Moderate
2463	22/04/2013	Failure to reduce number of preventable cases of C.difficile due to lapses in care, resulting in adverse patient outcomes	Chief Nursing Officer	Trust Infection Prevention & Control Committee	12	Moderate
2464	22/04/2013	Norovirus outbreaks resulting in adverse patient outcome and impact on patient flow	Chief Nursing Officer	Trust Infection Prevention & Control Committee	12	Moderate
2663	22/04/2014	If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets.	Chief Operating Officer	Cancer Board, TMC	12	Moderate
2461	18/04/2013	Problems with the functionality, reliability and timeliness of eznotes system, negatively impacting patient care	Chief Executive	EPR Prog Board	9	Low
2565	02/09/2013	Delay or failure to act upon clinical diagnostic test results leading to patient harm	Chief Medical Officer	Safe Patient Group	9	Low
2957	30/06/2015	Breaching hygiene code due to inadequate or ineffective assurance around environmental cleaning	Chief Nursing Officer	Trust Infection Prevention & Control Committee	9	Low
2732	07/10/2014	If the Trust does not adequately prepare for emergencies, there may be an uncoordinated response and subsequent adverse events	Chief Operating Officer	EPRR	8	Low

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**1941 Lack of available bed capacity may cause overcrowding in ED which can lead to suboptimal care & a poor patient experience**
Date opened	29/06/2010
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services

Initial Risk Level	Major	Almost certain	20	High

Director/Committee	Chief Operating Officer /
Description/Impact	If there is insufficient bed capacity at times of high Emergency Department (ED) demand, the ED becomes overcrowded, patient flow is adversely affected and patients are nursed in inappropriate areas such as corridors. In the corridors there is a lack of privacy, no call buttons or suction which results in poor patient experience, increased clinical risks and stress for staff whilst working in these conditions. Patients have to be continually moved to be seen and be treated making it difficult to keep track of where patients are physically located together with their notes. The overcrowding also means that the Trust cannot meet the 95% target for 4 hour waits or ambulance handover times for which the trust is fined. This situation is resulting in increased complaints and incidents.
Key Controls	Escalation Policy when the department reaches capacity Additional equipment PCIP/UrCOT for monitoring and service improvement plan in place Corridor Policy Additional corridor nursing staff to manage patients Use of rapid triage where nursing staffing numbers allow GP's working in ED at WRH Use of Locum doctors to fill gaps in rota Additional equipment Joint statement management of patients in the corridor/cohorting patients by WMAS and WAHT Full Capacity protocol
Sources of Assurance	External Audit-CCG have undertaken an audit of the GP function Management Assurance-Monitored monthy through UrCOT Management Assurance-Monitored through PCIP

Performance Monitoring	EAS targets ED harm reviews 15 minute triage validation
Gaps in Control	Availability of Agency staff to fill shifts for both the transfer team and corridor GP gaps in rota Clinical staff vacancies/ middle grade cover/use of locums and risks associated Varying skill mix with regard to GP's Ability to fill locum shifts for Doctors and last minute sickness Lack of beds/patient flow within the trust thus restricting flow out of the A&E department
Gaps in Assurance	

Current Risk Level	Major	Almost certain	20	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Delivery of Workforce Plan for Medical and Nursing Staff at WRH in preparation for expansion to ED	Randeep Kular Deputy Director of Operations	08/04/2016	Business case for nursing establishment has been submitted to the executives and is awaiting approval. The medical workforce plan is currently being written New weekly operational group set up led by Sarah Smith and Randeep to put in place operational plans associated with the ED expansion. Includes workforce and equipment issues	
Monitoring of improvement programme for patient flow.	Randeep Kular Deputy Director of Operations	08/04/2016	Monitoring of programme to improve patient flow is being undertaken by SRG (system resilience group for urgent care) This includes external agencies who have been allocated actions to deliver. Internally the new UrCOT group are responsible for an urgent care and patient flow improvement plan. PCIP (patient care improvement plan) is where progress on the actions to improve urgent care and patient flow is tracked. Delayed transfers of care numbers have reduced in line with SRG requirements. On going work with ECIP team continues to focus on multidisciplinary accelerated discharge process.	

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Expansion of ED and improve patient flow	Randeep Kular Deputy Director of Operations	22/04/2016	Business case and building plan was produced and submitted to the TDA to request funding for expansion of ED. Capital support application was submitted which was supported in AUG 15. Progress is being monitored through UrCOT work stream and ED expansion group. The work programme includes best practice ward rounds workstream to assist with early discharges and improve patient flow and enhance patient experience. Meetings with all ward managers at AGH and WRH have been led by the CNO to ensure the roll out of best practice ward rounds. Further work around a discharge lounge with increased capacity has begun and will also suppport improvements to patient flow 24/9/15 Delays to progress due to factors outside of the Trust's control. Expected by Dec 15.Expected delivery date Now Feb 2016 4/12/11 expansion work has commenced; completion expected March 2016 Due to slippage in ground work the proposed opening dates is now May 2016. Operational and planning meetings have been commenced on weekly basis.	
Extra equipment purchased for ED	Clare Bush Senior Sister/Department Manager	20/05/2014	All equipment now received in the ED	04/06/2014
UCIP plan in place	Paul Bytheway General Manager		Actions are progressing - progress reports are submitted to EAST on a monthly basis	25/06/2014
Deliver frality unit summer 2014	Caroline Lister Directorate Manager		Frailty Unit - now named 'Silver' is established with clinical leadership provided by Elderly Care. AMU have dedicated nurse leader (Donna Kruckow) and the unit on AMU reconfigured to provide a higher standard of care.	20/09/2014
Daily review of nursing staff in order to plan additional nursing staff for corridor	Clare Bush Senior Sister/Department Manager		All shifts escalated. Do not always fill. Matron/band 7 nurses work in numbers. Some training has been cancelled early 2014	30/09/2014
New Departmental escalation policy for ED in progress	Clare Bush Senior Sister/Department Manager		Edited and now completed and approved via EAST	30/09/2014
Additional Capacity Summer 2014	Paul Bytheway General Manager		Additional capcity was opened as and when required on Avon 5	10/10/2014
Workforce plan agreed for Nursing	Clare Bush Senior Sister/Department Manager	04/05/2015	The Workforce plan was completed and presented to EAST. This is now being refined and updated to include immediate requirements. This will be represented on 22/10/14 for agreement at relevant committee as agreed by Ann Carey;. Workforce plan has been agreed and recruitment process has begun 16/12/14	25/05/2015
Winter capacity plans	David Allison Directorate Manager		Report completed. Awaiting approval through governance route.	30/06/2015
Implementation of Urgent Care Centre at Alex	Michael Dobb Operations Manager		Fully functional project steering group in place with all supporting processes, such as risk log, action plan, leadership etc. This led by the CCG. All actions are on track.	30/06/2015
Implementation of Urgent Care Centre at WRH	Stuart Cannonier Directorate Manager for Medicine	31/07/2015	GP's now working in ED at WRH. A rota is in place	30/06/2015
Focus on workforce model for AMU	James Young Consultant - Diabetes and Endocrinology	31/08/2015	A 5 day rota has now been agreed. The 7 day AEC and Acute recruitment plan will incorporate how we move towards 7 day service. This is currently being worked through.	24/09/2015

Target Risk Level	Major	Unlikely	8	Low

Corporate Risk Report

Progress	Current bed remodelling planning underway within the acute trust this will look to repatriate a larger bed base to the medicine take which will realign the medicine demand for ED. Currently the medicine division are working on an AEC plan which will look to reduce attendances through ED, thus reducing the footfall into ED and reduce the number of patients admitted to the hospital. this will help with patient flow.

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2372 Failure to address the causes of falls resulting in patient harm and financial penalties**
Date opened	16/11/2012
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services

Initial Risk Level	Major	Possible	12	Moderate

Director/Committee	Chief Nursing Officer /
Description/Impact	Failure to address the causes of falls to prevent and reduce the risks to inpatients falling in hospital can result in levels of harm ranging from minor to catastrophic.
Key Controls	Patient Slips, Trips and Falls Policy (Management arrangements & description of individual controls) Falls Risk Assessment - tool and practice Care plans (triggered by the risk assessment findings) Visual aids for identifying patients at risk to staff e.g. orange wristbands Therapeutic guideline - access to special care arrangements Equipment - high/low beds, STEDY frames, walking aids, bed rails & guidance Patient information - to enable patients to be involved in preventing falls Staff training - FallSafe basic falls prevention and reduction training and RCP e-learning module Falls Risk Assessment - tool and practice 48 post -fall reviews following all falls resulting in harm Environmental Assessments of known high risk areas e.g. bathrooms/toilets Serious Incident Reviews and action plan development following all falls with harm
Sources of Assurance	Internal Audit- Success measures monitoring - monthly audits Standards-Falls monitoring via the Quality Dashboard. Standards-CQUIN target monitoring. Peer Review-RCP Falls Audit Review-Internal-Monitoring of care bundle implementation and audits via falls steering group Peer Review-Serious Incidents revewed by Falls Steering Group

Performance Monitoring	Falls incident data.CQUIN Date collection.
Gaps in Control	Defined leadership in respect of medical staff involvement in the wider falls agenda. Pre and post falls assessments not routinely undertaken Failure to complete all required documentation/assessments in a timely manner Not all in- patient areas are dementia friendly environments Gaps in monitoring and apprpriate falls prevention intervention for patients with delirium
Gaps in Assurance	Lack of information available in respect of the environmental audits that should be performed in each clinical area annually. The Falls Datix proforma is not always fully completed (gap in staff knowledge). Documentation not always completed SI Investigations not always completed in a timely manner

Current Risk Level	Major	Possible	12	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Development of an e-learning module for medical staff.	Martina Morris Lead Nurse for Safer Care	31/07/2013	Development completed on the 20.08.2013 and there is a meeting planned for September with Mark Wake to discuss the implementation.	21/08/2013
Rapid spread programme - commenced in November 2012	Martina Morris Lead Nurse for Safer Care	30/08/2013	Programme commenced on 2nd November. Weekly delivery group meetings in place to implement the action plan.23.04.13 - the programme continues and a number of measures have been implemented to reduce the incidence of adult inpatient falls. Weekly success measure audits continue as well as spot check audits. Education and training of staff continues.21.08.2013 - the programme has been implemented and the implementation is being monitored.	21/08/2013
Reducing number of in-patient falls	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	31/01/2014	Monthly sucess measure audits in place. Red toilet seats being introduced as part of improving bathroom environments.Environmental audits of bathrrooms carried out and template for improvment developed	27/08/2014
To improve documentation pre and post falls	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	01/12/2014	Documentation has been reviewed and is currently being piloted. Planned 'go live date December 1st 2014. Each SI reviewed for compliance and monthly falls audits monitor compliance.	16/01/2015

Corporate Risk Report

Trust wide falls action plan for reduction in falls and falls with harm	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	31/12/2015	The action plan is reviewed monthly by Falls Steering Group	30/04/2015
Establish a Patient harm component to the new Trust Operational Governance Meetings	Mari Gay Interim Chief Nursing Officer	15/02/2016	Patient harm section added to OGM workplan	15/02/2016

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	The total number of falls is reducing year on year: 2012/13 1742 falls, 2013/14 1640, 2014/15 1496. The number of falls with harm has significantly decreased from 2013/14 44 falls, 2014/15 24 falls with harm. The actions to further reduce falls are captured in the falls action plan. A county wide falls prevention and rediction pathway is being developed. tThe Falls Steering Group has now been incorporated into the Trust Harm Free Group who will oversee falls prevention and reduction

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2396 Poor quality clinical record keeping may lead to a variety of harms to patients and organisation**
Date opened	15/01/2013
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Catastrophic Possible **15** Moderate

Director/Committee	Chief Medical Officer / Electronic Patient Record Programme Board (HRC)
Description/Impact	Quality of clinical record is on occasion too poor to facilitate good quality care. Sometimes illegible, info missing or omitted. Potential causes are workload pressures, including interruptions. As a result staff may not complete the record to the standard required. This leads to a variety of potential harms to patients and organisation. Such as: error in care due to poor communication, harm to patients, reputation damage, possibility of receiving an Article 24 letter, litigation, failure of CQC outcomes, financial penalties, reduced income due to poor coding.
Key Controls	Clinical record keeping policy Clinical record keeping training as part of induction Improvement in data capture forms such as Comorbidity form Monthly clinical record keeping audit - feedback on performance to clinical teams Performance management of record keeping standards through Health record committee
Sources of Assurance	Clinical Audit-Monthly clinical record keeping audit

Performance Monitoring	Monthly record keeping audit - Quarterly reports reviewed at Clinical Health Records Committee
Gaps in Control	No robust monitoring of creation of action plan and implementation of action plan following audit No competency testing or manadatory training for clinical record keeping policy
Gaps in Assurance	Lack of improvement plan(s) following highlighting of gaps on annual audit

Current Risk Level   Catastrophic   Possible   **15**   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Review completion of record keeping e-learning	Steve Graystone AMD Patient Safety	30/03/2016	Update of league table requested from Sandra Berry Feb 2016	
Update clinical record keeping policy and re-launch	Steve Graystone AMD Patient Safety	31/03/2016	HW drafted, SG and SM updated. HW to submit to clinical leads prior to TMC approval.	
Introduce e-forms (direct entry) to eZnotes to address issues such as legibility, time and date.	Steve Graystone AMD Patient Safety	29/04/2016	In IT Workplan, currently at initiation stage.	
Results of clinical record keeping audit reviewed at HRC. Clinical teams not completing the audit have been instructed to complete within 3 months. Those with poor (<60% compliance) to devise actions and reaudit within 3 months.	Steve Graystone AMD Patient Safety	28/10/2013		31/10/2013
Introduce new health records audit methodology - monthly audit of smaller numbers with reports to Directorates	Steve Graystone AMD Patient Safety	31/10/2014	Audit method and tool developed. Divisional/Directorate audit to commence December 2014.	31/10/2014
Establish mechanism for raising issues to program board and feed back to Divisions	Steve Graystone AMD Patient Safety	30/04/2015	Monthly audit process piloted in Feb 2015 and found acceptable. Routine monthly audits commmenced April 2015 with quarterly reporting schedule to EPR programme Board	30/04/2015
Enhance monthly documentation audit to include clinical appropriateness	Rabia Imtiaz Consultant Obstetrician	29/02/2016	New questions added to documentation audit regarding content of notes.	29/02/2016

Target Risk Level   Catastrophic   Unlikely   **10**   Low

Progress	Review of action plans to improve performance scheduled on clinical HRC agenda. Completion will be monitored through this committee and exceptions reported to SPG.

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**2461 Problems with the functionality, reliability and timeliness of eznotes system, negatively impacting patient care**
Date opened	18/04/2013
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care

Initial Risk Level	Moderate	Likely	12	Moderate

Director/Committee	Chief Executive / Electronic Patient Record Programme Board (HRC)
Description/Impact	Viewing historical case notes is slower using eZ notes. Clinical staff not familiar with the new system and find it difficult to locate clinical documents. No prepping of paper case notes making clinical documents more difficult to locate. No colour scanning of documents that had been specifically placed in colour to make identification of specialty documents easier. New working practices not yet embedded, therefore administration staff making mistakes which affect identification of documents within the clinical viewer.
Key Controls	Training material revised and available to clinical staff Identify administration staff who are not yet following the new processes and complete further competency training Scan prep solutions in place pending smart indexing Some specialities have reduced capacity to ensure clinical staff have time to adequately review case notes Upgrades to improve speed, resilience and usability
Sources of Assurance	Internal reports to the Board-Incidences and recovery actions reviewed through reports to HCR committee

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level	Moderate	Possible	9	Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Provide mobile devices to anaesthetic team / consultants	Stuart Cooper Acute IT	02/02/2016	The Trial was completed following positive feedback, and national IDC funding, 400 ipads were purchased in March 2015 aswell as the mobile version of the casenote viewer. a project plan is being developed to roll out the ipads in 4 phases, the first phase 'Anaesthetic' roll out will be completed by July 2015. Dec update: Issue with Ipads has now been resolved with support from Supplier.Testing fix on the deployed (40) iPads pre-Christmas, all being well another 60 will be deployed on the interim MDM in January. Awaiting delivery of strategic MDM from ComputaCenter in January. Upon successful delivery, the 100 iPads already deployed will be reconfigured and additional iPads will be rolled out	
Clinical staff training	Stuart Cooper Acute IT	06/04/2016	The EPR Programme will work with divisional medical directaors and the executive team to agree the most appropriate training approach for our clinical staff so that they are competant in using our clinical systems to deliver patient care safely. HRC clinicians staff reported thier views on current training to the ICT training team leader. Awaiting response after training team have finished NHS mail roll out.	
Launch smart indexing enhancement	Stuart Cooper Acute IT	01/07/2016	Proof of concept approved by clinical staff. Project initiated. Configuration work started. Project plan drafted. Initial product testing due October 2014. Configuration and user testing March to July 2015. Planned implementation date August 2015. Dealys due to upgrade delays / DR plans.	
Monthly clinical review meetings to review progress and address issues.	Stewart Messer Chief Operating Officer	31/10/2013	Monthly meetings in place. These have been combined into the IT clinical user group meetings	03/08/2013

