Worcestershire NHS
Acute Hospitals NHS Trust

There will be a meeting of the **Worcestershire Acute Hospitals NHS Trust Board** on
Wednesday 2 November 2016
at 09:30 – 11:30 in **Alexandra Hospital Board Room, Redditch**

From 11:45 to 12:45, the Chairman and Trust Board will discuss topics with the Public
Topics should be emailed to kimara.sharpe@nhs.net by
Tuesday 1 November 12 noon

Caragh Merrick
Chairman

Please take papers as read

AGENDA

1	**Welcome and apologies for absence**	Chairman	
2	**Patient Story**	Interim CNO	
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest** *To declare receive the updated declaration of interest register*	Chairman	**Enc A**
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **7 September 2016** as a true and accurate record of discussions.*	Chairman	**Enc B1**
6	**Matters Arising**	Chairman	**Enc B2**
7	**Chairman's Update Report** *For information*	Chairman	**Enc C1**
8	**Chief Executive's Report** *For assurance*	Interim Chief Executive	**Enc C2**
	STRATEGY **Board Assurance Framework 2665, 2904, 3140**		
9.1	**Winter Plan** *For approval*	Interim COO	**Enc D1**
9.2	**Trust Management Group** *For assurance*	Interim CEO	**Enc D2**

Worcestershire NHS
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QUALITY AND PATIENT SAFETY Board Assurance Framework 2790, 2902, 3038, 2895			
10.1	**Quality Governance Committee report** *For assurance*	Committee Chair	**Enc E1**
10.2	**Patient Care Improvement Plan** *For approval*	Director of Planning and Development	**Enc E2**
WORKFORCE Board Assurance Framework 2678, 2894, 2893			
11.1	**Medical workforce report** *For assurance*	Acting CMO	**Enc F1**
11.2	**Nursing and Midwifery Workforce** *For noting*	Interim CNO	**Enc F2**
FINANCE AND PERFORMANCE Board Assurance Framework 3291, 3290, 3193			
12.1	**Finance and Performance Committee** *For assurance*	Committee Chair	**Enc G1** ***To follow (mtg 31-10-16)***
12.2	**Integrated Performance Report** *For assurance*	Director of Planning and Development	**Enc G2**
12.3	**Financial Performance Report** *For assurance*	Interim Director of Finance	**Enc G3**
RISK MANAGEMENT/GOVERNANCE			
13.1	**Board Assurance Framework** *For approval*	Interim Chief Nurse	**Enc H1**
13.2	**Audit and Assurance Committee report** *For assurance*	Committee Chairman	**Enc H2**
ITEMS TO BE RECEIVED			
14.1	**Security Annual Report** *For approval*	Interim Chief Operating Officer	**Enc I1**
ITEMS FOR INFORMATION			
15.1	**Charitable Funds committee report** *For assurance*	Committee Chairman	**Enc J1**
16	**Any Other Business**		
	Date of Next Meeting The next public Trust Board meeting will be held on **Wednesday, 11 January 2017**		

11:45 – 12:45
Topic discussion – topics determined by the Public
Please email your topic to kimara.sharpe@nhs.net by Tuesday 1 November, 12 noon

Patients Respect Improve and Innovate Dependable Empower

*Taking **PRIDE** in our health care service*

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).

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: November 2016 **Enc A**

Report to Trust Board

Title	**Declaration of Interests**
Sponsoring Director	**Caragh Merrick** **Chairman**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Trust Board is requested to note the updated declaration of interests for Trust Board members
Previously considered by	N/A

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

Related Board Assurance Framework Entries	N/A
Legal Implications or Regulatory requirements	
Glossary	

Key Messages

Attached is the updated declaration of interests for Board members.

Title of report	
Name of director	

Worcestershire NHS
Acute Hospitals NHS Trust

Enc A

TRUST BOARD OF DIRECTORS' REGISTER OF INTERESTS 2016/2017

Name	Designation	Declared Interest

Caragh Merrick	Chairman	• University of Birmingham
		  ○ Member of Council
		  ○ Honorary Treasurer
		• Royal College of Art
		  ○ Member of Council
		  ○ Deputy Chair of Council
		  ○ Honorary Treasurer
		• UCAS
		  ○ Trustee/Non Executive Director
		  ○ Chairman of Finance Committee
		• HELP Musicians UK
		  ○ Trustee/Non Executive Director

John Burbeck	Vice Chairman	• Director – Burbeck Ltd • Spouse is a Director of Burbeck Ltd • Spouse is the Company Secretary of The Joint Clinic • Spouse is self-employed management consultant providing support to the private health sector and IT companies • Spouse is Trustee, Age UK (Kidderminster, Redditch and Bromsgrove Branch) • Spouse – director of BBK Ltd, a small company undertaking marketing for small business including the health sector
Rob Cooper	Interim Director of Finance *until October 2016*	• RTC Financial Solutions
Rob Cooper	Director of Financial Recovery *from November 2016*	• RTC Financial Solutions
Denise Harnin	Director of Human Resources & Organisational Development	• HRD/Becon Consultancy
Alan Harrison	Non-Executive Director *from May 2016*	• Deputy Chair and Senior Independent Director – South Warwickshire NHS FT • Chairman – Fry Housing Trust • Director – The Albatross Theatre Project • Magistrate – HMCS

Name	Designation	Declared Interest
Stephen Howarth	Non-Executive Director	• Director – Worcester Golf and Country Club
Stewart Messer	Chief Operating Officer	• None
Rab McEwan	Interim Chief Operating Officer *until October 2016*	• Director, Taylor McEwan Ltd
Bryan McGinity	Non-Executive Director	• Director, Trustee and Treasurer – COB Foundation, company limited by guarantee (National Health Charity) • Chairman – South Worcestershire FE College
Gareth Robinson	Interim Chief Operating Officer *from October 2016*	• *To be advised*
Jill Robinson	Interim Director of Finance *from November 2016)*	• Substantive employer – NHS Improvement
Kimara Sharpe	Company Secretary	• Secretary – Princess of Wales Hospital League of Friends • Director, Kimara Sharpe Consultancy Limited • Member, Worcestershire Health and Care NHS Trust
Andrew Sleigh	Non-Executive Director	• Director – Pinoak Ltd • Non-Executive Director – Alta Innovations Ltd • Chairman – Geolang Ltd • Non-Executive Director V-Auth Ltd Deputy Chair Birmingham Science City • Non Executive Director - Smart Antenna Technologies Ltd
Sarah Smith	Director of Strategy, Planning and Improvement	• None
Janice Stevens	Interim CNO	• Ambassador for the Prince's Trust
Lisa Thomson	Director of Communications	• None
Chris Tidman	Interim Chief Executive	• None

Name	Designation	Declared Interest
Bill Tunnicliffe	Associate Non-Executive Director	• Spouse works for Worcestershire Acute Hospital NHS Trust • Main employment - University Hospital Birmingham NHS Foundation Trust. • Associate Medical Director (UHBNHS FT) with responsibility for appraisal and revalidation of medical staff. • Co-investigator - NHIR HTA funded trial (REST study Ref 13/141/02).
Mark Wake	Chief Medical Officer *Until April 2016*	• British Medical Association- member • Medical Defence Union-member • ORS (UK ENT research society)-member • Relationship with senior member of Trust