Corporate Risk Report

Review and improve prep of historical notes	Heather Warner Operational Manager	30/01/2014	Options identified. Options costed. Options approved / rejected. 1 option trialed. Awaiting implementation date when scanning re-commences. Awaiting indexing software demo with OCnsultants on 24th Sept before progressing. Proof of concept demo completed. Meeting w/c 25 Nov with consultants and Mark Wake to approve sign up to OCR indexing of historical notes.	03/10/2014
Review of eZnotes board membership	Jas Cartwright Head of Clinical Informatics	12/01/2015		02/03/2015
Re-establish focus groups for system users	Jas Cartwright Head of Clinical Informatics	31/03/2015	A Clinical Systems user group has been set that engages with clinicians across the trust to highlight issues/problems with existing systems which includes eZ Notes.	01/05/2015

Target Risk Level	Moderate	Possible	9	Low

Progress	Implementation of smart indexing project now likely to be January 2016

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**2462 Failure to prevent MRSA bacteraemia due to lapse in care resulting in adverse patient outcomes and reputational damage**
Date opened	19/04/2013
Strategic goal	
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Major Likely **16** High

Director/Committee	Chief Nursing Officer / Trust Infection Prevention & Control Committee
Description/Impact	Risk of breach of national zero tolerance of trust attributable MRSA bacteraemia; and risk of non payment for associated episode of care and reputational damage.
Key Controls	Protocols for blood culture sampling within Pathology Handbook Post Infection Review process in place Protocols for MRSA Screening of elective and non-elective admissions Use of DH Saving Lives Care Bundles for the prevention of device related infection Bespoke training for medical and nursing staff involved in sampling of blood cultures Peripheral Vascular Device documentation prompting twice daily phlebitis score assessment Blood culture sampling kit in use to promote best practice in sampling Peripheral vascular device insertion kit in use to promote best practice Post Infection Review process in place Training - MRSA screening, patient management, taught and e-learning modules and bespoke training for the prevention of device related infections Care pathway and documentation for management of MRSA patients Alert system to identify known MRSA patients on Patient Administration System
Sources of Assurance	Internal reports to the Board-MRSA BSI monitoring via Quality Dashboard Strategic Health Authority-DH Target monitoring - zero tolerance against background of 3 cases in 2013/14 Internal reports to the Board-Monitoring of BSI contamination rates against nationally expected rate of 3% Review-External-MRSA Screening compliance monitoring for elective and non-elective admissions Self-assessment against standards-Peer audit of compliance with DH Saving Lives Care Bundles for the prevention of device related infection Review-Internal-Post Infection Reveiw Process and implementation of lessons identifed.

Performance Monitoring	
Gaps in Control	OASIS alerting system not always used at ward level to identify known MRSA positive cases Clinicians failure to consult microbiological records for previous and current infection status Clinicians failure to recognise associated risks of BSI from MRSA colonisation Failure to recognise association between MRSA risk and underlying dermatological conditions e.g. Psoriasis Failure to follow process for blood culture sampling can lead to contaminant results which still count towards targets
Gaps in Assurance	

Current Risk Level   Major   Possible   **12**   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Work with information team to refine MRSA screening data	David Shakespeare Infection Control	29/04/2016	Work continues between IPC and information team with regard to screening in high risk areas. For 2015/16 this has increased compliance to 96.2%. Further meetings are scheduled with a specific agenda to include a review of the status of Hereford patients, a review of MAU and Severn Suit Short Stay patients and a review of exclusions. 07/03/16 Update subject to a breifing paper at TIPCC on the 10/03/16.	
Information team to remove day case procedures from MRSA screening to assess impact on overall figures	Hayley Wharton Information	31/05/2016		
Information team to review MRSA screening process	Hayley Wharton Information	31/05/2016	Process may involve review of IT system interfaces with respect to MRSA screening data; this may take some months to achieve. 22/03/2016 Paper recieved at TIPCC new method of calculation for high risk electives approved. Next step to replicate process for high risk non-elective. Information team now working on this.	
Develop more robust IPC structure to facilitate strategic working	Celina Eves Interim Deputy Chief Nursing Officer	31/10/2013	23/02/2014 New Associate CNO commenced in post 01/02/2014 Associate CNO post appointed - start date TBC	31/10/2013

Corporate Risk Report

MRSA Action Plan	Anne Dyas Consultant Microbiologist Alex	31/10/2013	Review bi-monthly at TIPCC Version 13 of action plan to TIPCC July 2013 Action completed	31/10/2013
F&F Group to review MRSA screening to meet target	Lindsey Webb Chief Nursing Officer	31/12/2013		07/10/2014
HCAI Action Plan to be implemented	Lindsey Webb Chief Nursing Officer	31/03/2014		21/11/2014
Review of Dept. Health (2014) 'Implementation of modified admission MRSA screening guidance', to determine Trust response.	David Shakespeare Infection Control	31/03/2015	Health economy meeting took place to discuss future direction for MRSA screening. The guidance allows for cessation of universal admission screening in favour of targeted screening for high risk procedures. The group included Consultant Microbiologists, Associate Chief Nurse Infection Control and CCG Infection Control Lead. The group decided to not deviate from current universal admission screening. This appears to be in line with neighbouring Trusts.	28/05/2015
Targeting high risk areas to improve and report compliance with MRSA screening	David Shakespeare Infection Control	31/07/2015	Compliance rates for high risk areas now reported to Quality Governance Committee. Further exclusions agreed.	20/08/2015
Identify patients in high risk areas since April 2015 who are showing as not having an MRSA screen and maually check whether they did or not	David Shakespeare Infection Control	25/02/2016	Information team have identified 68 patients under T&O and a further 132 patients who were admitted to Severn Suite and Ward 16, again to check if a screen was undertaken. This will help to identify information system issues as to why screens undertaken have not been captured.	26/02/2016
Seeking alternative assurance on compliance by matching specific OPCS codes with MRSA screens	David Shakespeare Infection Control	31/03/2016	29/10/15. OPCS codes for this purpose to be agreed. 10/12/15- Information Team reviewing the screening process for the high risk wards as defined in DOH 2014 MRSA screening guidance. The Information Team and MRSA screening co-ordinator are testing the accuracy of screening figures for 2 high risk areas, during December 2015, to ascertain if the patient record matches the published figures. 07/03/16 Now working towards high risk catergories as identified in national MRSA Screening guidance.	07/03/2016

Target Risk Level	Major	Possible	12	Moderate

Progress	Risk re-rated following case occurring in Feb 2015, and further work being undertaken to establish assurance around MRSA screening compliance.

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2463 Failure to reduce number of preventable cases of C.difficile due to lapses in care, resulting in adverse patient outcomes**
Date opened	22/04/2013
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Nursing Officer / Trust Infection Prevention & Control Committee
Description/Impact	NHS England have set an Clostridium difficile objective in 2015/16 of no more than 33 Trust attributable cases with potential financial penalty and reputation damage if avoidable cases exceed this trajectory. This will impact patient outcomes, experience and will impact length of stay and patient flow.
Key Controls	Protocol for management of Clostridium difficile infection and prevention of spread Diarrhoea and vomiting rapid risk assessment tool Prompts for when to send sample in poster and prompt questions on ICE laboratory requesting system All new cases of Clostridium difficile infection are reviewed by an IPC Nurse and ward /clinical staff advised on management Review (minimum weekly) of all inpatient Clostridium difficile infection cases by IPC Nurse and Consultant Microbiologist Weekly reminder to matrons and ward managers of location of all cases and need to audit clinical practices in relation to patient management C.difficile included in Ward and Divisional performance dashobards. Antibiotic stewardship programme including training for clinicians Diarrhoea and vomiting rapid risk assessment tool Red Amber Green (RAG) cleaning system Monit cleaning and environmental audits undertaken by Estates Team; and monthly IPC ward audits undertaken Antimicrobial Management Group in place
Sources of Assurance	Internal reports to the Board-Clostridium difficile monitoring via Quality Dashboards Strategic Health Authority-TDA monitor NHSE target Strategic Health Authority-Root Cause Analysis of all cases of trust attribuable Clostridium difficile infection (CDI) Internal Audit-Infection Control Team audit of clinical practices in management of CDI Internal reports to the Board-Reports to TIPCC on outcomes of RCA and antibiotic usage. Review-Internal-Review of all C. diff Toxin cases with clinicians at accountability meetings

Performance Monitoring	
Gaps in Control	Environmental constraints due to side room availability Medical review of patients with symptoms of diarrhoea - variable assessment Failure by ward staff and clinicians to use OASIS alert system to identify known CDI patients Capacity pressures may prevent use of optimum process (HPV) for total room decontamination Position at end of August 2015, will now be above trajectory for point in year with risk of not meeting trajectory at year end
Gaps in Assurance	Difficulty in consultant medical colleagues availability to attend accountability meetings - matron and nursing staff represented

Current Risk Level   Major   Possible   12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Review with clinical support division, director of pharmacy and consultant microbiologists the provision for antimicrobial stewardship	Richard Cattell Pharmacy	29/04/2016	TIPCC on 02/11/15 heard that the trust has no dedicated provision for an antimicrobial pharmacist, with associated risk of non-compliance with completion of stewardship audits as required by NICE guidance. Meeting proposed to discuss way forward. Meeting scheduled for 21st December 2015. 24/12/15 - First discussion meeting held Rachel Montgomery to discuss with Mari Gay next steps about provision. 26/02/16 - ACN IPC and Microbiologist (Dr Hugh Morton)have met with the new Director of Pharmacy who agrees that provision of an antimicrobial pharmacist is a key priority for the department and will investigate possible sources of funding. This would facilitate increased provision of information via antimicrobial prescribing audits.	
Revisions to C.difficile review process for 2016/17	David Shakespeare Infection Control	31/05/2016	ACN IPC is working with CCG IPC Lead to review process and terminology for reviewing and recording cases for 2016/17. This will have a focus on an identification of lapses of care and associated actions to remedy. A review is also required on how current IT configurations capture periods of increased incidence. 07/03/2016 - Paper to be recieved regarding 2016/17 process at TIPCC on 10/03/16.	

Corporate Risk Report

Revitalise trust arrangements for anti-microbial stewardship	Emma Yates Consultant Microbiologist	31/05/2016	Revitalised anti-microbial stewardship meetings have commenced. These will look at compliance with anti-microbial prescribing policy and make amendments where necessary. 24/12/15 - Further review of antimicrobial prescribing policy and guides to take place. For update at next TIPCC on 10th March, 2016. 22/03/2016 - Item discussed actions for TIPCC members to consider how antimicrobial pharmacist can be established.	
Clostridium difficile recovery plan	Chris Catchpole Consultant Microbiologist	30/09/2013	CDI Recovery Plan progress is reported monthly to TIPCC. Refer to plan. Action completed	31/10/2013
Refer to Infection Prevention and Control Team Objectives 2013/14	Chris Catchpole Consultant Microbiologist	31/03/2014	22/09/2013 - currently cases are within trajectory. Cases within trajectory at 2013/14 year end (40 against 48)	06/08/2014
Ensure long term availability of hydrogen peroxide decontamination while achieving best value for the Trust	David Shakespeare Infection Control	18/08/2014	Business case approved at TMG 21/05/14.	07/10/2014
Actions following preventable case identified in Aug 2014	David Shakespeare Infection Control	31/05/2015	Re-iteration of D&V risk assessment and isolation precations has been completed for Nursing and Medical staff.	28/11/2014
Review and revitalise CDiff accountability process	David Shakespeare Infection Control	30/09/2015	All accountability meetings currently up to date. As at 16/10/15, number of acute attributable C.Diff cases have reached 17. This is over the TDA trajectory of no more than 13 cases at this point in the year, however if the trajectory is divided equally across the year there should be no more than 16.5 cases at this time of the year. There remains a high likelihood that the Trust will exceed the agreed annual trajectory at the end of the financial year. 29/10/15. Process now referred to as "Clinical Case Review". Other minor changes to process include focus on matron accountability.	04/11/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	2015/16 target set by NHS England at no more than 33 hospital attributable cases

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2464 Norovirus outbreaks resulting in adverse patient outcome and impact on patient flow**
Date opened	22/04/2013
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care

Initial Risk Level	Major	Possible	12	Moderate

Director/Committee	Chief Nursing Officer / Trust Infection Prevention & Control Committee
Description/Impact	The potential for outbreak due to Norovirus with associated impact on service continuity due to ward lockdown. Risk that patients cannot be admitted to appropriate speciality specific ward, failure of the 4-hour access standard, cancellation of elective activity and inability to discharge patients to other healthcare facilities including Care Homes.
Key Controls	Early identification of symptomatic patients requiring isolation in admitting areas and inpatient areas Completion of D&V risk assessments Early reporting and lockdown of affected areas Appropriate use of HPV environmental decontamination Regular observation and audit of cleanliness and IPC standards IPCT training of all clinical staff Monit training of all clinical staff who sign off cleanliness Clear communication regarding closing of infected areas (public and staff) Completion of D&V risk assessments Trust Policy for Presumed Outbreaks of Viral Diarrhoea and Vomiting WAHT-INF-013 Trust planning for winter preparedness includes potential for Norovirus outbreaks Communication from CCG of current status of Norovirus in Community settings (daily during outbreaks)
Sources of Assurance	Internal Audit-PEOG monitors cleaning and associated scores Internal Audit-Commode audits bi monthly; monthly IPC ward audits Internal Audit-High Impact Intervention monthly audits Internal reports to the Board-TIPCC reports and annual infection control reports Internal Audit-Practice audits by IPC Nurses during outbreak and as part of annual programme

Performance Monitoring	
Gaps in Control	Environmental constraints due to lack of ensuite facilities on wards at the Redditch site Insufficient side room availability during outbreaks (all sites) Avoidable admissions during outbreaks Environmental constraints due to shared sluice facilities between wards on WRH site
Gaps in Assurance	

Current Risk Level	Major	Possible	12	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Continue with daily and weekly surviellance of Norovirus locally and regionally	David Shakespeare Infection Control	29/04/2016	Daily updates recieved of position in community regarding care homes affected and any residents who may need hospital admission. Daily and weekly updates recieved from PHE with regards to local and regional position. This informs our state of readiness for any potential outbreaks.	
Implement system for IPC Team to review use of single rooms weekdays and identify daily plan in conjunction with bed management team	Heather Gentry Infection Control Nurse	01/10/2013	New staff in post, however 0.8wte IPC Nurse moving to ward sister role on Beech 2 so again will be carrying vacancy. White board system amended to assist with daily side room reviews, extended working hours to commence 1st October 2013 including weekend cover. System in use since 1st October 2013 - white board needs amendments to improve process, separate case being developed by Emma Streete and informatics.	21/10/2013
Develop Winter Plan 2013/14	Jane Schofield Director of Emergency Care	30/08/2013	Version 12 final draft with COO and pending approved D&V POlicy due for sign off at TIPCC on 18/11/13 - Andrea Melileo aware Version 8 of winter plan available at end August 2013. Planning meeting with LHE (local health economy) partners held on 16/09/13 to discuss LHE infection control plans for winter. Version 6 of winter plan available by 29th June 2013 after circulation to GMs and service leads. Further meeting of planning group on 16/08/13 to finalise plans. IPC Team paper tabled. Nov 13 - Winter plan agreed with commissioners - with conditions	25/11/2013

Corporate Risk Report

Develop revised Norovirus materials for 2014/15 winter season.	David Shakespeare Infection Control	01/10/2014	Revised pull ups and posters have arrived in Trust for use.	01/10/2014
Procure new gel dispensers for hospital entrances	David Shakespeare Infection Control	30/04/2015	Gel dispensers procured and installed 4th April 2015.	04/04/2015
Multi-agency peer review	David Shakespeare Infection Control	30/06/2015	Peer review completed. Actions around format of outbreak meetings included in peer review action plan following peer review on 8th April 2015. Actions to be included in annual report.	29/05/2015
Conduct end of season Norovirus debrief ascertaining lessons for 2015/16 winter	David Shakespeare Infection Control	31/08/2015	Debrief held on 04/08/15. Further IPCT team meeting to be held to clarify Norovirus update distribution list and format of email, modification of use of SitRep for recoding of cases. DIPC to chair outbreak meetings following agreed trigger point of closure of 3 wards.	10/08/2015
Implement actions from debrief for winter 2015/16	David Shakespeare Infection Control	31/10/2015	Modifications on SitRep completed to streamline collation of data around Norovirus. Discussions taking place about extent of Norovirus testing this winter. Outbreak meetings to be held when single ward formally closed. This threshold to be discussed with new DIPCC. Due date updated to reflect this. 29/10/15 - Further actions agreed for Norovirus planning including sitrep updated, outbreak meeting template updated, testing regime agreed, norovirus planning including in Trust Winter Plan.	04/11/2015
Communicate revised testing regime to operational and capacity teams	David Shakespeare Infection Control	16/12/2015	Revised testing regime discused and agreed at TIPCC 02/11/15. For communication across Divisions and capacity teams. Norovirus testing not to be used as a capacity tool and affected patients to be managed on symptoms only. Pooled testing to be used for patients but affected staff will continue to be tested on an individual basis. 10/12/15 - ACNO to issue Trustwide communication regarding arrangements for norovirus for winter 2015/2016.	24/12/2015
Health Economy Norovirus meeting to establish internal and external communications in the event of outbreaks	David Shakespeare Infection Control	25/02/2016	Discussion with CCG/IPC lead who will host meeting early January. 26/02/2016 - Meeting not held but there is clarity about internal/external communications via comms team, outbreak meetings and relevent Director.	26/02/2016