Kimara Sharpe
Company Secretary
November 2016

Worcestershire NHS
Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON

WEDNESDAY 7 SEPTEMBER AT 09:30 hours

Present:

Interim Chairman of the Trust:	John Burbeck	
Board members: (voting)	Rob Cooper	Interim Director of Finance
	Stephen Howarth	Non-Executive Director
	Rab McEwan	Interim Chief Operating Officer
	Bryan McGinity	Non-Executive Director
	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 Planning and Development
	Lynne Todd	Board Advisor
	Bill Tunnicliffe	Associate Non-Executive Director
In attendance:	Kimara Sharpe	Company Secretary (minutes)
	Paul Crawford	Patient Representative
	Tim Carter	Deputy Head of Communications
	Gary Ward	Divisional Medical Director (Medicine Division)
	Lisa Miruszenko	Deputy Chief Nurse
	Caragh Merrick	Incoming Chairman
Public Gallery:	Press	0
	Public	7
Apologies:	Stewart Messer	Chief Operating Officer
	Alan Harrison	Non-Executive Director
	Marie-Noelle Orzel	Improvement Director
	Andrew Short	Acting Chief Medical Officer
	Jan Stevens	Interim Chief Nursing Officer
	Lisa Thomson	Director of Communications

85/16 **WELCOME**

The Interim Chairman welcomed members of the public to the meeting.

86/16 **PATIENT STORY**

Ms Miruszenko introduced Ms Cassie Williams, Breast Screening Manager and J, a patient who had recent experience of the service.

Ms Williams described the services offered to women aged 50 to 65. Screening was offered every three years. She then invited J to give her story. J stated that she had received her second screening invitation and she attended the Bromsgrove centre for her screen. She was slightly anxious because her first screen had picked up a benign

cyst. After the second screen, she received a letter stating that the screen had been abnormal and asked her to return for further investigations. She had seven biopsies and was asked to return the next day for a further 9 biopsies. During this second set of biopsies, the machine had broken down. The staff had been extremely good and reassuring during this time. She was in the machine for 1 hour 40 minutes. A 4mm cancerous tumour had been discovered.

She then spoke passionately about the necessity for screening, describing how many women do not attend for screening as they are anxious. She had thought that cancer meant a lump in the breast, She realised now that this was not so and that screening was the only way of detecting some cancers such as hers. She ended by saying that she wished to start a campaign to encourage people to attend for screening.

Mr Burbeck thanked J for her story and invited questions from board members.

Mr McEwan also thanked J and welcomed the focus on early detection of cancer. He asked whether there were any aspects of her care that she would wish to improve. Ms Williams outlined the circumstances in relation to the machine breakdown and confirmed that all the staff acted appropriately. She welcomed J's enthusiasm for promoting the screening programme. Uptake was falling nationally and a local campaign would be helpful.

In response to Mr Howarth, J confirmed that Bromsgrove was easy for her to access. Ms Williams stated that Herefordshire patients needed to travel to Bromsgrove if further investigations were needed. She was working with the commissioners to provide a more local service.

Mr Burbeck thanked J for attending and wished her all the best for any future treatment she may have to have.

Resolved: that
The Board

- Noted the content of the story

87/16 **ANY OTHER BUSINESS**

No other items of business were raised.

88/16 **DECLARATIONS OF INTERESTS**

The Board noted the following declarations of interest:

The Interim Chairman:

- Spouse is a Director of BBK Ltd a company in the business of marketing for small companies including the health sector

Stephen Howarth

- Director of the Worcester Golf and Country Club

There were no additional declarations of interest.

89/16 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 6 JULY 2016**

Resolved that:-

- The Minutes of the public meeting held on 6 July 2016 be confirmed as a correct record and be signed.

90/16/1 **MATTERS ARISING/ACTION SCHEDULE**

The Company Secretary confirmed that all the actions had been completed or not yet due.

91/16 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

The following question was raised by Mr David Trigger:
As a Member of the Evesham Dementia Action Alliance, may I ask the Board to say what steps have been taken at each of the Trust hospitals to ensure compliance with the dementia-friendly Charter for Hospitals and is it anticipated that all the work will be completed in time for the CQC inspection expected in the Autumn?

Mr Burbeck invited Mr Tidman to respond. Mr Tidman stated that this was an important area for the trust as many patients with physical needs also had dementia. He has requested a gap analysis in relation to provision of services for patients with dementia which will be discussed by the Trust Board at a future meeting.

Ms Miruszenko confirmed that many improvements had been undertaken including improving signage and the introduction of dementia friendly clocks. Assessment of patients for dementia and delirium was very good within the Trust. She confirmed that the buildings were not conducive to being dementia friendly.

Mr Trigger stated that the latest PLACE assessment had placed the trust in the bottom 10 of all trusts. He asked whether there was the funding to improve the trust's facilities for patients with dementia. Mr Tidman confirmed that there was.

92/16 **Interim Chairman's Report**

Mr Burbeck congratulated Sara Treacy, a doctor at the Alexandra Hospital on representing the Republic of Ireland in the 3000m steeplechase final at the recent Olympic Games in Rio.

He confirmed that he has had a positive meeting with Redditch District councillors to discuss the developments at the Alexandra Hospital. He has also met with the Redditch MP, leader of the Council and the Chief Executive to plan the next stages of public consultation.

He attended a follow up meeting with the CCG lay representatives, Mr McEwan and Mr Cooper and CCG executives to constructively discuss how to jointly tackle the challenges faced by the Health Community. The dialogue was constructive and a number of ideas were discussed.

Mr Burbeck then presented the paper outlining a revised governance structure. He stated that the paper had been developed after advice form a number of areas including the buddy Trust, Oxford. The work followed on from the concern that the CQC raised about ward to board reporting. He asked for approval to disband the Strategy and Transformation Committee but withdrew the proposal to disband the Workforce Assurance Group following a recent meeting of that Group. The Group had proposed a radical review of the purpose and function which he supported.

Resolved that:-
The Board

- Noted the achievement of Sara Treacy
- Approved the revised Governance Structure as detailed

93/16 **Interim Chief Executive's Report**

Mr Tidman confirmed that the emergency changes to the pathway for very sick

children was being implemented as from today. All paediatric inpatients would now be at the Worcestershire Royal Hospital. He thanked the partners who had supported the changes including the West Midlands Ambulance Service, Birmingham Children's Hospital, the CCGs and the Trust staff. He confirmed that the communication strategy would continue with the use of social media, posters and leaflets.

He then went onto detail the changes being made. Over 80% of current attendance would remain at the Alexandra Hospital. Seriously ill children will be seen at Worcestershire Royal where access to high quality care is available, 24 hours a day. There is a national challenge with paediatric staff and similar changes are being considered or being implemented in other areas across the country. He concluded by stating that he would like early progression of the public consultation to avoid any further emergency action being taken.

Mr Tidman then turned to radiology. He went onto state that the Trust had received an unannounced visit from the CQC on 27 July which focussed on the backlog of plain films still to be reported by a Radiologist. The Trust has subsequently received a section 31 notice from the CQC setting out the need for more robust governance and monitoring of this backlog and a number of additional actions have been put in place by the Executive and Divisional management teams. To provide an independent view of the Trust's approach to clearing the backlog and its broader governance arrangements for Radiology, the Trust has also commissioned an external peer review from the Royal College of Radiologists. The Quality Governance Committee approved the Trust's proposed approach to reviewing patients who may have been affected by the backlog.