Target Risk Level	Moderate	Blank	12	Moderate

Progress	

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2565 Delay or failure to act upon clinical diagnostic test results leading to patient harm**
Date opened	02/09/2013
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care

Initial Risk Level Moderate   Likely   `12`   Moderate

Director/Committee	Chief Medical Officer / Safe Patient Group
Description/Impact	The failure to access, acknowledge and act upon the results of diagnostic tests may result in an inappropriate delay and lack of timely treatment resulting in harm to patients. Analysis of the NHSLA database shows that a failure or delay in interpreting or acting on test results is one of the most common factors related to clinical negligence claims. The responsibility to act lies with the requesting clinician or team.
Key Controls	Policy for the management of clinical diagnostic tests (outline management plan) Local guidelines and protocols for accessing, reviewing and acting upon results (limited) Radiology reporting system for significant unexpected / urgent / critical results - email/phone - WAHT-CG-564 Pathology reporting system - phone ICE - diagnostic test request and reporting system
Sources of Assurance	

Performance Monitoring	Ad Hoc audit of degree of review completed by FY2 Dr assigned to pathology.
Gaps in Control	Administrative process that are not robust enough to capture and relay results to the requesting clinician Human factors - clinicians rely on being told abnormal results rather than seeking them Multiple inpatient moves that move the patient away from the requesting clinician System failures - e.g. Evesham endoscopy performed by a GP with no mechanism to return and act upon results Patient are sometimes discharged before the test results are available and not followed up by the requesting clinician. Lack of local procedures (for higher risk tests) to follow-up test requests, review results, act upon them and inform patients
Gaps in Assurance	Audit of compliance done ad-hoc by FY2 in pathology. No systematic monitoring & alerting

Current Risk Level Moderate   Possible   `9`   Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Establish process for ongoing review and performance management regarding speciality level unviewed results	Andy Phillips Interim Chief Medical Officer	30/06/2016	Report by speciality established. To be discussed at SPG April 2016	
Provide an action plan to the CCGs in response to the contract query	Mark Wake Chief Medical Officer	13/09/2013	Completed on 13th September. Letter attached to the ruisk assessment	13/09/2013
Risk assessment to determine the high risk clinical diagnostic procedures and prioritise action to mitigate the risks through local procedures (as per policy)	Mark Wake Chief Medical Officer	31/12/2013	A task & finish group was set up by the CMO to review the issues around reviewing diagnostic tests at the same time as the contract query was issued. ICE provides an aduit function that shows where and who is not responding to diagnostic test results ~ this is typically in the region of 2 - 3%. Radiology systems do not have this function and other methods are being used to determine responsiveness. This action has been superceded by the T&F group work.	01/08/2014
ICE is reported to place investigation results in the on-call consultant's inbox, not the requesting (non-consultant) doctor. The cause needs to be investigated	Gemma Noon Application & Integration Support Manager	30/06/2014	Gemma Noon contacted and asked to review the issue. Followed up with suppliers. They confirmed the Trust should not use the inbox functionality in ICE.	16/10/2014
Undertake notes based audits in radiology and outpatients.	Mark Wake Chief Medical Officer	29/05/2015	Analysis complete. Report taken to QGC in Mar 2015. To be distributed to Divisions for action.	26/05/2015
Implement next version of ICE software which will include a personalised inbox with the facility for alerts.	Andy Phillips Interim Chief Medical Officer	30/09/2015	Diagnostic inbox functionality has been implemented.	30/09/2015

Corporate Risk Report

Develop report of non-acknowledgement rates per speciality	Nicola O'Brien Deputy Head of Information	22/04/2016	The report was produced by the Information Department and a request has been made to add Specialty to this report. They have added this request to their worklog with the deadline of 22/4/2016 March 2016 update: Report established.	24/03/2016

Target Risk Level	Moderate	Unlikely	6	Very Low

Progress	Updated ICE software with inbox and alerting facility on track for implementation. Routine monitoring of review of results will also be implemented with the new version of ICE.

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2649 Workforce shortages affecting the consultant on-call rota for emergency surgery at AGH**
Date opened	11/04/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care
Initial Risk Level	Major Possible 12 Moderate

Director/Committee	Chief Operating Officer /
Description/Impact	Delay in introduction of countywide on call rota is leading to workforce shortages and recruitment challenges, resulting in vulnerability of the emergency general surgery service at AGH which may affect patient outcomes. Maintaining full emergency general surgery services across both WRH and AGH is challenging. As a response to concerns generated by HSMR data in late 2013, a cohort of emergency general surgery patients was transferred to WRH from AGH in February 2014. This has led to improved HSMR at AGH with no accompanying decline at WRH, demonstrating a positive clinical impact due to the change. However, it has led to increased emergency surgical patient admissions on the WRH site, leading to increased pressure on the CEPOD theatre list and the general surgery wards. Conversely, emergency admissions on the AGH site have reduced. The reduction in general surgery admissions and complexity of work on the AGH site could lead to nursing and medical staff becoming de-skilled, and is resulting in recruitment challenges. Nursing recruitment is a particular challenge across surgical wards at AGH, and this is thought in part to be connected to the current uncertainty regarding reconfiguration. The consultant and middle grade on call rotas at AGH are vulnerable due to gaps and ongoing recruitment challenges. Recent middle grade and consultant resignations have led to difficulties in providing substantive cover, resulting in multiple locum cover. A high proportion of sessions covered by locums can involve issues regarding of continuity of care. In addition, consultants on the AGH on call rota have varying sub-speciality interests. Whilst recent and ongoing 'general surgery' experience is appropriate for some ambulatory services, contemporaneous experience would be required for surgeons undertaking higher risk procedures which should be within their sub-speciality area. The potential risks associated with failing to reconfigure emergency general surgery toward a countywide model include: • Inability to maintain consultant and middle grade on call rotas at AGH • Inability to recruit satisfactorily to nursing posts at AGH, leading to potential patient safety concerns on the surgical wards • Inability to provide out of hours care for emergency surgery patients at AGH • Inability to support patients in ED that require surgical intervention at AGH out of hours Inability to support other patients being treated by other specialties (medicine, urology, ITU) at AGH with surgical input out of hours
Key Controls	Constant monitoring of surgical on call rota Constant monitoring of ward staffing levels and intervention where required Ongoing recruitment campaigns for middle grade and consultant staff Ongoing recruitment campaigns for nursing staff and use of agency staff where possible Triggers developed for action if service deteriorates
Sources of Assurance	Self-assessment against standards-On-call rota – frequency / gaps Self-assessment against standards-Consultants in post to participate in the on-call rota Self-assessment against standards-Ratio of permanent consultants Vs locums Self-assessment against standards-Performance data such as HSMR, unplanned return to theatre, delayed emergency surgery Self-assessment against standards-Ratio of permanent Middle Grades v Locums Self-assessment against standards-Nurse staffing levels on AGH wards in accordance with workforce plan.

Performance Monitoring	Please see attached draft Sustainability Dashboard
Gaps in Control	Service is susceptible to further sickness or retirement
Gaps in Assurance	no known gaps

Current Risk Level   Major   Likely   16   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Countywide rota being scoped to mitigate potential issue with AGH rota	Graham James Consultant Oral and Maxillo-facial Surgeon	29/02/2016	Rota scoped - awaiting implementation delayed due to delays in reconfiguration. Due date changed to end of October. Rotas available and ready for implementation. Update Dec 2015: Alternative rota models being reviewed. Due date updated to Feb 2016.	
New trust grade surgical posts being developed to increase attractiveness of positions	Val Doyle Surgery	30/01/2015	adverts completed	15/04/2015

Corporate Risk Report

Establishment of a Task and Finish Group set up from 14/05/2015	Val Doyle Surgery	14/05/2015	Group established, ongoing weekly meetings underway.	14/05/2015
Ongoing review of workforce on the Alex site by operational team	Val Doyle Surgery	31/12/2015	Full complement of fully trained surgeons at AGH, all are GI surgeons	16/12/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	The acute Trust is unlikely to be in a position to maintain 2 separate consultant on call rotas in emergency general surgery, and additional actions may be required to maintain quality. Plans are being drawn up to instigate a county-wide consultant on call rota. This would require the movement of more emergency surgery work from AGH to WRH. It is thought that countywide rotas will allow rotation of consultant and middle grade posts and help improve recruitment potential, thus enabling the Trust to stabilise the rotas and attract good quality candidates.

The general surgery department is working on a clinical model to develop a countywide ambulatory emergency general surgery service at AGH, which would redirect patients from WRH to create more capacity for emergency admissions on that site. Direct access to a consultant for GP's is part of the proposal for the ambulatory emergency general surgery service at AGH. 24/7 dedicated middle grade surgical cover would be maintained at AGH, which is the appropriate level suggested by national guidance. This would also allow the continued support for other departments (including Trauma and ED) at AGH out of hours.   It would also allow more utilisation of theatre and ward facilities on the AGH site, and allow for rotation of both nursing and medical staff between sites. This would potentially help with recruitment and retention of staff.

Discussions have taken place between clinical stakeholders regarding level of surgical provision required on each site if a countywide rota was introduced.
An options apraisal has been completed with partners and current and future risks assessed against the proposals.
12/05/2015 A Task + Finish Group – Implementation of a Single County-wide Acute Surgical Model for Emergency and Ambulatory Care Pathways has been set up. First meeting being held on 14th May 2015"

13/07/2015 Work being undertaken with both internal and external stakeholders includes
- Options appraisal
- Capacity and workforce analysis modelling
- Quality impact assessment
- Operation plans have been drawn up
- Risk assessments undertaken
- Interim on-call rota has been agreed and is   ready for implementation
- Patient pathways have been agreed

10/11/15
- Confirm and challenge meeting completed with the executive team
- All Rota's are available and ready to go live
- Agreement in principal to go live on the 23rd November 2015
- Pre implementation checklist developed
- Work being over seen by the safer services task and finish group
- Communication strategy developed

03/11/2015
- Service model adapted to minimise impact on WMAS and site bed occupancy
- Aiming to implement in December 2015 |

Next Review Date	12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2661 Increased pressure in emergency demand may impact on the safety of patient care & failure to meet performance standards**
Date opened	22/04/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care

Initial Risk Level	Major	Likely	16	High

Director/Committee	Chief Operating Officer / Trust Management Committee
Description/Impact	Description: If emergency demand continues to increase and there is a lack of downstream flow in the local health economy then EAS performance will be compromised. This is an indicator on safety, quality of care and patient experience. Impact: - Sick people wait too long to be seen in the ED - Total LOS is increased with associated safety issues for the elderly - Hospital mortality rate increases - Patients leave ED without being seen - Medical errors and incidents increase
Key Controls	Escalation management system PCIP implementation Senior Immediate Assessment Nurse (SIAN)
Sources of Assurance	Internal reports to the Board-Monitoring demand and utilisation of capacity / improvement via divisional performance reporting Management Assurance-Monthly quality and safety monitoring via divisional quality forums. Internal Audit-Ambulance handover and EAS reporting audits

Performance Monitoring	CAE1.1 % of patients waiting less than 4hrs in A&E CAE1.1a 4 Hour Waits (%) - Trust inc. MIU - from September 14 Ambulance handover incidents in ED
Gaps in Control	WMAS conveyances have increased significantly since introduction of NHS111. Fully implemented admission avoidance schemes Patient flow centre not integrated with ward processes Emergency demand increases ahead of forecast due to service reconfiguration
Gaps in Assurance	Further information and assurance being sought through the Systems Resilience Group (SRG).

Current Risk Level	Major	Likely	16	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Reconfigure beds across sites to improve patient flow	Rab McEwan Chief Operating Officer	29/02/2016	Proposed new due date end December 2015. Update Dec 2015: new due date Feb 2016	
Implement SIAN service	Rab McEwan Chief Operating Officer	18/04/2016	Feb 2016 update: Partially implemented SIAN service. Due date extended to April 2016.	
Trust Clinician formal review of final CCG QiPP Schemes including evidence of plans and PIDs.	Mark Wake Chief Medical Officer	30/06/2014	Overdue - Sufficient detail has not been received - DoR has contacted counterparts in CCGs	22/12/2014
Increase in bed capacity implemented.	Stewart Messer Chief Operating Officer	30/09/2014	The Divisions are currently working through the final schedules for the site reconfiguration for the specialities which will take place in September	22/12/2014
It is proposed that a Local Health Economy Action Plan is to be developed and monitored through Systems Resilience Group.	Stewart Messer Chief Operating Officer	28/02/2015	System wide action plan complete. Protocol introduced around risk assessment for patients presently being managed in the corridor of the ED	31/07/2015
Develop plan for winter 2015/16	Rab McEwan Chief Operating Officer	31/10/2015	Submitted to Trust Board in October 2015	07/10/2015
Ensure compliance with College of Emergency Medicine guidance that initial assessment is carried out by clinical staff within 15 minutes of arrival	Robin Snead Divisional Director of Operations	30/11/2015	Actions have been implemented to achieve compliance with 15 minute assessment standard in place. Further actions required, as contained within the PCIP.	13/11/2015
Create Full Hospital Capacity protocol	Rab McEwan Chief Operating Officer	31/10/2015	Full Capacity Protocol implemented 30/11/2015	30/11/2015

Target Risk Level	Major	Possible	12	Moderate

Corporate Risk Report

Progress	

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2662 Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT**
Date opened	22/04/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care

Initial Risk Level	Catastrophic	Possible	15	Moderate

Director/Committee	Chief Operating Officer / Trust Management Committee
Description/Impact	Description: If emergency demand continues to increase it will result in insufficient elective capacity to deliver the 18 week RTT admitted target and to reduce the in-patient backlog. Impact: Compromised care and patient experience with patients waiting longer for planned procedures.
Key Controls	Waiting list management with PTL daily. Somerset Cancer Registry to monitor cancer waiting times & escalation reports to Operational teams to act upon Weekly access meetings Additional activity through existing theatre capacity and WLI's.
Sources of Assurance	Management Assurance-Divisional monitoring waiting lists Management Assurance-Surgery Division monitoring medical outliers daily Management Assurance-Monitoring backlog weekly. Internal Audit-Divisional Governance Structures Audit Internal Audit-Waiting List Initiative (WLI) Expenditure Audit

Performance Monitoring	PW4.0 Backlog > 18 weeks (Outpatients + Day Case + Elective Inpatients) PW4.1 Backlog > 18 weeks (Day Case + Elective Inpatients)
Gaps in Control	The Trust lacks clarity and control of the management of new referrals to the waiting list The Urgent Care Strategy is not delivering the expected benefits as described in BAF No. 2661 and a system-wide action plan is still in development The Trust has little control of the commissioning of independent sector capacity.
Gaps in Assurance	Further information and assurance being sought through the CCG 18 week RTT Working Group, CCG Contract Monitoring Board and Systems Resilience Group (SRG).

Current Risk Level	Catastrophic	Possible	15	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Acute Trust to plan additional activity through existing theatre capacity	Rab McEwan Chief Operating Officer	15/02/2016	Action updated, WLI removed due to Trust financial position. Existing capacity being used. Due date updated.	
Acute Trust to work with CCG to support the improved uptake of independent sector capacity where clinically appropriate.	Stewart Messer Chief Operating Officer	28/02/2015	Independent sector uptake has increased by 33%	28/02/2015
Patient pathways review by Transformation Team. Assertive recycling of theatre lists. KTC realignment plan (Jan15)	Stewart Messer Chief Operating Officer	28/02/2015	Patient pathway review undertaken. KTC realignment plan approved by Trust Board Dec 2014. Now being implemented.	31/08/2015
CCGs to agree plans with the Trust for management and reduction of GP referrals.	Rab McEwan Chief Operating Officer	30/09/2015	Agreed key specialities with CCG, where there is a significant backlog, GP's are to refer to alternative providers. Trust has developed speciality level action plans to achieve 92% incomplete standard by September 2015. Due date changed to reflect this.	31/12/2015

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	

Next Review Date	12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2663 If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets.**
Date opened	22/04/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care
Initial Risk Level	Catastrophic Likely 20 High

Director/Committee	Chief Operating Officer /
Description/Impact	Description: If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets. Impact: Failure to achieve these targets impacts patient care, potentially affecting clinical outcomes. This may also damage Trust reputation
Key Controls	Daily cancer waiting list management Somerset Cancer Registry to monitor cancer waiting times & escalation reports to Operational teams to act upon. Implemented new patient level tracker for all cancer standards Bi-weekly performance management regime Monthly reports provided to Board with speciality breakdown Recovery action plans for site level breaches of 62 day standard
Sources of Assurance	Management Assurance-Monitoring PTL daily. Management Assurance-Monitoring medical outliers daily. Management Assurance-Monitoring backlog weekly. Internal Audit-Data Quality- Cancer Waits Internal Audit

Performance Monitoring	CCAN1.0 31 Days: Wait For First Treatment: All Cancers CCAN2.0 31 Days: Wait For Second Or Subsequent Treatment: Surgery CCAN5.0 62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers CCAN6.0 62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers CCAN7.0 62 Days: Wait For First Treatment From Consultant Upgrades: All Cancers CCAN8.0 2WW: All Cancer Two Week Wait (Suspected cancer) CCAN9.0 2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)
Gaps in Control	The Trust lacks prior warning of national Cancer Awareness Campaigns The Urgent Care Strategy is not delivering the expected benefits as described in BAF No. 2661 and a system-wide action plan is still in development
Gaps in Assurance	Further information and assurance being sought through the CCG Contract Monitoring Board and Systems Resilience Group (SRG).

Current Risk Level   Major   Possible   12   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Outsourcing to both NHS and private sector	Stewart Messer Chief Operating Officer		Closed in Dec 2014 update	22/12/2014
KTC Utilisation plan	Stewart Messer Chief Operating Officer	30/06/2014	Closed in Dec 2014 update	22/12/2014
Assertive recycling of theatre lists	Stewart Messer Chief Operating Officer	30/06/2014	Closed in Dec 2014 update	22/12/2014
Recruitment to consultant gaps	Stewart Messer Chief Operating Officer	28/02/2015	Added to Trust action plan action	22/12/2014
CCGs and NHSE to alert the acute Trust to upcoming National Cancer Awareness campaigns	Stewart Messer Chief Operating Officer	28/02/2015	Information on upcoming National Cancer Awareness campaigns recieved.	28/02/2015
Trust action plan include: recruitment to consultant gaps, ringfencing of cancer beds, restructuring Cancer Board, weekly cancer Patient tracking List meeting chaired by D.Ops.	Rab McEwan Chief Operating Officer	28/02/2015	Cancer bed ringfencing established, weekly cancer patient tracking list meetings established. Cancer Board restructured and will commence in new structure in April 2015. Two week wait target achieved in Feb 2015 and on track to achieve target for YTD. 62 day target yet to be achieved.	31/08/2015
Appoint Head of Elective Performance and Patient Access	Rab McEwan Chief Operating Officer	14/03/2016		04/01/2016

Corporate Risk Report

Target Risk Level	Catastrophic	Possible	15	Moderate

Progress	

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2664 Insufficient out of hospital capacity to meet the needs of patients with on-going healthcare needs**
Date opened	22/04/2014
Strategic goal	Design healthcare around the needs of our patients, with our partners
Strategic objective(s)	Get better every day

Initial Risk Level	Major	Almost certain	20	High

Director/Committee	Chief Operating Officer / Trust Management Committee
Description/Impact	If there is insufficient out of acute hospital capacity to meet the needs of patients with on-going healthcare needs then patients will be forced to stay in an acute hospital bed for longer detrimentally affecting their clinical outcomes, ongoing independence and experience of care.
Key Controls	System wide Capacity Plan sets out the required service capacity by pathway to menu of out of hospital care. Capacity meets normalised flow and peak pressure flow requirements. Commissioners have agreed resource plan with all relevant providers. Monitoring of patients +10 days on a weekly basis with H&CT/ASS. Weekly monitoring of patient list and +10 day cases with partners with actions taken as appropriate
Sources of Assurance	Management Assurance-Monthly review of capacity and utilisation at senior level across system. Management Assurance-Urgent Care Strategy Group, Review-External-Commissioner QIPP programme Internal Audit-Temporary Staff Booking Audit

Performance Monitoring	PIN3.1 Delayed Transfers of Care SitRep (Patients) - Acute PIN3.2 Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute Acute bed days occupied by patients 'Fit to Go'
Gaps in Control	Patient Flwo Centre not integrate with ward processe and challeneg on assessment of patient need
Gaps in Assurance	System wide capacity plan not available at this time.

Current Risk Level	Major	Almost certain	20	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Obtain health economy sign off of the Worcester wide choice policy	Rab McEwan Chief Operating Officer	20/05/2016		
Act on report recommendations across local county.	Stewart Messer Chief Operating Officer	30/06/2014	Complete	31/08/2015
Commission an economy wide capacity review and report	Chris Tidman Acting Chief Executive	30/06/2014	Complete	31/08/2015
As a last resort, open up winter surge capacity and limit elective workload	Stewart Messer Chief Operating Officer	31/08/2015	Closed	31/08/2015
Commission a Discharge to Assess Pathway via Nursing Homes using Operational Resilience Funding	Stewart Messer Chief Operating Officer	31/08/2015	Commissioned pathways in place however capacity remains an issue i.e. DTA pathway 1 - struggling to recruit the carers required to deliver this outcome and the roll-out to the base wards within the Acute has been delayed (trying to use the Community beds in the short term). DTA 3 has been delayed as the beds have yet to be commissioned. There are system wide issues with the three pathways - this will be discussed at SRG.	31/08/2015
Elect to fine Social Care based on Section 2 and Section 5 notifications	Stewart Messer Chief Operating Officer	31/08/2015	Not pursuing this action.	31/08/2015
Close collaboration with CCG and County Council on reconfiguration of Trust bed base to include nursing home beds as part of winter resilience plan	Rab McEwan Chief Operating Officer	31/10/2015	Commissioned as pathway 3 capacity	01/11/2015
Weekly review of DTOC's led by SWCCG to speed up discharge	Rab McEwan Chief Operating Officer	29/02/2016	Weekly review implemented and ongoing.	18/02/2016

Target Risk Level	Major	Possible	12	Moderate

Progress

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**2709 Risk to critically ill patients having delayed admission to ITU due to lack of bed spaces (spaces occupied by wardable patients)**
Date opened	19/08/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	

Initial Risk Level Major Likely `16` High

Director/Committee	Chief Operating Officer /
Description/Impact	There is risk of potential harm to critically ill patients requiring admission to critical care. Transfer of patients ready for ward step-down is often delayed due to capacity pressures across the site. Guidelines for the Provision of Intensive Care Services (GPICS). Standard 2.11 states that Discharge from Critical Care to a general Ward must occur within 4 hours of the decision. Standard 2.12 states that Discharge from Critical Care must occur between 0700hrs and 2159hrs. These standards are not currently being met by the Trust.
Key Controls	Representation at bed meetings Patient flow managed via PCIP urgent care plan
Sources of Assurance	Internal Audit-On-going monthly monitoring of delayed discharges Review-Internal-Daily escalation and monitoring of patients suitable for ward stepdown at bed meetings

Performance Monitoring	Daily escalation of wardable patients by the Divisional representative at the daily bed meetings. On-going monthly monitoring of delayed discharges Delayed discharges DATIXd and referred to bed management team for investigation
Gaps in Control	
Gaps in Assurance	

Current Risk Level Major Likely `16` High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Improve clinical site corrdination at AH and WRH through Hospital at Night and Clinical Site Coordination Team	Rab McEwan Chief Operating Officer	14/03/2016		
Risk to be included in Exception report to QGC	Faye Rafferty Quality Governance Manager	08/02/2016		08/02/2016

Target Risk Level Major Unlikely `8` Low

Progress	Currently there are on-going delays of stepping down level 1 patients to their respective wards due to emergency/capacity pressures across the sites. It is anticipated that re-establishment of assessment areas and improved patient flows will resolve these delays. There has been no progress made by the Trust in addressing failure to step down from the intensive care units. This is highlighted in the July 2015 critical care dashboards. The Trust is a National outlier in intensive care discharge performance. 02.03.2015. High level of patients remaining on ITU but ready for discharge to ward highlighted to Division at QG meeting.

Next Review Date 12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2711 Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.**
Date opened	29/08/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services

Initial Risk Level	Moderate	Likely	12	Moderate

Director/Committee	Chief Nursing Officer /
Description/Impact	There are national shortages in some particular nursing/midwifery specialitities which means that the Trust is unable to recruit sufficient qualified nurses to maintain agreed safe staffing levels. There are site specific recruitment difficulties afffecting some areas possibly to percieved uncertainty over services e.g. Alexandra Hospital
Key Controls	Use of flexible staffing via NHSP and third party agencies Re-deployment of staff as appropriate Monitoring of daily staffing levels by shift and escalation where staffing falls below minimum agreed staffing levels Existing staff offered zero hours contracts Quarterly recruitment events Weekly and monthly monitoring of nursing and midwifery vacancies Enhanced exit interview process Surveys of student finalist employment intentions/influences Re-deployment of staff as appropriate Agreement to over recruit to posts where possible.
Sources of Assurance	Internal reports to the Board-Monthly Board reports on safe staffing levels

Performance Monitoring	Vacancies for registered nurses and health care support workers. Registered Nursing staff and health care support worker turnover.
Gaps in Control	There is a national shortage of nurses. There continues to be high use of external agencies in some clinical areas.
Gaps in Assurance	

Current Risk Level	Major	Likely	16	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Implemenation of new roles	Lisa Miruszenko Deputy Chief Nursing Officer	02/05/2016	Job Descriptions for 3 new Roles, Ward Administrator, Ward Housekeeper and Assistant Practitioner have been agreed and recruitment. to the Ward Administrator role in the first instance has commenced	
Specific Nursing & Midwifery Recruitment & Retention Strategy to be agreed. Reviewing Nursing & Midwifery recruitment pocesses to reduce timescales	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	31/12/2014	Centralised recruitment processes are in place for Bands 2 and 5 to minimise recruitment time.Nursing and Midwifery Recruitemnt & Retention Strategy has been approved by the Board.	16/01/2015
Growing Nursing & Midwifery NumbersDeveloping un-registerd workforce through apprenticeships. Implementing and delvering a Return to Practice Programme with University of Worcester. Developing new roles such as Emergency Nurse Practitioners	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	30/01/2015	New cohort of health Care Apprentices recruited. Return to Practice Programme recruited to with some candidates offered HCSW posts prior to commencement of and during course to facilitate completion and retention post completion.ENP programmes ongoing.	16/01/2015
Implement tighter monitoring of vacancies and attrition to the Nursing & Midwifery Workforce Action Group	Lisa Miruszenko Deputy Chief Nursing Officer	28/02/2015	Vacancies reported monthly via workforce group and traingulated with HR and Finance information.	24/03/2015
Development of Neonatal Workforce.Targeted recruitment events. Discussion with University of Worcester to create pre-registration neo-natal pathway. Raising profile of Neonatal Nursing as a career pathway for qualified Adult Nurses. All nurses rescrui	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	31/03/2015	Recruitment events have seen recruitment to vacant posts posts and additional staff have been enrolled on specialist courses with extra places on course continuing to be purchased.	26/05/2015

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Recruitment Activity Targeted recruitment events for specific specialities. General recruitment events for newly qualified and experienced staff. Attendance at local jobs and careers fairs. Recruitment abroad (Europe)	Sonya Murray Associate Chief Nursing Officer – Workforce & Education	30/11/2015	Action closed as overtaken by work of Task and finish group	14/10/2015
Task and Finish Group to implement Nurse Recruitment Action Plan	Lisa Miruszenko Deputy Chief Nursing Officer	31/12/2015	T&F group established, action plan developed, including multiple actions in the following categories: Recruitment Process, Agency Spend, Additional Capacity, Attraction &Retention, Working with University, New Roles	17/12/2015
Establishment of new roles subgroup to look at roles supplementary and complementary to nursing.	Lisa Miruszenko Deputy Chief Nursing Officer	**31/03/2016**	Group has met and agreed terms of reference. Scoping of current and possible future roles being undertaken. Action plan to be developed once scoping complete to track progress..	18/02/2016

Target Risk Level	Insignificant	Possible	3	Very Low

Progress	The Trust is seeing slight upward trend in recruitment to registered nurse posts. Vacancies for Health Care Support workers are reducing. A case for overseas recruitment initially in the Phillipines and or India has been submitted to the Executive Team for consideration. Quarterly Trust Recruitment Events are taking place. Trust representatives attend local and regional recruitment events. Proactive measures are being taken to actively newly qualified nurses from local HEIs.

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**2732 If the Trust does not adequately prepare for emergencies, there may be an uncoordinated response and subsequent adverse events**
Date opened	07/10/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	

Initial Risk Level	Moderate	Likely	12	Moderate

Director/Committee	Chief Operating Officer / Emergency Preparedness, Resilience & Response
Description/Impact	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health service as 'emergency preparation, resilience and response' (EPRR).
Key Controls	
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level	Minor	Likely	8	Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Business Continuity Management Planning	Stuart Allen Emergency Preparedness	31/03/2016	Stuart to observe UHCW Business Continuity Management meetings – awaiting dates from John Dodds, Emergency Planning Manager UHCW. No response from John Dodds. However John Dodds is leaving UHCW to join NHS England EPRR Team working with Herefordshire and Worcestershire locality so support will be available early 2016. Stuart Allen to discuss at the EPAG meeting 4th February 2016.	
Commence EPRR and Command, Control and Coordination awareness training programme for all staff groups	Stuart Allen Emergency Preparedness	31/03/2016	Work with the Fire Training Team to include awareness training to all staff groups on EPRR and Incident Command, Control and Coordination attached to the mandatory fire training sessions.	
Update CBRN plan	Stuart Allen Emergency Preparedness	31/03/2016	CBRN Decontamination Plan was updated in December 2014 following consultation with the ED Clinicians. WMAS completed a successful capabilities audit on 12th May. Plan needs updating to include Deliberate Individual Chemical Exposure (DICE – also known as chemical suicide) and Initial Operational Response (dry decontamination now known as IOR). Stuart Allen will update plans and consultant the ED clinicians and WMAS.	
Conduct Communications Cascade Test and table top exercise	Stuart Allen Emergency Preparedness	30/04/2016	Major Incident Communications cascade test conducted 12th July and 20th December 2015. Under the Civil Contingencies Act these are required to take place every 6 months. The next communications cascade exercise in 2016 will call the control team in out of hours to test setting up the control room and work through a table top exercise scenario involving decision making based on current site and Trustwide operational position and forward planning considerations e.g. contacting LHE to discuss activating the Full Capacity Protocol early the following morning.	

Corporate Risk Report

Testing of EPRR Arrangements Document to include considerations for the use of other plans	Stuart Allen Emergency Preparedness	30/04/2016	On-call Managers, Matrons and Executive EPRR awareness training took place in September and November 2015. Tests of the Major Incident Plan Communications Cascade also took place in July and December 2015. The next test of the communications cascade in 2016 will include testing the Trust EPRR Arrangements document which will include calling the senior Command, Control and Coordination Team in to test setting up the Incident Control Room and working through a table top exercise which will include considerations for the use of other plans. Other plans identified will be used to complete future training and exercising.	
Conduct peer-review of EPRR	Stuart Allen Emergency Preparedness	17/06/2015	Peer review conducted with Emergency Planning Manager from UCHW. Findings will be provided by July 2015, and these will be acted upon.	17/06/2015
Complete review of NHSE core standards	Stuart Allen Emergency Preparedness	31/07/2015	NHSE EPRR Core Standards completed and submitted on 31st July 2015. The Trust overall self-assessment was submitted as Partial compliant with the intention of increasing this to Substantial within 6 months. A draft paper to Trust Board was also submitted. This paper will be presented to the September Trust Board meeting.	07/08/2015
Develop a training programme	Stuart Allen Emergency Preparedness	30/09/2015	Training has been conducted for on-call managers, matrons and executives covering on-call arrangements and expectations and major incident training. Training to all other staff groups still needs to be arranged. This could possibly be done as an add on to mandatory fire training (?30mins). 12/11/2015 Training programme established.	30/10/2015

Target Risk Level	Minor	Rare	2	Very Low

Progress	

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2736 Lack of Section 12 approved doctors to act as Responsible Clinician prevents legal detentions under Mental Health Act**
Date opened	13/10/2014
Strategic goal	Design healthcare around the needs of our patients, with our partners
Strategic objective(s)	Deliver effective care
Initial Risk Level	Moderate Almost certain 15 Moderate

Director/Committee	Chief Medical Officer / Trust Management Committee
Description/Impact	WAHT hospitals are registered with the Care Quality Commission to provide regulated activities, including "Assessment or medical treatment for persons detained under the Mental Health Act 1983" (MHA). Each time a patient is made subject to Section 2 or 3 of the Act, the Act and its code of practice require that a Responsible Clinician is identified. The Trust does not have any Section 13 approved doctors to act as Responsible Clinician to coordinate detentions under MHA.

Inevitably some patients with acute medical conditions will also have acute mental health conditions that need detention under the MHA. There is no formal process for accessing a Responsible Clinican for these patients, without this any detention is unlawful |
| Key Controls | Negotiations lead by Lindsey Webb are taking place with Worcestershire Health and Care Trust for the provision of Responsible Clinician cover.
Negotiations are taking place on a case by case basis to get agreement from consultant psychiatricst to undertake the Responsible Clinician role whenever a detention takes place uner the MHA
Mental Health Act detentions are recorded on DATIX |
| Sources of Assurance | Management Assurance-Monitoring of Mental Health Act detentions reported on DATIX and checking that these have had a responsible clinician appointed |

Performance Monitoring	
Gaps in Control	If a detention takes place outside office hours it will be very difficult to gain agreement with WHCT for a Responsible Clinician
Gaps in Assurance	Not all detentions are recorded as detentions on DATIX at the time so do not come to the attention of the Lead Nurse, Safeguarding Adults in a timely manner and some may never be known outside the Division.