Mr Sleigh asked whether it was necessary to have two viewing of the x-rays. Mr McEwan confirmed that at present the policy required it, but if the x-ray was over two years old, the value of reviewing the x-ray was limited. Mr Tidman added that the peer review would determine best practice for all types of x-rays.

Mr Tidman went onto the demand pressures within the Emergency Departments (EDs). He expressed concern about the queuing within the EDs and the overcrowding. There was an added challenge of discharging patients to enable the flow through the Trust. There were a number of patients who waited more than 12 hours for admission over one weekend in August. He stated that Mr McEwan and Ms Stevens were developing different systems to ensure flow and early discharges.

He was hopeful that by chairing the new A&E Delivery Board, he will be able to drive more system wide improvements. He has visited Oxford to view the improvements they have made to patient flow. The Winter Plan would outline the initiatives being developed and this would be presented to the next Trust board.

In response to Mrs Todd, Mr McEwan confirmed that the impact of the Junior Doctors' strikes has been to improve emergency department performance but it has negatively impacted on outpatient and elective surgery. If the strikes go ahead, then the back log will increase significantly. He will discuss this in detail with the Finance and Performance Committee.

Mr Howarth asked whether the development of the A&E delivery board was a national requirement. Mr Tidman confirmed that it was and stated that the health economy now needed to deliver on a focussed five point ED plan.

Resolved that:-
The Board

- Received the assurance within the report.

94/16 STRATEGY

94/16/1 **Future of Acute Hospital Services in Worcestershire**

Mr Tidman stated that the Health Economy was now preparing for the next NHS England checkpoint. The pre consultation business case (prepared by the CCGs) will be considered on by a health economy group on 7 September. The business case outlines the investment needed in relation to bed capacity and the environment.

The plan circulated with the papers outlined the actions being undertaken by the Trust in response to the Clinical Senate report. Mr Tidman reminded members that the recommendations were advisory and as such would be implemented when feasible.

Mrs Todd expressed concern about the continuing delay to the public consultation. Mr Burbeck echoed the concerns and stated that he would be advocating for a definite timescale for the NHS England review later in the week. Mr Tidman confirmed that the whole health economy echoed these sentiments. Similar comments were then made by Mr Sleigh and Mr Howarth.

Resolved that:-
The Board:-

- Noted the Trust's response
- Urged NHS England to approve the business case in a timely manner to facilitate consultation.

94/16/2 **Trust Management Group**

Mr Tidman presented the first report to the Board from the Trust Management Group which had been set up as a successor to the Trust Management Committee.

Mr Tidman was pleased to report that a strategy for acute medicine was presented. There was a commitment to ensure that ambulatory care was a success within the Trust and a clear vision for cross county working.

There was progress in the theatre utilisation work which will be discussed at the Finance and Performance committee. The clinician commitment to ensure more effective working was evident.

Approval was given to develop an ambulatory chemotherapy unit at the Alexandra Hospital. He was confident that more services would be able to be located on the Redditch site.

In response to Mr McGinity, Mr McEwan confirmed that the theatre admissions unit had been agreed which should be operational prior to Christmas.

Resolved that:-
The Board

- Received assurance that the strategy for acute medicine is in development
- Noted the System Resilience Group has been disbanded and a Local A&E Delivery Board has been formed
- Noted the report

95/16 QUALITY AND PATIENT SAFETY

95/16/1 **Quality Governance Committee**

The Chair of the Committee, Dr Bill Tunnicliffe presented the report from the Quality

Governance Committee (Enclosure E1). The Report covered both July and August meetings.

Dr Tunnicliffe received and endorsed the new clinical governance structure. He stated that this would enable appropriate scrutiny and debate.

He was pleased with the progress with complaints metrics but was disappointed with the lack of progress of mortality reviews, sepsis and the pathway for fractured neck of femur.

Finally he expressed concern about the radiology situation. He was assured that the revised governance structure would be more able to pick up such issues but he was disappointed that the Committee had been unaware of the backlog. However assurance was given in respect of the actions now being taken and the harm reviews which have shown that no patients have come to harm.

Mr Burbeck echoed Dr Tunnicliffe's concerns about the progress with mortality reviews. Dr Ward indicated that the first meeting of the Clinical Governance Group (CGG) had been very positive and had shared frustrations with the current methodology. He was aware that clinicians needed to be held to account in respect of this area of work and the CGG members had indicated a willingness to ensure that rates improved. Ms Miruszenko stated that the CGG will be crucial in ensuring a collaborative approach to learning.

Mrs Todd was encouraged by the formation of the CGG but reminded members that a low completion of mortality reviews has been raised by QGC for the last 18 months. Dr Ward agreed but the CGG will ensure engagement across the whole trust in the process, which has been lacking. He also stated that clinicians need time to undertake the reviews. Dr Tunnicliffe agreed and confirmed that the governance time built into job plans needed reviewing and clarification.

Mr McGinity expressed concern that the division had not raised the issues concerning radiology and wondered whether data were available to enable adverse trends to be spotted. Mrs Sharpe confirmed that the divisional directors were now developing the key performance indicators as part of the assurance process and these would be discussed at the CGG and presented to the QGC.

Mr McGinity asked for clarification in relation to the centralisation of stroke services. Mr McEwan stated that the adverts were out for staff in the dedicated cross county team and the newly established single MDT was already showing benefits.

Resolved that:-
The Board

- Noted the approval of the revised clinical governance structure
- Noted the improving complaints metrics
- Noted the Alexandra Hospital was an outlier for mortality associated with fracture neck of femur in 2014, but is not currently
- Noted the lack of improvement in the time to theatre for patients with a fractured neck of femur
- Noted the invited visit by the British Orthopaedic Society
- Noted the actions being taken in respect of the back log of x-rays and the CQC unannounced visit
- Noted that the QGC approved the annual reports for Health and Safety, Clinical Effectiveness and Infection Prevention and Control

- Noted the report

95/16/2 **Patient Care Improvement Plan**

Ms Smith presented the report. She stated that progress with the PCIP had been slower than expected, with operational pressures and staff turnover impacting on managerial and clinical capacity. The organisational development programme needed to transform working practices and to support improvement capability should also not be underestimated.

Mr Tidman stated that he had commenced holding senior management to account via the weekly executive management meeting. He was concerned that in particular the urgent care and mortality metrics were not improving in line with trajectory. He agreed that there was more to do and that extra capability and capacity would be needed, coupled with clear accountability.

Mr Sleigh confirmed that the Urgent Care PCIP had been discussed at the Finance and Performance Committee. He was unable to give assurance to the board about its progress. He was concerned that front line staff were not aware of how they could make a difference and there appeared to be lack of commitment to implement some proven work streams for example, the SAFER bundle. Mr Tidman confirmed that a refreshed plan was being drawn up via the COO to 'reset' the urgent care system from early October and that this would be reported back to F & P.

Mrs Todd also expressed concern about the lack of progress and she gave an example of how the Women and Children division have implemented their actions and raised awareness with front line staff.