Current Risk Level   Moderate   Almost certain   15   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Ensure roles are covered with suitable medical staff	Andy Phillips Interim Chief Medical Officer	31/07/2015	Chief Executive is commissioning a peer review of the specifications with a Mental Health Trust. Due date updated.
Update March 2016: CMO is in discussion with Health and Care Trust CMO regarding service provision. Propose new due date May 2016	
To be escalated to the February Risk Executive Committee	Lindsey Webb Chief Nursing Officer	10/02/2015	Risk was accepted onto the Corporate Risk Register at REG on 10th February.	10/02/2015

Target Risk Level   Moderate   Rare   3   Very Low

Progress	CMO has met with the H&CT Company Secretary and they plan to work together to develop a business case to support funding for 2 FTE posts to be presented to commissioners. The Trust is providing a regular update at Clinical Quality Review meeting with CCGs.

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**2746 If W&C Division are unable to sustain safe staffing levels it will be unable to provide safe patient care at all sites**
Date opened	24/10/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care
Initial Risk Level	Major Likely 16 [High] High

Director/Committee	Chief Operating Officer /
Description/Impact	In the event that Women and Childrens Services are unable to sustain safe staffing levels and an appropriate level of trained /skilled Paediatric, Obstetric, Maternity, Neonatal and Gynaecology staff, we will be unable to continue to provide safe patient care at all in-patient sites.

The risk is that in the absence of appropriately trained and consistent safe staffing rotas, the division will be unable to safely operate two fully functioning in-patient maternity and paediatric units.

If the staffing rotas are not covered adequately by skilled and competent staff on both sites, patient safety and quality of care will be compromised.
The risk to patient safety and quality of care significantly increases with rapid turnover of short term locum staff.

If the quality of staff skills and competency is not of a high standard, morbidity and mortality rates will rise, affecting outcomes for women, babies and children.

This overarching risk covers the following key areas:
• O&G Middle Grade Medical Staffing rotas
• Neonatal Trained in Speciality Nursing staff rotas
• Paediatric Middle Grade Staffing rotas
• O&G Consultant rotas
• Adherence to national and local guidelines to ensure safe patient care
• Inability to maintain Deanery training status
• Maintenance of high quality Maternity, Paediatric and Gynaecology care

The above issues are all interlinked and the inability to maintain parts of the above may lead to disruption to the provision of maternity, paediatric, gynaecology and neonatal services. |
| Key Controls | Robust monitoring of morbidity and mortality rates
Task & Finish groups implemented as individual risks heighten
Robust communications with other departments that affect the daily working of the services (anaesthetics/ surgery etc.)
Develop and test Contingency plans
Maintenance of Deanery training status
Monitoring of adherence to national and local guidelines
Monitoring of adherence to governance processes and patient safety standards
Constant monitoring of staffing rotas with escalation to bank and agency staff.
Task & Finish groups implemented as individual risks heighten
Weekly meetings with executives to review staffing and query indicators |
| Sources of Assurance | |

Performance Monitoring	Please see attached draft Sustainability Dashboard
Weekly ratings and escalation of agreed triggers to Exec team
Gaps in Control	National shortage of these key staff groups
Gaps in Assurance	Performance data trended over time

Current Risk Level   Major   Likely   16 [High]   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Weekly safety risk meeting review medical rotas and trigger points.	Cathy Garlick Director of Operations - Women & Children	15/03/2016	Weekly review of rotas see attached	
Developemnt of paediatric emergency centralisation plan	Andrew Gallagher Consultant	18/03/2016	Draft plans in development including staffing should emergency centralisation be required. V4 draft plan being reviewed by DoP 10/3/16	
Temporary closure of Alex Special care unit on 18th Feb	Cathy Garlick Director of Operations - Women & Children	14/07/2015	RCA report completed	18/02/2015

Corporate Risk Report

Emergency plans accepted	Cathy Garlick Director of Operations - Women & Children	07/08/2015	Emergency plans accepted and shared with wider health partners	07/08/2015
Tansfer of Emergency Gynae activity form Alex to WRH from 6/8/15	Cathy Garlick Director of Operations - Women & Children	04/09/2015	Temp transfer of all emergency gynae activity to WRH from Alex due to inability to adequately staff O&G medical rotas	07/08/2015
Communication with Deanery	Cathy Garlick Director of Operations - Women & Children	22/04/2015	Completed and ongoing	31/08/2015
Monitoring of risk matrix indicators	Cathy Garlick Director of Operations - Women & Children	22/04/2015	Risk indicators established. Thresholds for Executive escalation agreed at Trust Board.	31/08/2015
Full Contingency Plan should service change be required on safety grounds	Cathy Garlick Director of Operations - Women & Children	29/05/2015	Contingency plan developed	31/08/2015
O&G Middle Grade Task & Finish Group	Cathy Garlick Director of Operations - Women & Children	30/06/2015	Task and finish group presently closed but may need to be re-instated at a future date.	31/08/2015
Paediatric Middle Grade task & finish group to be established	Andrew Short Consultant Paediatrician	30/06/2015	Task and finish group operational	31/08/2015
External SI, Neonatal Near Misses weekend of 2/3/4 May 2015	Cathy Garlick Director of Operations - Women & Children	08/06/2015	External SI process commenced due to Near Miss x2 over the weekend due to staffing difficulties due to short term sickness. Awaiting final report. D/W Fay Bailey 30-9-2015 - The action can be closed. The contingency plan for short staffing and safe services has been agreed with commissioners.	30/09/2015
temporary closure of NNU at Alex on 15/8/15	Mari Gay Interim Chief Nursing Officer	30/10/2015	round table to review incident held, report awaited	30/10/2015
temporary suspension of maternity and neonatal in patient service at Alex site due to inability to safely staff neonatal nurse rotas	Cathy Garlick Director of Operations - Women & Children	06/11/2015	Services transferred safely Extensive Internal and external comms Staff induction and orientation review of gynae envirnoment and ability to meet 18 week RTT standards	06/11/2015
Initiate temporary suspension of maternity and neonatal in patients on Alex site until Feb 16	Cathy Garlick Director of Operations - Women & Children	29/02/2016	Review of temporary closure, staff meeting held Jan 2016. Andy Phillips executive updated W&C staff regarding the extension of temporary relocation of services.	09/02/2016
review of emergency changes submitted to trust board for consideration	Cathy Garlick Director of Operations - Women & Children	28/12/2015	Paper submitted to board and external partners. Accepted that trust cannot revert to 2 site opertions for maternity and neonatal care. internal consultation with staff to commence	15/02/2016

Target Risk Level	Moderate	Possible	9	Low

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Progress	Forecast / horizon scanning for potential future issues: Neonatal Nursing staffing Risk, being monitored within Directorate, The rota remains fragile with the notification of further maternity, adoption leaves and additional resignation. One new starter. Unable to offer posts at Julys interviews. Re-advertise posts. 2 locum junior consultants are in post. The sickness/absence rate in the O&G consultant body has improved, however, 3 consultants remain on redistricted duties (for differing reasons). O&G Middle grade rotas remain difficult to manage due to the inability to fill all vacant shifts. In order to keep 2 fully operational maternity sites, the temporary move of emergency Gynae activity form Alex to WRH will remain in place until February 2016 (next doctors rotation date). We have had to move a number of antenatal clinic appointments to evenings/weekends to ensure that women with risk factors receive the appropriate maternal and fetal monitoring they require. Paediatric medical staffing remains RED for Alex, however we have been successful in attracting short and long term locum doctors. The Deanery has not consented to a county wide rotation for this speciality, therefore the risk sits mainly on Alex site. Summary / Comments: The medical staffing rotas are increasing difficult to manage. Staff are working additional hours and acting down as able. This is not sustainable. The emergency measures taken to transfer all emergency Gynae activity to WRH site has allowed the retention of 2 in patient maternity sites at the current time. Paediatrics medical rotas are becoming increasingly fragile on the Alex site. Consultant are acting down in order to maintain a safe service. This is not sustainable. Update 13/11/2015: temporary suspension of maternity and neonatal in patients on Alex site from 6th Nov until Feb 16 Update Jan 2016 Maternity and Neonatal services remain located at WRH Gynae emergency care located at WRH. Major elective activity compromised due to bed capacity. Minor elective work at Alex, evesham and KTC Paediatric medical and nursing staffing rotas remain fragile, weekly monitoring continues Update 22/2/16. review of emergency centralisation of maternity and neonatal services presented to trust bpard. Accepted that division cannot operate a safe and sustainable 2 site model, thereofre service to remain centralised for foreseeable future. internal staff consultation to commence

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2747 Failure to prepare for serious new or emerging pathogens (eg Ebola, MERS) leading to exposure of public, patients and staff.**
Date opened	26/11/2014
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care
Initial Risk Level	Major Possible 12 Moderate

Director/Committee	Chief Nursing Officer /
Description/Impact	Failure to prepare for serious new or emerging pathogens of serious national or international public health concern eg Ebola or MERS CoV leading to risk of exposure to patients, staff and the public. For example: if the trust fails to prepare for potential patients that meet Public Health England criteria for a suspected case of Ebola or MERS CoV or do not manage them correctly this may lead to clinical staff caring for a patient being exposed to the virus. Other patients and visitors may also be exposed.
Key Controls	Ebola steering group with associated guidance from workstreams in place, including Clinical, Personal Protective Equipment, Laboratory, Waste/Cleaning/Decontamination, Community/WMAS issues and Trust organisational issues Agreed Trust choice of PPE with donning and doffing training and associated action cards. FFP3 mask fit testing for staff in A&E and Ebola response team Clinical algorithms developed for management of suspected cases. Identification of holding areas at WRH, Alex and KGH. Identification of suspected cases via screening questions at all portals of entry to the Trust Identification of necessary actions in the event of a suspected case presenting to the Trust Debrief held post suspected case at WRH - lessons identified and implemented Agreed Trust choice of PPE with donning and doffing training and associated action cards.
Sources of Assurance	

Performance Monitoring	
Gaps in Control	Unable to isolate ventilation to identified Ebola room (A&E at WRH) without also switching off supply to Cath Lab as on same air system
Gaps in Assurance	

Current Risk Level	Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
New program of FFP3 mask fit testing	Heather Gentry Infection Control Nurse	29/04/2016	Mask company have provided train-the-trainer sessions. Plan to disseminate to key areas, eg ED's, MAU's, Avon 3. Concern remains limited buy-in for fit testing from the Division, usually due to staffing pressures and capacity. 02/11/2015 - TIPCC heard that FFP3 fit testing in targeted areas including A&E departments MAU wards, respiratory wards and paediatrics continues with more staff now fit tested. 24/12/15 - FFP3 fit testing continues, further training for FFP3 hood alternative is planned for admitting areas, (for staff members with beards/not possible to fit test). 07/03/16 Attendance at training sessions offered by IPC has been limited. Training for hoods at WRH also outstanding. Lead nurse IPC updating TIPCC on 10/03/16.	
Telephone installation in designated holding room at WRH; to allow contact tracing by Public Health England and to minimise direct contact by WAHT staff	Christopher Pollard Specialty Registrar	19/12/2014	Completed. Solution is to use A&E portable phones for communication by clinician.	30/04/2015
Debrief following suspected MERS case	David Shakespeare Infection Control	07/08/2015	Debrief held. Lessons for CCG/WH&CT to remind GPs around risk of MERS following relevant travel history. New poster in development for acute trust with regard to reminding patients and carers of importance of disclosing travel history and for clinical staff to act on this history.	07/08/2015
Refresh trust-wide guidance and assess resilience of plans for MERS CoV	Stuart Allen Emergency Preparedness	30/09/2015	Emergency Planning Officer held a planning meeting to look at MERS CoV plans again with regard to awareness of arrangements and to test resilience. Microbiologist and IPCT to conduct a walkthough of the EDs on both sites to test awareness of MERS guidance. Clarification of arrangements for level of PPE to be used for suspected MERS cases.	30/09/2015

Corporate Risk Report

Action plan for Ebola Steering Group	Chris Catchpole Consultant Microbiologist	31/12/2015	Ebola sterring group no longer operational. Will be re-convened if required.	16/10/2015
Re-establish Ebola PPE group as trust high level PPE group with remit to establish trust standard for high level PPE	Heather Gentry Infection Control Nurse	25/02/2016	Group re-established. Further clarification required re donning and doffing and gowns. 29/10/15, second meeting held and high level PPE agreed. The pictorial guide is in development. 02/11/2015 - TIPCC heard that a new high level PPE policy is at an advanced stage based on PPE requirements for Ebola and MERS CoV. Pictorial guide being updated. 10/12/15 - New poster denoting 4 levels of PPE at advanced stage of development- For final approval at TIPCC. 24/12/15 - High level PPE poster approved at TIPCC on 16/12/15 pending minor amendments. To be published/distributed by end of Jan, 2016. 26/02/2016 - High level PPE agreed and pictorial guidance issued.	26/02/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	Recent debrief held regarding case of MERS coV held on 05/08/15 highlighted gap in control regarding risk to ventilation in Cardiac Cath Lab should A&E ventilation be switched off. However, proposed extention to A&E at WRH includes dedicated isolation room with seaprate air / ventilation supply. Planning meeting held 10/08 to include updates to policy, roll out of further FFP3 and PPE training, revision of foreign travel awareness / disclosure posters and walk through scenario for both A&E Depts. to be led by the Emergency Planning Officer. Following incident on 3rd September 2015, risk around FFP3 fit testing for A&E and other key staff noted. Therefore risk increased while training is planned and undertaken.

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2774 Failure to provide resilient IT infrastructure resulting in system unavailability which negativity impacts patient care**
Date opened	15/01/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and support staff

Initial Risk Level　　Major　　　　Almost certain　　**20**　　High

Director/Committee	Chief Executive / Trust Management Committee
Description/Impact	Power - there is an inherent risk of the power being overloaded and causing the systems located in the hub rooms to shut down unexpectedly. There is also exisiting trustwide power issues that are affecting the stability of the power in the existing hub rooms. Environmental - The exisiting hub rooms are not maintained to a sufficient level to provide manageable support for the hardware located within them. Data loss/security - Room access is not controlled or monitored and there are no procedures in place to minimise the number of staff members that have access to them. There is no limited resilience in place for the majority of the systems. Topology - The system resilience is not to a standard where there can be confident business continuity.
Key Controls	Rephase the power in the exisiting hub rooms to enable better power distrubition to ensure systems are kept up for a longer period of time. Map all applications to determine their dependancies, ensure that whole systems are not affected by environmental issues. Reduce the number of staff that have access to exisiting hub rooms to minimise any unplanned outages for systems. Recable the existing hub rooms to minimise any hazards and unplanned outages. Design and build two resilient datacentres to house all system sotrage and servers Upgrade existing systems to a supportable level and provide a baseline on the support for these systems Migrate the systems across to the new datacentres and pass the management and access control of the datacenters to Computacentre
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level　　Major　　　　Possible　　**12**　　Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Move to the new data centre	Stephen Asante-Boakye ICT Service Delivery Manager	20/06/2016	Data Centre implementation consists of several key stages: the build of the physical rooms, equipping the rooms, and moving our current IT systems onto the new platform. It was intended that the new platform would be ready to start accepting the move of systems from December 2015. However, at the time of writing, delays in building the physical rooms due to planning permission issues have resulted in a 4 month delay, and the complexities of the ICT design work by Computacenter have added a further month. Systems migration is now due to begin in May 2015 with the project tentatively expected to end in November 2016. The ICT team have been working with Computacenter to evaluate any impacts resulting from the delay and to mitigate against them by implementing either interim measures or some elements where possible ahead of schedule.	
Complete the discovery activities for current applications	Computacentre IT Contractors	31/03/2015	The discovery activities have been completed and any follow-on actions are being built into the data centre or the existing systems programme of work.	31/03/2015
Work with Oncology Centre staff, UHCW, and vendors to ensure a resilient radiotherapy IT infrastructure	Stephen Asante-Boakye ICT Service Delivery Manager	30/06/2015	A back-up Virginlink fibre network has been commissioned and is in use to connect the applications (MOSAIQ & Raystation) to UHCW. The cabinet on the 1st floor is being repatched to add resilience if anything happens to the ground floor hub room.	14/09/2015
Develop an project plan to deliver the data centre at KC	Computacentre IT Contractors	31/12/2015	Completed but project under review due to slippage. See implementation action entry.	14/09/2015

Target Risk Level　　Major　　　　Unlikely　　**8**　　Low

Corporate Risk Report

Progress	Data centre project is progressing

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2791 If the Medicine Division is unable to sustain appropriate staffing levels it will be unable to provide safe patient care**
Date opened	04/02/2015
Strategic goal	Invest and realise the full potential of our staff to provide personalised and compassionate care
Strategic objective(s)	Develop and sustain safe services

Initial Risk Level   Major   Likely   16   High

Director/Committee	Chief Operating Officer /
Description/Impact	If the Medicine Division is unable to sustain staffing levels and an appropriate level of trained /skilled Consultants specialising in Emergency Medicine, Acute Medicine, Respiratory, Gastroenterology, Geriatrics, Stroke and general Nursing staff, it will be unable to continue to provide safe patient care at all relevant in-patient sites. The risk is that in the absence of appropriately trained and consistent safe staffing rotas, the division will be unable to safely operate two fully functioning Emergency Departments, Respiratory, Gastroenterology, Acute Medicine, and Stroke services. If the staffing rotas are not covered adequately by skilled and competent staff on both sites, patient safety and quality of care will be compromised. The risk to patient safety and quality of care significantly increases with rapid turnover of short term locum staff and/or an over-reliance on locum staff. If the quality of staff skills and competency is not of a high standard, morbidity and mortality rates will rise, affecting outcomes for patients. This overarching risk covers the following key areas: • ED, Acute Medicine, Respiratory, Gastroenterology, Geriatric and Stroke Consultant rotas • ED Middle Grade Medical Staffing rotas • Gastroenterology Speciality Nursing staff rotas • Adherence to national performance indicators and local guidelines to ensure safe patient care • Inability to maintain Deanery training status • Maintenance of high quality Emergency, Acute Medicine, Respiratory, Gastroenterology, Stroke and Geriatric care The above issues are all interlinked and the inability to maintain parts of the above may lead to disruption to the provision of unscheduled care services. See also risks: 1719, 2516, 2558, 2692, 2714, 2766, 2785, and BAF risk 2829
Key Controls	Robust monitoring of morbidity and mortality rates Task & Finish groups implemented as individual risks heighten Robust communications with other departments that affect the daily working of the services (diagnostics/ surgery etc.) Develop and test Contingency plans Maintenance of Deanery training status Monitoring of adherence to national and local guidelines Monitoring of adherence to governance processes and patient safety standards Constant monitoring of staffing rotas with escalation to bank and agency staff. Task & Finish groups implemented as individual risks heighten Monitoring of risk matrix indicators (ED and Acute Medicine) Development of a workforce plan document Weekly meeting now held with deputy director of ops and HR to discuss/monitor and progress any issues.
Sources of Assurance	

Performance Monitoring	0. 1+The following measures are used to evaluate performance: ED Middle grade medical staff rotas ED and Acute Medicine Consultant rotas Base ward nursing rotas Respiratory Consultant rotas Geriatric Consultant rotas Gastroenterology Consultant rotas WRH Stroke Consultant rotas Please see attached performance report
Gaps in Control	Regional competition UK labour market shortages
Gaps in Assurance	

Current Risk Level   Major   Likely   16   High

Action Plan

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Action	Responsibility	Expected Completion	Progress	Date Done
Acute Medicine Consultants – job plans to be written, funding to be secured	Robin Snead Divisional Director of Operations	14/03/2016	Shared jobs are at present being advertised through NHS jobs,await till closing date and short listing has occoured.	
Development of a Nursing Pool	Julie Kite Divisional Director of Nursing Medicine	25/03/2016		
Create a workforce strategy document	Robin Snead Divisional Director of Operations	30/03/2016		
Geriatrics – progressing recruitment of integrated physicians with CCG/WHCT	Robin Snead Divisional Director of Operations	30/03/2016	Currently working with external head hunting agencies to target recruitment for specific consultant posts across the division	
Gastroenterology - Business case being prepared for additional 2 WTEs (1 on each site). High use of waiting list initiatives to attempt to meet targets for RTT, services struggling on both sites.	Robin Snead Divisional Director of Operations	31/03/2016	This has been delayed due to the current financial controls within the trust.	
Job Planning	Nick Hudson Consultant Physician	31/03/2016	Dates have been scheduled for job planning to occour	
Recruit Consultant Medical Staff in Stroke services, Respiratory services and Emergency Medicine	Robin Snead Divisional Director of Operations	25/07/2016	Currently working with external head hunting agencies to target recruitment for specific consultant posts across the division	
ED Workforce Review Task & Finish Group	Robin Snead Divisional Director of Operations	12/10/2015	Stuart Cannonier is currently writing the business case to be produced by 8th October 2015	22/10/2015
Medical Workforce Plan	Anthony Scriven Consultant Cardiologist	30/11/2015	This is being progressed with Nicky Callaghan in line with the trusts central workforce strategy group, chaired by denise Harnin	30/11/2015

Target Risk Level	Moderate	Possible	9	Low

Progress	Currently out to recuitment for consultant medical staff in Stroke services, respiratory services and emergency medicine. Currently working with Nicky Callaghan to complete a complete workforce strategy document for Medicine by April 2015 Respiratory consultant jobs had two candidates who both withdrew from the process days prior to interview, posts back out to advert. Stroke consultant posts currently out to advert. Elderly care posts out to advert by 7th June 2015 See controls above Currently working with Hunter Healthcare to target consultant level recruitment for Acute medicine, Respiratory, Elderly Care posts. Interviews are expected to take place in February 2016. Jo Kenyon(Deputy Director of Operations) is now the divisional lead for medical staffing and is co-ordinating the recruitment of all the vacant posts. Furthedr posts are currently out to advert for specialty and acute medicine hybrid job plans. Active recruitment to stroke consultant physicians posts is also ongoing.

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2856 Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury**
Date opened	07/04/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Catastrophic Likely 20 High

Director/Committee	/
Description/Impact	Plant and equipment failure resulting in loss of service.
Key Controls	Increased reliance on specialist contractors Increased holding of stock and spares Emergency arrangements in place with contractors (e.g. Heating, Fire and Air Con) Use of comprehensive specialist contractors
Sources of Assurance	

Performance Monitoring	We are proceeding cautiously with operating and maintaining critical plant and equipment throughout the estate to keep vital services on line, planned maintenance shut downs are traditionally difficult to arrange but as services age, the need becomes more acute to allow proactive identification of failing equipment. Mean time between failures has inevitably increased and there's a significant burden on our workforce and revenue budget as a result Until there is certainty in the Estates Strategy, it would be extremely difficult to effectively target funds without running the risk of abortive or nugatory costs
Gaps in Control	
Gaps in Assurance	

Current Risk Level   Catastrophic   Likely   20   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Funding being sought through CPG	Ray Cochrane Directorate support manager	04/07/2016	Ongoing, due date updated to April 2016. Final adjustments being made to Capital Programme mtg between CT, Jl & HK w/c 21 March with view to being considered at next CPG April 2016. Note this is an ongoing risk and will remain for many years to come. It is wholly dependant on receipt of sufficient funds to clear down estates backlog. Due date updated to reflect this.	
Salix Funding sourced for major equipment replacement	Ray Cochrane Directorate support manager	04/07/2016	Ongoing, due date updated to April 2016	
Detailed capital and backlog plans developed for 2015/16	Ray Cochrane Directorate support manager	30/06/2015		31/12/2015
Distressed capital bid being prepared	Ray Cochrane Directorate support manager	30/06/2015	Bid complete and requested	31/12/2015

Target Risk Level   Catastrophic   Unlikely   10   Low

Progress	Paper presented to Risk Executive Group 7th December 2015

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**2857 Failure to manage water system resulting in transmission of harmful pathogens to patients or staff**
Date opened	07/04/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care
Initial Risk Level	Catastrophic Possible **15** Moderate

Director/Committee	Chief Nursing Officer / Trust Infection Prevention & Control Committee
Description/Impact	Failure to manage water system resulting in transmission of harmful pathogens to patients or staff. The Trust is required to have a board approved water safety policy in place and a requirement for a water outlet flushing process that can be demonstrably audited.
Key Controls	Supervision of Estates actions and responses by dedicated Trust microbiologist Governance via monthly Water Safety Group meetings Authorising Engineer (Water) appointed Flushing process developed and partially implemented - Augmented care areas flushed daiily and audited by infection control AHR and KTC have flushing process, flushing folders have been distributed to wards, one training session has been held at WRH, another was held at AHR on 04/01/16. WRH no recorded process at present, Flushinng folder will be isssued to WRH 17th and 18th March 2016. Initial audit of KTC and AHR gave a compliance score of approximately 80% Water Policy Finalised and Water Safety Plan developed final version being reviewed by SN / MA in January for approval by WSG and TIPCC- staff working to draft plan Hard FM Contractor being directly managed by the Trust to ensure compliance with Water Safety Plan LL Construction and SPC engaged to resolve perceived design failures of Worcestershire Oncology Centre (Biocide system now fitted to oncology building and SPC are looking to change Water Tank location to prevent build up of heat Dedicated water quality technician appointed to manage water systems across county. Standardised log book in use Governance via monthly Water Safety Group meetings Water treatment plant installed in the radiotherapy building dosing the system with active chlorine results now improving, engineering controls now also in place to increase water usage and prevent temperature rise
Sources of Assurance	Management Assurance-Auditing of flushing records Management Assurance-Authorising Engineer audit Management Assurance-Auditable Estates water log book External Audit-Authorising Engineer carries out annual audit External assessment against standards-Legionella risk assessment carried out every two years and Pseudomonas risk assessment carried out by independent consultants to assess Trust compliance against applicable standards

Performance Monitoring	Performance reporting process for flushing being pursued. Water supply testing results monitored by Water Safety Group Positive patient test results in augmented care areas investigated to determine whether hospital attributable
Gaps in Control	Potential for gaps in the flushing regime - will be audited in KTC / AHR by water quality Technician - need to finalise arrangements for WRH Presence of sub-optimal plumbing in augmented care areas eg flexible hoses - A DAF has been raised to remove all flexible hoses from augmented care work due to be completed in January Water tank storage temperature has improved due to engineering works in Radiology building - high cold water temperatures are being found at the outlets due to low usage and lack of turnover. The system does not rely on temperature control alone as a means of Legionella control as system is now being dosed with a biocide plant
Gaps in Assurance	Augmented care areas identified however vulnerable patients will be present in other areas of the Trust Auditing of flushing not yet part of a rolling program KPIs to be enhanced for Water Safety Group POWCH and Evesham have conducted water risk assessment but links with the Health and Care Trust required for assurance

Current Risk Level	Major Possible **12** Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Complete Water Safety Plan with ratification at TIPCC	Simon Noon Principal Engineer & Statutory Standards Manager	30/06/2016	Water Safety Plan in progress, but requires further modification.	
Carry out Risk Assessment	Simon Noon Principal Engineer & Statutory Standards Manager	31/07/2015	Legionella assessment complete, Pseudomonas ongoing, interviews presently completed, awaiting issue of risk assessment	16/09/2015
Point of use filters fitted to outlets	Simon Noon Principal Engineer & Statutory Standards Manager	07/09/2015	Filters fitted and are replaced monthly and as required resulting from positives sampling results. Filters fitted to all clinical areas in Radiotherapy and a protocol for removing filters based on HTM04-01 addendum has been agreed based on agreed clear results.	16/09/2015

Corporate Risk Report

Daily flushing of all outlets in augmented care areas	Simon Noon Principal Engineer & Statutory Standards Manager	07/09/2015	Flushing in each unit requested in accordance with HTM 04 -01. Kidderminster and Alexandra Hospitals implemented, however this is a generic statement and does not identify individual outlets. Worcester Royal Hospital is carrying out Flushing in Augmented care and this has been audited by infection control.	16/09/2015
Enhanced testing regime implemented	Simon Noon Principal Engineer & Statutory Standards Manager	18/12/2015	In Radiotherapy and Laurel monthly tesing continues until 3 clear test results are obtained after which frequency can be extended to every 6 Months at agreed sentinel test points. Additional samples have been agreed at AHR but the final test programme is still to be agreed by Trust Microbiologist, AE and Estates department. 04/12/2015 At the Alex we are testing 20 points per month for legionella and we are testing 100% of augmented care areas for pseudomonas six monthly at KTC and the Alex. Kidderminster we are testing seven points per month for legionella.	18/12/2015
Cascade water safety training to stakeholders	David Shakespeare Infection Control	25/02/2016	Being planned, dates received from Hydrop, these are being cascaded to maximise attendance at sessions which will be held at each site. 10/12/2015 - Dates for training at WRH 23/12/2015 and ALEX 15/12/2015. 24/12/15 - First training session low attendence; more sessions to be planned Feb/Mar 2016.	26/02/2016
KPIs for water safety to be developed and reporting process established	Simon Noon Principal Engineer & Statutory Standards Manager	31/03/2016	Reporting process is in place, via regular monthly water quality testing and a monthlyy water report. Discussions about further developing this report are underway including performance indicators, including flushing performance, PPMs and aggregate of high risk pathogens identified. 04/11/2015 New contractor has started. Will report on PPM completed against target at December TIPCC.	23/03/2016
Establish and embed revised system of undertaking and recording water flushing trustwide	Simon Noon Principal Engineer & Statutory Standards Manager	29/04/2016	Augmented care areas - flushing is undertaken and recorded by clinical staff. There remains a gap in assurance around flushing for non-augmented care areas. 07/03/16 Outstanding issues continue with regard to nursing and housekeeping responsibility for flushing.	23/03/2016

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	Records and processes being improved significantly and subject is regularly discussed at Water Safety Group, TIPCC, Quality Governance Committee. Water is regularly tested and the results subject to actions agreed in the Trust Water Safety Plan as required by HTNM04-01 addendum Flushihg log books distributed, adherance to requirements to be monitored. there is a concern to buy in to flushing this to will be monitored the WSP requires microbiologist sign off(estates and SE water have already approved the document. there is an ongoing issue wiht microbiology to achieve sign off based on availability of resource. A meeting to disucuss furhter is planned to resolve.

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**2864 Failure to follow pressure ulcer prevention procedures (risk assessments, position changes, correct equipment) resulting in harm**
Date opened	20/04/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care

Initial Risk Level	Moderate	Possible	9	Low

Director/Committee	Chief Nursing Officer /
Description/Impact	Pressure ulcers can occur as a result of a variety of factors.

Immobility is the primary contributing factor in the development of pressure injuries. The majority of RCA investigations find patients that have developed a pressure injury were not moved (or not documented as having been moved).

The most common concerns are reduced awareness of those patients at risk. This may be caused by insufficient pressure ulcer risk assessments and/or re-assessments.

Pressure re-distributing mattresses are available, but are not always used in a timely manner for the patients that require them. |
| Key Controls | Pressure area risk assessments on admission
Intentional care and comfort rounding
Repositioning in beds and chairs |
| Sources of Assurance | Self-assessment against standards-Monthly Matrons PUP Audits. |

Performance Monitoring	Patient Safety Thermometer - point prevalence, reported Via CQUIN group for 2014/15.
Not a CQUIN for 2016. To be reported via contracting.
Monthly incidence reported on Trust Dashboard.
Patients who develop hospital acquired PU's have a root cause analysis to determine cause and if avoidable or unavoidable.
Gaps in Control	Staff knowledge of policy and procedures
Staff time available to conduct rounding and attend to repositioning
Staff documentation of pressure relieving activities
Gaps in Assurance	

Current Risk Level	Moderate	Likely	12	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Discuss opportunities for improving risk assessment paperwork to increase likelihood of completion	Elaine Bethell Tissue Viability	30/04/2016	Awaiting response from Nursing Professional Development team. 24/12/15 - awaiting amended care and comfort tool from Servicepoint to be trialled during January 2016. New Care and Comfort chart is ready for use but the TV Lead has been informed by Jo Logan that quantities of the "old" ones must be used first. The estimated date for use is April 2016. 22/3/16 - Jo Logan is to meet with Service point to update the amended C and C to include A and E trolleys and Repose. A and E WRH were using a different chart to the rest of the hospital. This amended chart will ensure standardisation across the Trust.	
Discuss opportunities to ensure staff are prompted to turn patients	Elaine Bethell Tissue Viability	30/04/2016	Exploring possibility of using electronic whiteboard to prompt staff and to explore ideas using Datix as an automatic prompt with the Trust Risk Officer.	
Implement 'react to red skin' pathway with 2 hourly repositions	Elaine Bethell Tissue Viability	30/04/2016	24/12/12 - To be trailled alongside care and comfort documentation by end January 2016. This has now been rolled out and is being implemented within T&O on both sites. Aim being to roll out to rest of Trust over the next couple of months.	
Replace chairs not fit for purpose	Elaine Bethell Tissue Viability	30/04/2016	Audit by mid-January to identify chairs that are not fit for purpose due to ingress and/or tearing. Report expected by end February 2016. Divisions to then replace identified chairs. 18/2/16 Audits carried out, results to be analysed and presented at the March TIPCC meeting,	

Target Risk Level	Minor	Unlikely	4	Very Low

Progress	

Next Review Date	12/04/2016

Corporate Risk Report

Risk	**2899 Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, poor clinical outcomes**
Date opened	19/05/2015
Strategic goal	Design healthcare around the needs of our patients, with our partners
Strategic objective(s)	Deliver effective care

Initial Risk Level	Major	Possible	12	Moderate

Director/Committee	Chief Operating Officer / Trust Management Committee
Description/Impact	If the Trust does not provide full clinical services seven days per week (eg consultant cover, nursing and therapy staffing, access to imaging and theatres) quality of care will be inconsistent. This could lead to increased length of stay and reduced performance in clinical outcomes such as morbidity and mortality.
Key Controls	Cover provided during weekends, variable across services On-call arrangements in many areas
Sources of Assurance	Clinical Audit-Benchmarking, clinical audit, and peer review conducted against professional standards and guidelines in various specialities Care Quality Commission-CQC inspections

Performance Monitoring	Length of stay performance data Numbers of complaints Mortality data split by day and time, site, etc (eg HSMR)
Gaps in Control	Potential difficulties recruiting in light of regional/national shortages in some groups Cost required to implement
Gaps in Assurance	Presently no data/scorecard available indicating performance against seven day working (eg proportion of service providing weekend consultant ward rounds)

Current Risk Level	Major	Possible	12	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Conduct baseline assessment on 7 day services assessment tool and agree action plan	Rab McEwan Chief Operating Officer	31/03/2016	Self assessment complete. Awaiting further information from the Department of Health regarding the future of the national audit. Due date updated to reflect this.	
Establish seven day per week working group	Denise Harnin Director of HR & OD	31/07/2015	Group has formed and is reviewing consultant staffing required for seven day working	31/07/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	Risk transferred from BAF to Corporate Risk Register following Trust Board meeting 2nd March 2016.