Mr Tidman acknowledged the frustrations around the lack of progress with the outcomes at this stage, but stated the importance of simplifying the approach and the messages to staff, as it is this 'buy in' that is crucial to making a stepped change. At times, the detailed mechanics of the PCIP may be over engineering the solution. He agreed with Mrs Todd that the Women and Children division's approach should be replicated.

Dr Ward complimented Ms Smith on her work to develop the PCIP and stated that much was now changing at the frontline, particularly around urgent care that would begin to come through as performance improvement.

Resolved that:-
The Board

- Received the latest published PCIP report and to support the further actions described to ensure that satisfactory progress is being made.

96/16 WORKFORCE

96/16/1 **Workforce Assurance Group**

Mr Burbeck, Chair of the WAG presented the report (enclosure F1). He confirmed the discussions at WAG in respect of the new governance structure but emphasised the necessity to change the focus of the Group to become more strategic.

Mr Burbeck stated that the number of medical vacancies caused concern. Assurance was not given that the divisions were progressing each medical vacancy. Processes had been reviewed and improved within the HR department so as not to cause delay once the divisions have agreed to progress the vacancy. Mrs Harnin confirmed that there were 130 vacancies across the Trust which needed to be reviewed and determined whether to progress as a vacancy or to change the role. Mr Tidman agreed

that this area needed to be managed and progressed.

Mr Sleigh stated that the Finance and Performance Committee had also expressed concern about the number of vacancies and was not assured that the divisions were undertaking robust planning to take into account the increased demand for care.

Resolved that:-
The Board

- Noted the report

96/16/2 **Nursing and Midwifery Workforce**

Ms Miruszenko presented the report (enclosure F2). She confirmed that the main focus was on recruitment. The housekeeping and ward administrators would commence on 19 September and there were a further 50 people interested in the band 4 roles. She was working with HR to understand more about why staff were leaving and what the Trust could do to retain staff. The recruitment events were continuing.

Resolved that:-
The Board received assurance in relation to

- Nursing and Midwifery Workforce metrics and associated actions
- Safe Staffing Status

Mr Tim Carter joined the meeting

97/16 FINANCE AND PERFORMANCE

97/16/1 **Finance and Performance Committee Report**

Mr Sleigh, Committee Chair, presented the report from the Finance and Performance Committee held on 1 July 2016 (enclosure G1). The six month review showed the Trust on track with an operational deficit. He was pleased that the divisions were managing costs and income but there were £15m of risks to manage. There were plans in place.

Mrs Todd asked for an update on the Theatre utilisation project. Mr Sleigh confirmed that work was well on track but initiatives had yet to be embedded. Mr Cooper added that PWC are working with the Trust to achieve a sustainable position and he was hopeful that results would be shown from September. He described the actions being taken by the Divisional Senior Leadership team.

Resolved that:-
The Board

- Noted that the audit conducted by PwC confirms the reality of the £10m savings in agency spend during Q4 of last financial year with this reduction continuing in 2016/2017.
- Congratulated the teams for achieving the planned deficit at Q1, and completing a rigorous re-forecasting of the rest of the year.
- Noted the financial forecast aligns with the planned deficit, but that £15M of risks to that forecast have been identified with plans largely in place for mitigation. Also the potential upside of £2-5M from enhanced elective activity.
- Focussed on areas where operational performance continues to fall behind the planned trajectory, in particular addressing the Referral to Treatment (RTT) targets, strengthening implementation of the Patient Care Improvement Programme (PCIP), and delivering the PwC project to improved productivity in operating theatres.
- Noted that the Committee has approved initiation of designs and submission of a

distressed capital loan bid to complete the closure of A Block at Kidderminster, decommissioning Aconbury East and essential refurbishment of infrastructure. Also approved were Bundles 1 and 2 of the proposed car parking improvements subject to conditions being met.

97/16/2 **Integrated Performance Report**

Ms Smith presented the report. She reminded members that the Quality Governance Committee and the Finance and Performance Committee scrutinise the respective performance.

She expressed concern with the Trust's performance. NHS Constitution standards continued not to be met. There is a clear trajectory in place for recovering the position with action plans in place. The Finance and Performance Committee had considered this in detail. She was of the opinion, however, that there needed to be a refocus on the RTT targets. Mr McEwan agreed and confirmed that he was meeting with divisions and articulating the need to deliver targets.

She reminded members that urgent care was contained within the PCIP report and quality and workforce metrics had been discussed by the respective committees.

Mr Sleigh stated that the Trust needed to focus on the Sustainability and Transformation Fund targets as achieving these would ensure additional funding for the health economy.

Mr McGinity asked for more detail about the position in respect of endoscopy. Mr Tidman confirmed that plans were in place to increase the throughput.

Resolved that:-
The Board

- Reviewed the Integrated Performance Report for July 2016; the key performance issues and the mitigating actions.

97/16/3 **Financial Performance Report**

The Interim Director of Finance, Mr Cooper, presented the financial performance report (enclosure G3) and highlighted the main points. He reported that there was a £300k negative variance in July due to performance issues. He had identified a risk of £14-15m but he considered the Trust on track to meet the end of year financial target. He went on to outline the risks:

- Pay costs – The control cap is £22.9m and the forecast is £22.8m. Medical recruitment is key to the achievement of the forecast. Mrs Harnin explained the work being undertaken with the centralisation of medical coordinators which would have an immediate impact due to the control which will be exerted.
- Cost pressures: There were weekly meetings to identify these and controls were in place.
- CIP – there was £4.7m still to be identified.
- Lack of achievement of CQUINs – he is working with divisions on this issue.
- STF achievement – this is reliant on the achievement of performance targets.

Ms Miruszenko left the meeting.

Mr Burbeck stated that the Finance and Performance Committee had analysed the situation in detail. He welcomed the focus on risks.

Mr Tidman reinforced the necessity to deliver the performance targets which would

then deliver the financial performance. He confirmed that there would be a concentration on medical recruitment.

Resolved that:-
The Board
- Noted the Trust's financial position

98/16 **GOVERNANCE**

98/16/1 **Health and Safety Annual Report**

Mr McEwan presented the Report which had been reviewed and endorsed at the recent Quality Governance Committee.

Resolved that:-
The Board
- Approved the Annual Report

98/16/2 **Trust Infection Prevention and Control Committee Annual Report**

Mr Tidman presented the report which had been endorsed by the Trust Quality Governance Committee. He commended the work of the infection control team.

Resolved that:-
The Board
- Approved the Annual Report.

98/16/3 **Register of Seals**

Resolved that:-
The Board
- Noted the register of seals

DATE OF NEXT MEETING

The next Trust Board meeting will be held on Wednesday 5 October at 09:30 in the Charles Hastings Education Centre, Worcestershire Royal Hospital, Worcester.

Mr Burbeck thanked Mrs Todd for her work as a non-executive director and latterly as a Board Advisor. He particularly thanked her for her work as the link to the Women and Children division. He wished her well for the future. Mrs Todd responded by saying that she had enjoyed her years working for the Trust.

Mr Burbeck introduced Mrs Merrick, the incoming Chairman and invited her to say a few words. Mrs Merrick stated that she was delighted to be commencing as Chairman in the coming week. Her top priority was to recruit a stable Board and she would be shortly advertising for a Chief Executive. She was hopeful that she would quickly make considerable progress on the recruitment of both executive and non-executive directors to enable the Board to move forward in challenging times.

The meeting closed at 12:00 hours.

Signed _____ **Date** _____
Caragh Merrick, Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT 2 NOVEMBER 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
7-9-16	CEO report	93/16	Discuss with F&P the implications of the junior doctor stroke on waiting times				Action unnecessary s the junior doctor strikes have been called off.	
7-9-16	PCIP	95/16/2	Reset of system in respect of urgent care – to be discussed at F&P	RM			Transferred to F&P	
7-9-16	WAG	96/16/1	Progress needed with the medical vacancies	CT			Discussed and progressed through TMG, October 2016	
7-7-16	FOAHSW	72/16/1	Present Trust's response to the clinical senate report to the next board meeting	CT	Sept 2016		On agenda. Closed.	
7-7-16	BAF	76/16/1	Review CRR in relation to emergency surgery	RM	Sept 2016	Oct 2016		
7-7-16	WAG	74/16/1	OD strategy to be presented to TB in September	DH	Sept 2016		Deferred. For discussion with the Chairman for way forward	

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 2 November 2016 **Enc C1**

Report to Trust Board

Title	**Chairman's Report**
Sponsoring Director	**Caragh Merrick, Chairman**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is requested to: • Note the Chairman's Action taken on 28 September • Approve the revised remuneration committee membership • Receive the update with respect to the Board appointments • Note the report
Previously considered by	Not applicable

Priorities (√)

Investing in staff	
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	

Related Board Assurance Framework Entries	2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services 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	

Key Messages

This paper details the Chairman's Action taken on 28 September, recruitment to Board posts and changes to the membership of the Remuneration Committee.

Title of report	Chairman's Update report
Name of director	Caragh Merrick

Date of Trust Board: 2 November 2016 **Enc C1**

REPORT TO TRUST BOARD – 2 NOVEMBER 2016

1. Chairman's Action

On 28 September 2016 approval was given to spend winter monies of £600k to open Evergreen ward. This decision, a Chairman's Action, was taken during a Board Development session so was endorsed by the whole board, including the presence of all the non-executive directors (except Alan Harrison).

2. Remuneration Committee

I should like to appoint John Burbeck and Bryan McGinity as NED members of the Remuneration Committee with immediate effect.

3. Board composition

As this will be the last meeting in public attended by Stephen Howarth and Andrew Sleigh, whose terms of office end on 31 December, I should like to take this opportunity of thanking them for their service and I would like to wish them well for the future.

I will be able to give a verbal update at the meeting in relation to other non-executive director appointments.

As members are aware, I am keen to ensure that the trust has a stable board going forward. To this end, interviews for the permanent Chief Executive are scheduled for 9 November. Interviews for three non-executive directors are scheduled for 14 November. The closing date for these latter posts is 4 November and they can be accessed via the weblinks as follows: https://publicappointments.cabinetoffice.gov.uk/appointment/worcestershire-acute-hospitals-nhs-trust-3-non-executive-directors/ https://improvement.nhs.uk/news-alerts/non-executive-directors-x-3-worcestershire-acute-hospitals-nhs-trust/.

Once the permanent Chief Executive has been appointed, executive director posts of the Chief Nurse, Director of Finance and Chief Medical Officer will be progressed.

I am working with the Director of HR and OD on a Board Development programme which will commence in the New Year. Further details of this will be progressed at the Board of Directors' meeting in December.

4. Dates for 2017

Board members will be aware that I am keen to enhance public engagement. I intend to hold bi-monthly Board meetings in public, supplemented by public meetings in all areas of Worcestershire. The bi-monthly board meetings will be held in January, March, May, July, September and November in 2017. I am keen to develop our patient and public engagement and to this end, I would like to trial at the end of each meeting an hour's session for the Board to discuss topics put forward by members of the public. In this way, I intend to show that the Trust is an open and transparent organisation which listens to its constituents.

Title of report	Chairman's Update report
Name of director	Caragh Merrick

5. Recommendations

- Note the Chairman's Action taken on 28 September
- Approve the revised remuneration committee membership
- Receive the update with respect to the Board appointments
- Note the report

Caragh Merrick
Chairman

Title of report	Chairman's Update report
Name of director	Caragh Merrick

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2 November 2016 **Enc C2**

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 • Note the items covered in the report • Agree that Finance and Performance Committee will oversee the new monthly agency spend returns • Receive the assurance contained within the report
Previously considered by	Not applicable

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

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

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.

Date of meeting: 2 November 2016 **Enc C2**

WORCESTERSHIRE ACUTE HOSPITAL NHS TRUST

REPORT TO PUBLIC TRUST BOARD – 2 NOVEMBER 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 Future of Acute Hospitals in Worcestershire (FOAHSW) Programme

I attended a positive meeting on 21 October with NHS England to review the readiness to move to public consultation and I am expecting formal notification about the next steps. I will be able to give a verbal update at the meeting.

Attached to this report is a short paper on the principles of consultation which will be led by the CCGs with the Trust as an active participant.

4 NHS Improvement Shadow Segmentation

NHS Improvement has published the shadow segmentation for all trusts and foundations trusts, according to their support needs. The methodology for the segmentation is within the Single Operating Framework which was published in September. Worcestershire Acute is within segment 4, those trusts needing intensive support. 15% of acute trusts are within this segment, with a further 44% in segment 3.

5 2014/15 National Cancer Patient Experience Survey

The fifth National Cancer Patient Experience Survey results are now available on line at
http://www.ncpes.co.uk/index.php/reports/local-reports/trusts/3191-rwp-worcestershire-acute-hospitals-nhs-trust-2015-ncpes-report/file.

209 Clinical Commissioning Groups and 146 Acute NHS Hospital Trusts took part in the survey.

The local headline results are as follows:

- **77%** of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment
- **87%** of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment
- When asked how easy or difficult it had been to contact their Clinical Nurse Specialist **87%** respondents said that it had been 'quite easy' or 'very easy'
- **86%** of respondents said that, overall, they were always treated with dignity and respect while they were in hospital
- **92%** of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital
- **71%** of respondents said that they thought the GPs and nurses at their general

practice definitely did everything they could to support them while they were having cancer treatment.

Questions which scored higher than the expected range were:

Question	WAHT score	National average
All staff asked patient what name they preferred to be called by	76%	67%
Practice staff definitely did everything they could to support patient	71%	63%

Questions which scored lower than the expected range were:

Question	WAHT score	National average
Always given enough privacy when discussing condition or treatment	82%	85%
Patient given understandable information about whether radiotherapy was working	51%	60%

The latter score in relation to radiotherapy is almost certainly affected by the type of patients being treated with radiotherapy at our then, newly opened oncology centre. At that particular period of time the majority of such patients were palliative patients, which makes comparison with other centres unfeasible.

The results have been discussed at the Trust Management Group and the Cancer Board is taking forward an action plan and undertaking further local surveys.

I should like to thank all the patients who took part and congratulate the staff for such excellent results. Quality Health (who undertook the survey) will be presenting to the Trust on 9 November. Details have been circulated to members.