Next Review Date	12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2908 Use and release of information which is inaccurate, false or misleading resulting in reputational and legal damage**
Date opened	28/05/2015
Strategic goal	Ensure the Trust is financially viable and makes the best use of resources for our patients
Strategic objective(s)	Deliver effective care
Initial Risk Level	Major — Likely — 16 — High

Director/Committee	Finance Director / Data Quality Group
Description/Impact	The Trust depends on accurate data to ensure sound decision making for quality of care and to make best use of resources. If the Trust does not exercise due diligence on its data, it may utilise inaccurate data, affecting decision making and public records. The Care Act 2014 has put in place a new criminal offence applicable to care providers who supply, publish or otherwise make available certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation (False or Misleading Information Offence or FOMI). A further offence applies to the 'controlling minds' of the organisation, where they have consented or connived in an offence committed by a provider. On conviction organisations can be subject to an unlimited fine and be compelled to take remedial action and to publicise the conviction and the action taken to remedy the situation. Clearly there will also be reputational consequences for the organisation involved and these may be greater than the financial consequences. The possible consequences for individuals are very serious. Individuals can be subject to an unlimited fine, a custodial sentence of up to two years or both.
Key Controls	Training for staff about data quality Automated data quality checking for key data sets When problems identified with information systems, a project is undertaken to rectify
Sources of Assurance	Internal Audit-Data quality is included in the Internal Audit Calendar

Performance Monitoring	
Gaps in Control	Due to system update of Oasis to include RTT clocks, data has to be manually validated Some gaps in mandatory fields and data validation at point of entry
Gaps in Assurance	Internal Audit forward plan may not include all FOMI datasets

Current Risk Level — Major — Likely — 16 — High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
New clinical lead required for DQSG	Rebecca Brown Head of Information	04/03/2016		
A&E dataset roll out	Rebecca Brown Head of Information	11/03/2016	Information specialist to ensure roll out by end of contract	
Provide assurance mechanism around 'due dilligence'	Rebecca Brown Head of Information	25/03/2016	Project resource allocated to this work. Scope of work includes writing caveats for high level systems, relevant CDS's, then more specific data fields. Work completed on reviewing all business logic in A&E, and awaiting clinical sign off. (date altered to reflect new deadlines)	
Seek legal advice around suitable caveats to apply to reports	Rebecca Brown Head of Information	30/06/2015	Action split 25/8/15. Legal advice and further clarification sought. Legal briefing to Executives and NEDs scheduled for Board Development event in September 2015.	15/06/2015
Review all relevant datasets to ensure compliance with minimum standards	Rebecca Brown Head of Information	30/06/2015	Initial review completed. Further detailed work required for all key systems to establish risks and caveats. Outline for required FOMI assurance work written. Bring forward into a further more detailed action.	26/06/2015
Strategic ownership of data quality enhanced by nomination of a senior or executive level Data Quality Champion	Rebecca Brown Head of Information	31/05/2015	Executive Lead: CMO. Trust Clinical Data Quality Lead: Consultant Obstetrician /Associate Medical Director Clinical Effectiveness	07/08/2015
Re-establish Trust Data Quality Group, and ensure senior level representation is included	Rebecca Brown Head of Information	30/06/2015	Trust Strategic Data Quality Lead and Head of Information working on Terms of Reference and attendance for group. First meeting scheduled for October, then monthly for remainder of 15/16.	14/08/2015

Corporate Risk Report

Inclusion of FOMI dataset areas in the Audit and Assurance Committee forward plan	Michael White Finance	30/06/2015	Proposed for inclusion on the November Audit and Assurance meeting agenda.	25/08/2015
Create project plan for roll out of data quality kitemark	Rebecca Brown Head of Information	23/10/2015	Complete	16/10/2015
A&E dataset review	Rebecca Brown Head of Information	29/01/2016	Mapping complete. Engagement with A&E ongoing. Visualisation of new reporting being scoped. (note: updated delivery date on 15/12)	16/02/2016
Identify all modes of external distribution of FOMI related data	Rebecca Brown Head of Information	18/02/2016	Project resource allocated. Ongoing. Date for completion changed from 30/9/15 as scope of this action has been extended, and project resource as been lost. ACTION CHANGED TO ROLL OUT OF DATA QUALITY KITEMARK ACROSS TRUST DASHBOARD. RESOURCE NOT AVAILABLE FOR FULL ANALYSIS. Date changed - project support still not in place.	16/02/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	Further gaps and actions may be identified following the review of relevant datasets.

Next Review Date　　　　12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**2957 Breaching hygiene code due to inadequate or ineffective assurance around environmental cleaning**
Date opened	30/06/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Moderate Possible 9 Low

Director/Committee	Chief Nursing Officer / Trust Infection Prevention & Control Committee
Description/Impact	Failure of assurance mechanisms for environmental cleaning resulting in address areas of poor performance
Key Controls	Increased cleaning on Laurel 3 and ED in response to peer review 8th April 2015 Dedicated night cleaner in ED Completion of five compliance checks per week Uniform and PPE checks
Sources of Assurance	Self-assessment against standards-mini-PLACE (Patient Led Assessments of the Care Environment) process Management Assurance-Cleaning feedback - Hospedia Self-assessment against standards-Monitoring Team cleaning audit

Performance Monitoring	
Gaps in Control	Variability in the knowledge and experience of Nursing staff in completing Monit
Gaps in Assurance	Inter-rater variability for Monit scores, particularly between Estates and Nursing

Current Risk Level   Moderate   Unlikely   6   Very Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Triangulation of range of Facilities and IPC audits pertaining to environmental and nurse cleaning with view to establishing single audit and process	David Shakespeare Infection Control	10/03/2016	First Facilities and IPC meeting held to discuss triangulation of existing data with a view to enhancing assurance around cleaning trust wide. 24/12/15 - ACN IPC to meet with Head of Facilities during January to review entire process of audit of cleanliness and will recommend revised structure and process at the next TIPCC on 25/02/16. 26/02/2016 - Rivised method for triangulation of cleaning and IPC audits to be recieved at TIPCC on the 10/03/2016.	
Work with Nursing Directorate to ensure Monit is completed properly	Heather Gentry Infection Control Nurse	28/04/2016	Further Monit training sessions held with Matrons and housekeeping surpervisors. 02/11/2015 - TIPCC heard Monit Training with matrons and housekeeping supervisors continues. TIPCC 16/12/15 heard training continues but with limited uptake.	
Employ second auditor and report audit information to TIPCC	James Longmore Director of Asset Management & ICT	31/07/2015	Second auditor now in post allowing the team to carry out more independent audits, these are summarised and reported to TIPCC.	31/07/2015
Establish ISS supervisor checks of cleaning	Martin Long Facilities	31/07/2015	ISS have been asked to attend November 2015 TIPCC to provide assurance around their validation processes. 02/11/2015 - TIPCC heard from ISS representative that ISS manager checks of cleaning are now routinely in place.	04/11/2015

Target Risk Level   Moderate   Unlikely   6   Very Low

Progress	David Shakespeare and Martin Long are meeting after Christmas to blend together the content of all three Audit formats (Monit, PLACE and Control of Infection) - so that from a a Governance perspective, there will be a single report which goes to the Board. This single report will address all environmental cleaning issues, including any outstanding issues raised through either CQC, PLACE inspections and all other statutory guidance. Feb 2016 -Current evidence from IPCT daily updates show that effective cleaning mechanisms are operating on all three sites

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**2994 Failure to meet the NHS England Serious Incident Framework resulting in failure to learn and potential regulatory action**
Date opened	03/08/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services

Initial Risk Level	Major	Possible	12	Moderate

Director/Committee	Chief Nursing Officer / Safe Patient Group
Description/Impact	The Trust's processes for the identification, management, investigation and learning from serious incidents must meet the requirements of the NHS England SI framework and produce evidence of learning with improvement in safety for patients.

While a process of improvement has commenced, incident investigations need to continue to improve so that investigations are completed in the time required; the causes are determined; recommendations relate to the causes; and the resulting actions to achieve improvement are SMART, owned by the management teams and implemented effectively. |
| Key Controls | Policy for incident reporting and investigation
Patient Safety Team resources
Training in investigation for incidents & complaints
Serious Incident Review Group - review and approval of investigations - chaired by Executives, monitor new SIs and current investigation process
Divisional Quality Governance Team management of investigations
Commissioner (CCG) review and sign-off for SI investiagtion reports in STEIS |
| Sources of Assurance | Internal Audit-Internal audit of SI process |

Performance Monitoring	SI investigations open >60 days
Gaps in Control	Effective Divisional control of SI investigations - appointing investigators, monitoring progress with incidents and producing reports that are fit for first-time approval.
Effective application of investigation training to the investigation process
Availability of trained investigation leads / chairs
Phase 2 / sustainable training in investigation methods
Effective performance management - to include managers responsible for implementing actions arising from SIs - with escalation to Executives
Gaps in Assurance	Application of the Duty of Candour for SIs

Current Risk Level	Major	Possible	12	Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop and agree phase 2 training for investigations & workshops for trained staff	Chris Rawlings Head of Clinical Governance & Risk Management	31/03/2016	A proposal has been received to provide in-house training utilising our own trained staff. Costing to take place and agreement expected before end of November. Timescale of action amended due to 'pause' to reflect on work with W&C Division. Training new planned for the New Year.
December 2015 - Method of training staff agreed. Arrangements for external training provider to deliver and train our staff to continue in progress. Expressions of interest for internal trainers to be sought. Target date moved to February to allow for provider to a respond and arrange training.
March 2016 - Scoping of training need will be completed this week. Discussion with Oxford regarding provision of training will be undertaken when they engage as our 'buddy' trust. Deadline therefore moved. Funding for training secured from HEWM.	
Job planning to allow senior clinical staff to lead on investigations to be completed	Andy Phillips Interim Chief Medical Officer	31/03/2016	Job planning is in progress. This action is also recorded in the Internal Audit report on the SI system received in December 2015	

Corporate Risk Report

Revise incident reporting and investigation policies to match the revised process & disseminate the changes effectively	Chris Rawlings Head of Clinical Governance & Risk Management	31/03/2016	Policies are still in revision - several additional changes to process have been made through the work Consequence UK have been undertaking with the W&C Division and these need to be included in the final versions. They will be completed before the December SPG meeting and will include actions taken in response to the Internal Audit of the SI process. Further, smaller amendments will need to be made as the SI investigation process evolves. Target date for review moved to allow for review and revision to take place in early 2016 - the changed processes are starting to settle and a move to the neww weekly Governance Operational Meeting on 15th January needs to be included.	
Develop and agree ToRs for the SI Group	Steve Graystone AMD Patient Safety	31/08/2015	Draft ToRs prepared and reviewed at September 3rd SPG meeting. Post meeting review and amendment by CMO and CNO so will be resubmitted for approval.	03/09/2015
Develop and implement a plan to introduce the use of the Datix action module for the recording and management of SIs and then all incidents / complaints	Chris Rawlings Head of Clinical Governance & Risk Management	31/10/2015	Discussed and supported at the Datix User Group. Divisions requested to use the Datix Action module for all serious incident actions whaich are being reviewed at the SI Review Group monthly. A template report for the Divisions to use has been developed by the Datix Manager and the Information Department to make monitoring of progress with actions and reporting easier. The same request has been made for complaints.	30/10/2015
Hold workshops for staff who have attended training (1 day) and the Executive / DMTs (1/2 day) to explain and embed process and responsibilities for the SI investihgation / action / improvement process.	Chris Rawlings Head of Clinical Governance & Risk Management	30/11/2015	November 26th booked for Executives and held as planned Other dates being arranged. COmbined with action for Phase 2 training	26/11/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	SI Review Group transition complete. New ToRs require CMO / CNO to chair the meeting with Divisional Director attendance. Improved accountability, timeliness and quality of reports is expected. Initial Case reviews were introduced for all potential / actual serious incidents in October. Well received by the CCGs and sent to the CQC at their request between 5th October and 5th November. The W&C pilot of a new SI investigation approach has been delayed by operational factors. Each Division now holds a weekly meeting to review progress with SI investigations and new potential SIs December 2015 - New action added to complete job planning for senior clinicians to allow time to lead investigations and provide independent investigators. Target dates for revision of policies and Phase 2 training amended. Several actions in the PCIP are relevant to this risk.

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**2995 If Patient Safety Incidents are not managed in a timely way there will be missed learning and preventable harm**
Date opened	03/08/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Nursing Officer / Safe Patient Group
Description/Impact	High numbers of incidents that are either not acknowledged / opened or investigated in a proportionate and timely manner do not demonstrate an effective safety culture or process. The impact is a high likelihood of failure to effectively review incidents & near misses, failure to learn and failure to prevent avoidable harm.
Key Controls	Incident reporting policy Diatix Risk Management software to provide a reporting and management system Weekly review and reporting to Divisions of the open incidents and their status Divisional management teams targetting action at the areas / managers with high numbers of incidents open / in-process Datix User Training - provided to all new users - includes basic investigation training, explanation of responsibilities and use of Datix incident management module
Sources of Assurance	Internal Audit-Internal audit of the serious incident management system Internal reports to the Board-Monitoring by the Patient Safety Team of incidents with the provision of Quarterly - now monthly - reports to the Safe Patient Group
Performance Monitoring	Status of open incidents by Division, Location Exact and manager of the area where the incident occurred. Number of incidents not opened within 7 days number of incidents (excluding SIs) open beyond 20 working days Daily monitoring of incidents by the Divisional Quality Governance Teams with further monitoring of incidents that have been reported but not acknowledged (holding area) Setting targets for numbers of incidents open at any one time: The Women & Children's Division have agreed an initial target of a 100 open incidents at any one time (this does not include SI). This target will be reviewed in 3 months. Other Divisions will be considering their own targets
Gaps in Control	Performance management of the Directorates / managers in this area by Divisional management Teams Ownership of incidents and their review / appropriate closure by Directorate and department / ward managers Easy availability of reports from Datix - manually produced on a weekly basis by the PST
Gaps in Assurance	

Current Risk Level   Major   Possible   12   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Determine further controls to maintain / sustain the improvement in response and management while ensuring that each incident report is appropriately reviewed	Chris Rawlings Head of Clinical Governance & Risk Management	29/02/2016	Discussions held with Divisional representatives to review the position, actions already taken to improve response, share good practice and identify actions that will sustain the improvement. Each Division now holds a weekly meeting to review progress with SI investigations and progress with incident reports. Targets for numbers of incidents open at any one time have been set. The Medical Division will be arrnaging meetings with their outlying departments to determine assistance required. Report provided to the SPG on 4th December detailing progress made in most Divisions and further work required. Attached to the risk assessment. 24th December 2015 - The further controls have been determined but are taking time to have an effect in all the Divisions. The new weekly Operational Governance meeting will review incidents at three meetings per month, using the weekly incident performance reports, and so adds another level of monitoring / control. The completion date has been extended to February allow this control to be evaluated. March 3rd 2016 - W&C and TACO performance acceptable. Clinical Support, Surgery & Medicine is not yet. Advised to target staff and areas with high numbers of incidents open to understand the causes and offer additional support. Overall Trust performance = 60% after a few weeks in February where the initial target of 50% was met.	

Corporate Risk Report

Develop patient safety incident reports for Divisional use and to feed performance dashboards from Datix	Chris Rawlings Head of Clinical Governance & Risk Management	31/01/2016	Datix Manager commenced working with Information Department. Report to provide actions for incidents made available from 1st December 2015 24th December 2015 - good progress being made in developing reports and inclusion in dashboards. March 2016 - REports made available on-line in February 2016. Dashboard display in progress and expected to be in place by the end of March. Agreement with Datix to employ Datix Dashboards to provide individual user reports/display for all the modules used on the Datix log-in screen. this should be avaialable in March with development work required to tailor the reports to individuals.	29/01/2016

Target Risk Level	Major	Unlikely	<mark>8</mark>	Low

Progress	3rd November - Risk rating reduced to 'moderate' in response to the improvements made in incidents 'in process' - but action to determine further controls remains open until complete. Development of reports extracted from Datix on a live basis have commenced and will replace weekly report and provide data for dashboards when complete. New actions raised to cover this. 24th December 2015 - Action for further controls to be determined has been amended with the addition of the Governance Operational Meeting due to commence in January. March 2016 - W&C incidents remain under control. initial 50% target met for a few weeks in February but performance is variable. Improvements in other Divisions but further work required to review and close incidents within 20 working days where possible. The Medical Division is experiencing increasing numbers of open incidents which has been discussed with the DMD and DIvisional Quality Governance lead with an aim to support staff and areas with high numbers of open incidents. Both actions therefore remain open until p[erformance improves. Weekly reports continue with twice monthly reports to and discussion at the Operational Governance Meeting. Agreement with Datix to use the Datix Dashboard Module to provide tailored graphical reports to individual user's log-in screens. Available in March it will be developed before roll-out in April / May.