6 Long Service Awards

On Thursday 29 September, 54 staff received awards celebrating a total of 1400 years of service, hard work and commitment to our hospitals. Members of staff were called to the stage to receive their prestigious award, and a speech about each recipient was read out. The Chair and myself presented each staff member with a special gift of either a stunning star shaped glass trophy - for 40 years of service, or a beautifully engraved silver paperweight - for 25 years of service.

The Long Service Awards demonstrate the exemplary work carried out by staff across each of our three hospital sites, and shows the commitment each person has made over the years and what they continue to do for Worcestershire Acute Hospital NHS Trust.

7 Organ Donation

On Saturday 10 September, we held a gathering of donor's families and staff at Worcestershire Royal Hospital to share in the dedication and blessing in memory of Organ Donors.

The event included a blessing from Rev. David Southall and a speech from Chair of the Organ Donation Committee, Michael Aimies.

There was a wonderful turnout from both families and staff at the event. Further details are available on the internet.

8 Flu vaccination

The Trust is holding a number of flu sessions for staff. I am delighted that within the first three of weeks of launching the campaign, 48% of staff were vaccinated at this stage, which compares well against our peers. The aim is for at least 75% of staff to be vaccinated.

9 Executive and Divisional Medical Directors – Update

I should like to express my thanks to two Board Directors who have completed their term of office with the Trust. Rab McEwan, Interim Chief Operating Officer left in October and Rob Cooper, Interim Director of Finance will be concentrating on the financial recovery plan until March 2017. I am delighted to welcome Gareth Robinson as Interim Chief Operating Officer and Jill Robinson as Interim Director of Finance.

I am pleased to welcome Dr Jasper Trevelyan to the post of Divisional Medical Director – Speciality Medicine. Dr Gary Ward remains as Divisional Medical Director – Acute Medicine.

10 Local A&E Delivery Board (AEDB)

The second AEDB focused on the five workstreams that have been nationally mandated:-

1) Streaming at the front door – The scaling up of Ambulatory Care was noted as well as the enthusiasm and ownership of the recently appointed Acute Physicians.
2) NHS 111 – It was noted that a new contract had been let by the CCGs to Care UK for both GP out of hours and NHS 111. It was hoped that this would improve the accessibility of both services.
3) Ambulance services – It was noted that a new service specification was being developed by commissioners aimed at incentivizing ambulance services to adopt more proactive interventions to avoid hospital transfer.
4) SAFER bundle – It was recognized that SAFER was still not embedded and that further training and awareness was being planned via ECIST. The WHCT were asked to support the Acute Trust with some expertise as they had been recognized as exemplars with their community hospital SAFER bundle. It was noted that referrals to PFC had increased as a result of the 'system reset' which was positive.
5) Discharge to Assess – It was noted that out of 103 referrals in progress on the day before the AEDB, only 13 discharges were actually actioned on the day. The residual referrals were either awaiting work up, awaiting available capacity, awaiting further assessment or deemed not medically fit. Further capacity was to be commissioned to provide 12 "Discharge to Assess" beds to allow patients to step down from an acute bed, pending the ultimate destination. Further healthcare assistants will also be employed to unblock

Pathway 1 capacity.

It was agreed that the focus of the "system reset" continue both within the Trust and in the Worcestershire Health and Care NHS Trust, with the aim of increasing discharges and freeing up the MAU to stream new patients for assessment.

11 Staff Awards Ceremony

The annual staff awards ceremony will be held at the Chateau Impney Hotel on 18 November, where we will be joined by Olympian Colin Jackson CBE. The event will again be fully sponsored and based on the number and quality of nominations, it promises to be another inspiring and uplifting evening.

12 Mentors recognised

The following staff members were recognised at the recent University of Worcester Mentor Awards:

- Outstanding Mentor: Nurse - **Rebecca Clarke, Worcestershire Royal Hospital**
- Outstanding Mentor: Midwife – **Anna Meredith, Wyre Forest Community Midwives**
- Outstanding Mentor: Allied Health Professional – **Angela Goulden, Alexandra Hospital**
- Long Service Mentor: **Dr David Jenkins, Worcestershire Royal Hospital**
- Outstanding Practice Learning Environment – **Outpatients Department, Kidderminster Hospital and Treatment Centre**

13 Agency monitoring

NHS Improvement have developed more rigorous monitoring of agency spend. A checklist has been developed for Boards to gain assurance about the actions being taken. This checklist will be discussed at the Board Development session on 30 November, prior to sending it to NHSI after that meeting. There is a requirement for on-going monitoring. I would suggest that this is overseen by the Finance and Performance Committee on a monthly basis.

14 Sustainability and Transformation Plan (STP)

The draft plan was submitted on 21 October which had incorporated a number of the Trust Board's comments although concern still remained over the size of the financial and transformational challenge. The Trust has indicated that it is committed to working in partnership to deliver an integrated community and Acute service in Worcestershire as this is the only feasible way to sustain services.

15 Consultants

Please see the attached starters and leavers.

16 National Update

16.1 Public Administration and Constitutional Affairs Committee report into discharge arrangements

On 28 September the Public Administration and Constitutional Affairs Committee published their follow-up report to the Parliamentary and Health Service Ombudsman report dated May 2016 on unsafe discharge from hospital. This could take the form

of both early, unsupported discharge as well as delayed discharge.

The committee were concerned that the National Audit Office had also estimated in May 2016 that the NHS spends around £820 million a year treating older patients who are staying in hospital unnecessarily.

NHS England, NHS Improvement and the Secretary of State for Health have all been tasked with responding. The Government's response is awaited.

16.2 State of Care

The CQC Annual Report was launched in October. The report looks at the trends, highlights examples of good and outstanding care, and identifies factors that maintain high-quality care. The report reveals many health and care services in England are providing good quality care despite a challenging environment, but that substantial variation remains. It also finds that the sustainability of the adult social care market is approaching a tipping point, and its fragility is beginning to impact both on the people who rely on these services and on the performance of NHS care and in particular demand on pressured A & E Departments. A summary report is available at the following website:
http://www.cqc.org.uk/sites/default/files/20161013_stateofcare1516_summary.pdf.

16.3 A&E performance

NHS England figures show that A&E summer waiting time performance was worse than almost every winter for the past 12 years. Delayed transfers of care also hit the highest monthly level since data collection begun.

16.4 Government Announcements at Party Conference

In his speech to Conference, Jeremy Hunt set out the following:

- Expansion of Government funded medical student places with an additional 1500 a year by 2018
- Maximum wait of four weeks for suspected cancer from GP referral to diagnosis and Ofsted-style cancer ratings for CCGs
- New suicide prevention strategy
- Consultation on provision for the functions of the independent healthcare safety investigation branch 'to give doctors a safe space to speak freely about medical error'. This follows the philosophy used for decades in the airline Industry, which is widely recognised as one of the safest in the world. Hospital estimates of their avoidable deaths will also be published.

16.5 Shadow Health Team

The Shadow Health Team is as follows:

- Jon Ashworth – Shadow Secretary of State of Health
- Justin Madders – Shadow Health Minister
- Barbara Keeley – Shadow Cabinet Minister for mental health and social care
- Sharon Hodgson – Shadow Public Health Minister
- Julie Cooper – Shadow Community Health Minister
- Rt Hon Lord Hunt of King's Heath – Lords Shadow Health Spokesperson.

17 Recommendation

The Board is asked to

- Note the items covered in the report
- Agree that Finance and Performance Committee will oversee the new monthly agency spend returns
- Receive the assurance contained within the report

Chris Tidman
Interim Chief Executive

Date of meeting: 2 November 2016 **Enc C2**

Future of Acute Hospital Services in Worcestershire - The approach to consultation and engagement

The consultation will be delivered in line with the legal and statutory requirements set out in the legislation in the NHS Act 2006 as amended by the Health Act 2009 and the Health and Social Care Act 2012.

In the case of substantial developments or variation to services which are the commissioning responsibility of CCGs or NHS England, consultation is to be done by NHS commissioners rather than providers i.e. by the relevant CCG(s) or NHS England.

The basic principles of consultation are:

- the consultation will be carried out with an open mind as to the final recommendation;
- consultees will be given enough information to enable them to respond in an informed way;
- consultees will have enough time to respond (deemed to be 12 weeks);
- all the responses will be fully considered by the Programme Board before any final decision is made;
- The consultation will be scrutinised by Worcestershire County Council's Health Overview and Scrutiny Committee (HOSC). Worcestershire County Council will decide whether a Joint Overview and Scrutiny Committee should be established in co-operation with neighbouring authorities.

It is important to note that the HOSC has the power to refer any decision made by the local NHS to the Secretary of State. The circumstances for referral encompasses if:

- It is not satisfied with the adequacy of content of the consultation;
- It is not satisfied that sufficient time has been allowed for consultation;
- It considers that the proposal would not be in the interests of the health service in its area; and
- It has not been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

Consultation Objectives

1. To meet the legal and statutory requirements of a consultation.
2. To consult with key stakeholders in as thorough and appropriate a way as possible and take all reasonable steps to secure a written, cogent response to the recommendations from these key stakeholders, clearly demonstrating that these stakeholders have been given every opportunity to submit such a response, within the constraints of the consultation process.
3. To demonstrate that the consultation has fulfilled the engagement-specific principles of the 'four tests', to the satisfaction of the Secretary of State.

   The four tests are:

   - There should be clarity about the clinical evidence base underpinning the proposals;
   - The proposals have the support of the commissioning GPs involved;
   - The proposals genuinely promote choice for patients; and
   - The consultation demonstrates strengthened engagement with the public and patients.
4. To achieve an appropriate and reasonable balance between the legal and statutory

requirements for consultation, and the needs, expectations and demands of the populations, staff and stakeholders affected.

5. To ensure the consultation is as accessible as reasonable and possible to key stakeholders, including NHS staff, patients and the public.
6. To ensure that by the end of the consultation process the Programme Board has a good and thorough understanding of the issues raised and feedback given by those who have been consulted.

The Plan

To ensure a wide range of people are able to take part in the consultation it is proposed that a focused plan is adopted. This will ensure that key groups and individuals are able to take part including: local commissioners; NHS and other provider organisations in the area and other NHS and health related regulatory bodies, such as NHS England and the Care Quality Commission; local authorities; local MPs; Overview and Scrutiny Committees; Health and Wellbeing Boards; Healthwatch and Health Education West Midlands; charities and local groups.

Consultation activity will also aim to secure engagement with the widest group of stakeholders as time and resources allow. This group of stakeholders will include:

- Patients, and their relatives and carers
- Staff
- The public and local communities
- Seldom heard groups
- Voluntary and charitable organisations
- Patient groups
- Trade unions and staff representatives
- Pressure Groups
- Young people

1 Focusing engaging with Local Groups to generate wider engagement

This involves representatives from all regional and local groups (including GP patient and hospital patient groups), being invited to attend a meeting and event. Here the consultation will be explained and materials presented for each representative to take back to their meetings and groups to gain their thoughts and feedback.

The consultation team (which includes a clinical representative) will offer to attend any regional and local group meeting.

Question forms will enable any specific questions to be raised and answered centrally.

During the final stages of the consultation period representatives from the groups are offered the opportunity to come together to provide their feedback to the consultation team.

2 Open Events

Using local community centres in key areas surrounding each of the Trust's three sites, open day events will focus on patients, relatives and members of the public

giving them an opportunity between 7.30am and 9pm to drop-in and ask questions, collect materials and provide their views.

The consultation team (which includes a clinical representative) will take individuals through the changes, provide details and packs to complete or take away to ensure as many views are captured as possible.

Question forms will enable any specific questions to be raised and answered centrally.

3 Focused approach to groups of the population directly affected by the proposals

Contact via letter with DVD and information with groups whose members care may change as a result of any specific changes including schools, paygroups and nurseries.

4 The General Public – improving awareness

Using shopping centres around the three sites, leaflets and information is to be distributed with any questions captured and responded to centrally. This will also provide an opportunity to advertise the local events.

5. Hospital, GP and healthcare patients , carers and visitors

Materials and information, including how to get involved and provide feedback, is to be made available at GP surgeries, pharmacies, dental surgeries and optician, as well as on the hospital sites encouraging people to get involved.

6. Engaging with 'seldom heard groups'

Healthwatch, the Patient, Public and Stakeholder Advisory Group to the Programme Board and local councils will be asked to provide details of groups and networks to engage with during consultation, including those recognised as 'seldom heard' and reflecting the nine protected characteristics. This will be used to inform the targeted approach offering these groups an opportunity to get involved through specific and tailored activity (including personalised and focused meetings and materials).

Timeline

The Cabinet Office has published guidance which states that the public consultation can be anywhere between two and 12 weeks long with more complex consultations needing the longer timeframe.

Following the conclusion of the consultation, the Programme Board, the Governing Bodies of the Clinical Commissioning Groups and the Worcestershire Acute Hospitals Trust Board will consider the feedback and use this to inform their final recommendations.

Consultation materials and resources

The consultation will be supported by awareness raising activity, via traditional and online/social media, through newspaper adverts, posters and postcards which will signpost people to information about the consultation (including the formal consultation document) and how to respond to it through a variety of channels.

The spokespeople will include representatives from the three CCGs and the acute Trust,

with all having received training and support on their role. They will be supported with DVD materials, briefing documents and a standardised slide deck to ensure consistence of messages.

Collecting and analysing consultation responses
An independent organisation will be appointed develop the consultation questionnaire and to independently collect and analyse all consultation responses.

Consultant Starters

Dr David Wilson, Consultant Cardiologist, commenced 5/9/16
Mr Harm-Jan Stellingwerff, commenced 15/9/16
Dr Caroline Fox, Consultant O&G, commenced 19/9/16
Ms Manon Van Seters, Consultant O&G, commenced 3/10/16
Dr Danny Cheung, Consultant Gastroenterologist, commenced 3/10/16
Dr Ghazi Ghazi, Consultant O&G, commenced 3/10/16

Leavers

Dr Athiveer Prabu, Consultant Rheumatologist, last day of service 13/9/16
Mr David Robinson, Consultant T&O Surgeon, last day of service 30/9/16
Dr Karen Tait, Consultant Physician – Diabetes and Endocrinology, last day of service 3/10/16

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2 November 2016 **Enc D1**

Report to Trust Board

Title	**Winter Plan 2016/17**
Sponsoring Director	**Gareth Robinson, Interim Chief Operating Officer**
Author	**Inese Robotham, Deputy Chief Operating Officer**
Action Required	*To agree the plan, noting the additional expenditure to ensure patient safety in the local health economy.*
Previously considered by	*The Executive Team*

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

Related Board Assurance Framework Entries	*2790 As a result of high occupancy levels patient care may be compromised and access targets missed*
Legal Implications or Regulatory requirements	None
Glossary	

Date of meeting: 2 November 2016 **Enc D1**

Winter Plan 2016/17

1. Introduction

This paper summarises plans at WAHT for an integrated approach to service delivery across Worcestershire over the winter months. All acute NHS Trusts need to make special arrangements to anticipate and cope with changes in demand over the winter months. Four common factors cause and exacerbate winter pressures in the NHS:

- Norovirus
- Adverse weather conditions
- Seasonal illness such as flu and other respiratory illness
- Staff shortages due to the above.