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**3018 As a result of the care models on the Wyre Forest GP unit, medicines are not managed safely**
Date opened	15/09/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Catastrophic Possible **15** Moderate

Director/Committee	Chief Operating Officer /
Description/Impact	This risk follows on from Corporate Risk 2822, as described in March 2015: 1. Some prescribing on the GP unit is outside of trust policy. Examples include ranges of medications prescribed for syringe drivers which allow staff nurses to titrate doses for the patient but this relies on the nursing staff to select appropriate medication and for the palliative care team to monitor them. The nursing support on the ward is excellent and the palliative care team from Worcester provides excellent support but this needs ot be vreviewed in conjunction with the GPs. The GPs follow the community model of care which may be appropriate in this setting. 2. Warfarin prescribing is also at variance to trust policy. Nurses order INR checks on ICE, fax the results to the GP surgery and receive a fax return with dose schedule until next INR check. The fax is kept with trust warfarin prescription and is transcribed onto warfarin chart by the nurses, some of whom get a second check on transcribing. It is not prescribed on the chart by the prescriber. This again fits a community model of warfarin doses. There has been 1 example of an INRs not being checked for 1 week whilst patient is taking antibiotics which is at variance to trust policy although INR was in range after 1 week. 3. Documentation on the GP unit is variable. Some of the GP practices do not use the trust notes. The presumption is that the visits are documented at the surgery. Not all patients present on admission with any documentation. Some have a GP letter as would be received on admission to A&E. For others the nurse receives a verbal handover. The nursing staff are therefore relied upon to co-ordinate care. This poses challenges for pharmaceutical care for example the need to challenge the prescribing of ciprofloxacin as approriate anitibiotic and then in conjunction with the fact that the patient was epileptic 4. Communication between GPs and pharmacist is difficult due to the GPs clinical responsibilities in the practice and the need for a ward pharmacist to ask and receive responses to medication queries. It would be inappropriate for a pharmacist prescriber to act without the full history and consent of a GP. Current practice is to try to speak to the doctor who has seen the patient. If they are not available the duty doctor is requested. If the duty doctor is unavailable then a request for the duty doctor to telephone the ward is made. If the pharmacist is not on the ward the query is handed to the nurse responsible for the patient and documented in the notes. 5. Medicines reconciliation has not occurred prior to the ward pharmacist visit. If GP letters are available or the patient gives consent to access SCR medication reconciliation can occur. This has resulted in increased awareness of medication not prescribed or prescribed at variance to the prescription outside of the acute trust. There is currently no satisfactory way of confirming the variances with the prescribers in a timely manner which complies with trust policy. Verbal orders require a signature within 24 hours. 6. There is no current method of reporting prescribing errors to the GP prescribers within the trust which does not support investigation or learning from incidents.
Key Controls	Daily Clinical Pharmacist service available during normal working hours,Monday-Friday. All staff undergo annual medications training. All new staff undertake training followed by 5 supervised drug rounds by mentors before undertaking medicines administration
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level Catastrophic Possible **15** Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Ensure interim safety measures are effective	Robin Snead Divisional Director of Operations	21/03/2016		
Review contract with Worcestershire Health & Care Trust	Robin Snead Divisional Director of Operations	27/04/2016	Chris Tidman has contacted and held a discussion with Simon Haresnape requesting the HCT to confirm their theire commisioning intentions for WFGPU by 31st March 2016.	
Consider ward re-configuration to enable renegotiation of model of service delivery	Robin Snead Divisional Director of Operations	30/11/2015		12/01/2016
Discuss with Wyre Forest CCG as part of broader discussions with commissioners	Robin Snead Divisional Director of Operations	31/12/2015		12/01/2016

Target Risk Level Catastrophic Unlikely **10** Low

Corporate Risk Report

Progress	Wyre Forest Clinical Commissioning Group currently deciding on the future community ward based services required. Due to the delays, Robin Snead vto discuss interim solutions with Pharmacy and Wyre Forest CCG to provide further risk mitigation.

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**3019 As a result of the care models on Ward 1, medicines are not managed safely resulting in sub-optimal care**
Date opened	15/09/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services

Initial Risk Level Catastrophic   Possible   **15**   Moderate

Director/Committee	/
Description/Impact	Risk taken from past Corporate risk 2822, described in March 2015 as: 1. RMOs of varying quality employed by the trust. This has been a problem identified by the nursing staff and from a number of adverse events. The issues to date noted by the ward pharmacist cover knowledge of trust paperwork, dosing errors (chlorphenamine 40mg), lack of anticoagulant knowledge (thought warfarin was IV) , uncertainty over prescribing fluids and antibiotics (didn't know what cephalexin was). 2. Uncertainty over consultant responsibility for transfers to ward 1 from Worcester. All patients have a named consultant but it is unclear if they are then seen by that consultant therefore any outstanding care issues are not solved. 3. RMO's are locums therefore are not subject to the same guidance given by our deanery eg junior training posts are unable to prescribe chemotherapy. 4. Safe and timely discharges to the unit. For transfers from Worcester to a non acute bed on ward 1 there are additional difficulties ensuring all medications are supplied on discharge are in a suitable form for discharge as medications on the ward cannot be checked in pharmacy as off site. 5. To date there has been no medicines reconciliation on ward 1. This has been resolved by the addition of a ward pharmacist in the patients seen. e.g anastrozole omitted on a patient undergoing breast surgery. e.g A patient was prescribed ibuprofen post operatively but was already taking naproxen.
Key Controls	
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level Catastrophic   Possible   **15**   Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Agreed by Cape Medical that RMOs on KGH site will become more embedded in the clinical infrastructure on KGH site. E.g. RMOs will attend lists in Theatres with anaesthetists and surgeons and will join consultant physicians and surgeons on that site in OP	Julian Berlet Consultant Anaesthetist - Alex	29/03/2016		
All RMOs to undergo Trust Induction and will be granted access to relevant Trust IT systems	Julian Berlet Consultant Anaesthetist - Alex	29/03/2016		
All Consultants reminded that consultant responsibility continues if patients are transferred from Ward 1 to WRH	Julian Berlet Consultant Anaesthetist - Alex	07/11/2016		05/11/2015
Meeting with Cape Medical (company who provides RMOS)	Julian Berlet Consultant Anaesthetist - Alex	16/11/2015	Meeting held discussion regarding RMOs undergoing Trust induction and IT access	16/11/2015

Target Risk Level Catastrophic   Unlikely   **10**   Low

Progress

Next Review Date   12/04/2016

Corporate Risk Report

Risk	**3041 If the Trust does not increase efforts to save money, it may not realise the CIP target, worsening the financial position**
Date opened	16/10/2015
Strategic goal	Ensure the Trust is financially viable and makes the best use of resources for our patients
Strategic objective(s)	Use resources wisely

Initial Risk Level	Catastrophic	Likely	20	High

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	The £15.6m CIP target represents a significant challenge as it relates to 3.8% of total spend and elements of this are not influenceable. Delivering the required level of savings will require more radical approaches than have previously been taken, over-programming and delivering at a greater pace. At month 5, the forecast value of schemes stands at £9.3m.
Key Controls	Confirm and challenge meetings have been arranged to close the QIPP gap and improve delivery Finance and Performance Committee Executive accountability
Sources of Assurance	Internal Audit-CIP – Programme Management Audit

Performance Monitoring	Monthly Confirm and Challenge meeting includes CIP performance CIP report to Finance & Performance Committee
Gaps in Control	Operational pressures
Gaps in Assurance	

Current Risk Level	Catastrophic	Likely	20	High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Focus on developing flow in the organisation including medically fit for discharge	Rab McEwan Chief Operating Officer	31/03/2016		
Develop clear accountabilities along with training to develop financial capacity and capability	Rob Cooper Director of Finance	15/04/2016	Training being developed with a roll out plan.	

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	

Next Review Date	12/04/2016

Corporate Risk Report

Risk	**3044 If the Trust does not manage CCG QIPPs the financial plan will not be realised**
Date opened	21/10/2015
Strategic goal	Ensure the Trust is financially viable and makes the best use of resources for our patients
Strategic objective(s)	Use resources wisely
Initial Risk Level	Major Possible **12** Moderate

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	Financial plan has been set assuming £2.75m impact of CCG QIPPs as agreed by the Trust review panel. The Trust is working through the required actions to realign capacity in line with the income reduction. Further QIPP reductions are likely to be added as they are agreed by the Trust review panel.
Key Controls	Finance and Performance Committee Executive accountability Financial reporting to highlight key issues and facilitate corrective action Divisional management structures & divisional performance management monthly Robust QIPP plans signed off and divisional QIPP Confirm and Challenge meetings Monthly QIPP report to Finance & Performance Committee Expenditure controls
Sources of Assurance	Management Assurance-Monthly review via Finance and Performance Committee and Trust Board Management Assurance-Monthly monitoring of cost improvement programme delivery by divisions reported to F&P Internal Audit-Financial Management Arrangements & Reporting Audit Independent Assurance-Value for Money Audit

Performance Monitoring	Report to Turnaround Board - performance against the Financial Recovery Plan Financial reports to Finance & Performance Committee and Trust Board
Gaps in Control	Finalised project plans for all material elements of the QIPP programme Ability to realise savings in the face of operational pressures including safety issues and delayed discharges
Gaps in Assurance	

Current Risk Level	Major Possible **12** Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Work closely with CCGs to support the development of effective but realistic QIPP schemes for 2016/17	Haq Khan Deputy Director of Finance	30/04/2016	Structure in place for rapid identification and quantification of shared QIPP opportunities. Due date updated.	
Develop workstreams to deliver QIPP	Haq Khan Deputy Director of Finance	30/07/2016		
Realign capacity in line with the income reduction	Rab McEwan Chief Operating Officer	31/12/2016	Due date updated to reflect current approach	

Target Risk Level	Major Unlikely **8** Low

Progress	

Next Review Date	12/04/2016

Corporate Risk Report

Risk	**3078 Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner**
Date opened	23/11/2015
Strategic goal	
Strategic objective(s)	
Initial Risk Level	Major Likely [16] High

Director/Committee	Chief Operating Officer /
Description/Impact	Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner. The commissioners are aware that the community beds are insufficient for the numbers of patients that require rehab beds. Risks 1 Patients remaining in Trust beds when they require a rehab bed are not recieving rehab treatment 2 New patients are unable to be admitted to HASU/Stroke bed thus affecting performance measures being monitored by CCG, SSNAP, and CQC 3 Lenght of stay is therefore too long which means that new patients out lie on MAU and other wards blocking those beds to other admissions 4 Lenght of stay targets are not met (monitored by CCGs) 5 Thrombolysed patients cannot be moved fron ED directly to HASU. This is a hugh risk in terms of the correct pathway not being followed and level 2 care. The patient may have to stay in ED longer thus blocking a space and creating additional workload post thromboylsis during to the requirement for increased monitoring. 6 The Stroke Unit currently has 31 beds open and is commissioned for 29 7 The Trust has to make descisons to step patients down off the pathway and transfer them to AVON 4 so that it can accomodate new patients 8 The Trust risks reputational damage as it is not delivering local or national gold standards in stroke care 9 The financial risk - best practice tariff and stroke tariffs
Key Controls	Escalate downstrean capacity to PFC Escalate downstrean capacity to CCG Escalate to DDOps Medicine and COO Stroke patients not on ASU are assessed by a Stroke Consultant and MDT Outlier list held on ASU being reviewed daily Stepdown process identifying patients who can step off based on balance of patient needs
Sources of Assurance	

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level	Major Likely [16] High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Highlight to CCG'S the issues with availibility of stepdown beds	Robin Snead Divisional Director of Operations	31/05/2016		
Instigate a process of identifying patients who can step off the pathway based on a balance of patient needs	Caroline Lister Directorate Manager	26/02/2016	Process only utlised where there are extreme bed pressures. CCG's informed of action	24/02/2016
Introduce an outlier list to be held on ASU for daily consultant review	Philemon Sanmuganathan Stroke Consultant	26/02/2016	Outlier list in use, duplicated on whiteboard	24/02/2016
Introduce cultural change to ensure all Stroke pts not on ASU assessed by Stroke consultant and MDT	Philemon Sanmuganathan Stroke Consultant	26/02/2016	Patients are identified on a daily basis for step down 24/2/16	24/02/2016

Target Risk Level	Moderate Unlikely [6] Very Low

Progress	

Next Review Date	12/04/2016

Corporate Risk Report

Worcestershire **NHS**
Acute Hospitals NHS Trust

Risk	**3079 Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care**
Date opened	23/11/2015
Strategic goal	Ensure the Trust is financially viable and makes the best use of resources for our patients
Strategic objective(s)	Use resources wisely

Initial Risk Level Major   Likely   `16`   High

Director/Committee	Chief Medical Officer / Workforce Assurance Group
Description/Impact	Continued recruitment difficulties result in high levels of agency expenditure. At month 7 of 2015/16, medical staff are £4.4m overspent. This is split between 22 over established posts, at an agency cost of £2.5m with the remaining £1.9m being from increased premium costs of temporary staff net of any under establishments.
Key Controls	Working within framework Agency price cap in place Process embedded within divisions to identify need and authorisation by senior divisional management Escalation process for approval of rates or agencies outside framework system
Sources of Assurance	Management Assurance-WAG Medical Workforce Report

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level   Major   Likely   `16`   High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop strategy to increase substantial consultant body	Andy Phillips Interim Chief Medical Officer	15/03/2016	Update March 2016: Workforce Development Plan in progress, to be completed May 2016	
Review all non-substantive contracts with a view to identifying employment status	Julie Stupart Head of HR	31/12/2015	Report has been provided to Divisions for their follow up.	01/12/2015
MWAG to be reintroduced with specific TOR and workforce issues to be discussed and actions agreed	Andy Phillips Interim Chief Medical Officer	15/02/2016	No longer planned to be a separate group. This work will be incorporated into the work of WAG.	15/02/2016

Target Risk Level   Moderate   Possible   `9`   Low

Progress

Next Review Date   12/04/2016

Corporate Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**3097 If managers do not adhere to financial controls, there will be excess expenditure and financial recovery plan not met**
Date opened	27/11/2015
Strategic goal	Ensure the Trust is financially viable and makes the best use of resources for our patients
Strategic objective(s)	Use resources wisely
Initial Risk Level	Catastrophic Likely 20 High

Director/Committee	/ Finance and Performance Committee
Description/Impact	The trust has financial controls in place to effectively manage the trusts financial resources. For example, delegated authorised spending limits, business case process, budgeted establishment. These controls are not always adhered to for example, with agreements made outside formal trust procedures. The impact of this is that we will overspend and have detrimental impact on the Trusts financial performance and cash position.
Key Controls	Multiple financial controls in place as described in the Standing Financial Instructions and Scheme of Delegations Electronic budget holder training Support from Finance via budget holder meetings Disciplinary consequences if financial instructions breached Masking on iProc
Sources of Assurance	Internal Audit-Financial management internal audits of systems and processes

Performance Monitoring	Budget variance reviewed within division via budget holder meetings, meetings with Finance team. Detailed financial performance data provided to F&P committee.
Gaps in Control	It can be difficult to detect failure to adhere to controls until after it has occurred Staff are expected to manage within their scheme of delegation Electronic systems limit by amount but not by category of spend or vary by requesting department Discipline and escalation procedures not fully enacted
Gaps in Assurance	

Current Risk Level	Catastrophic Likely 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Identify breaches of financial code, and provide to Finance and Performance Committee with suggested actions	Rob Cooper Director of Finance	15/01/2016		
Implement enhanced financial controls as endorsed at November 2015 Finance & Performance Committee	Rob Cooper Director of Finance	16/12/2015	Chief Executive has met with Directors of Operations to explain the new financial controls which include agency caps and minimising contracted staff. This has also been sent formally to the Divisional Management Teams advising them of the changes.	30/12/2015

Target Risk Level	Moderate Blank 12 Moderate

Progress

Next Review Date	12/04/2016

Report to Trust Board (in public)

Title	**Board Declaration of Interests**
Sponsoring Director	**Kimara Sharpe** **Company Secretary**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Board is requested to receive the attached declaration of interests for assurance and inclusion in the Trust's Annual Report for 2015/16.
Previously considered by	Not Applicable

Strategic Priorities (√)

Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	√
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	
Develop and sustain our business	√

Related Board Assurance Framework Entries	Not applicable
Legal Implications or Regulatory requirements	Required under the Trust' Standing Orders
Glossary	

Key Messages

Title of report	Declaration of Interests
Name of director	Kimara Sharpe