At the same time, there is a requirement to continue with a full programme of elective care, as waiting times become shorter, and cancer related referrals and interventions have increased in number. It goes without saying that at the time of year when illness and demand for health and social care are at their highest, there are more sick and vulnerable patients who need care in the community, putting extra pressures on our staff, carers, relatives, primary and community care.

Our priorities over the winter months as a Trust are therefore:

- To assess, treat and rapidly discharge the sickest and most vulnerable patients in our catchment area
- To protect our limited capacity for ambulatory assessment and specialist treatment from the adverse effects of overcrowding
- To extend our services across 7 days within available resources, providing 24/7 care of the highest standards, particularly diagnostics to support clinical decision making
- To maintain and protect a full elective programme
- To support carers, primary, community and social care services in their efforts to maintain patient's independence, health and wellbeing in the community.

Financial implications in response to winter pressures are summarised in Appendix 1.

2. Demand

Figure 1 below shows the increase in ambulance conveyances to the Trust over the last three years.

Figure 1 - Ambulance conveyances 2013/14-2016/17

Number of Ambulance Conveyances - Patient First													
Financial Year	Month												Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	3175	3108	2931	3229	3111	2974	3077	3090	3587	3438	3030	3502	**38252**
2014/15	3404	3515	3522	3607	3520	3384	3585	3695	3868	3594	3324	3559	**42577**
2015/16	3376	3597	3542	3645	3575	3620	3791	3736	3957	3829	3793	3922	**44383**
2016/17	3696	4034	3838	3975	3722	3719	24522						47506

Forecast increase in total annual ambulance conveyances between 2013/14 and 2016/17 : 24.19%

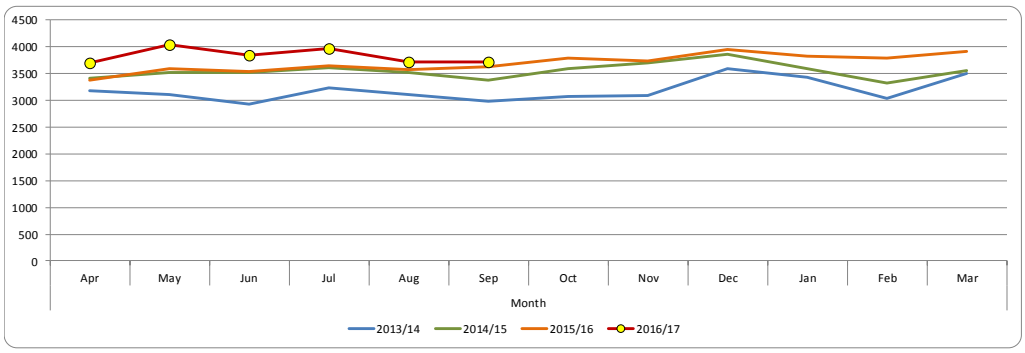
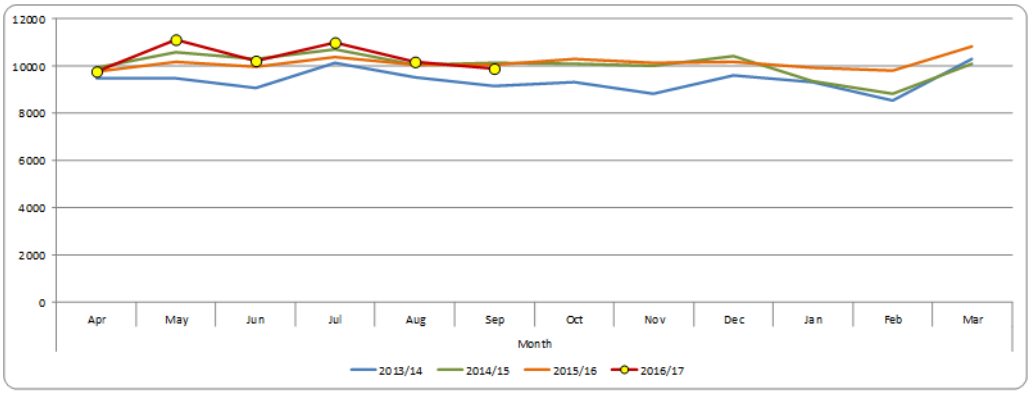


Figure 2 illustrates increase in ED attendances at WRH and ALX over the last three years.

Figure 2 – ED attendances 2013/14-2016/17

ED Attendances - Patient First													
Notes Includes First Attendances and Unplanned Follow Ups, but excludes Emergency Outpatient Clinics These figures exclude Kidderminster MIU.													
Financial Year	Month												Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	9486	9467	9056	10138	9513	9151	9305	8840	9611	9328	8544	10293	**112732**
2014/15	9937	10578	10310	10716	10067	10117	10100	10011	10419	9374	8835	10095	**120559**
2015/16	9767	10158	9976	10393	10056	10068	10301	10148	10168	9944	9823	10819	**121621**
2016/17	9758	11104	10216	11008	10161	9875	63667						125789

Forecast increase in total annual ED Attendances between 2013/14 and 2016/17 : 11.58%



3. Escalation

Capacity and demand are routinely monitored on a daily basis in our bed meetings, conducted three times a day and coordinated in the 'Hub' at Worcestershire Royal Hospital. Physical capacity (beds),

staffing levels, external capacity, and the range of operational and site specific issues that might impact on patient flow are regularly monitored. At times of increased pressure, leadership in the hub is increasingly senior, and a formal command and control structure is implemented across the whole Local Health Economy (LHE). There is also an expectation that the LHE will support the Trust and other emergency service providers by caring for more patients in the community at a higher level of acuity. The Trust has agreed a full capacity protocol with local partners, which sets out the framework for distributing the risk of hospital overcrowding internally and externally to the Trust.

Internal escalation is tied into the system-wide escalation process, and there are 4 defined levels of internal escalation:-

Escalation Level	Managed In Hours by	Managed Out of Hours by
1 – Normal working	Site Leads and Bed Manager	Site Leads and Bed Manager
2– Moderate Pressure	Lead Capacity Manager / Clinical Site Co-Coordinator and Divisional Representatives	On Call Manager with Clinical Site Co-coordinator
3 – Severe Pressure	Directors of Operations with co-ordination by Lead Capacity Manager.	On call Exec Director supported by On call Manager.
4 – Extreme Pressure	Chief Operating Officer / Deputy COO	Team Nominated by Chief Operating Officer

4. Surge

There is a predictable surge in demand following the Christmas and New Year Bank Holidays and at other times over the winter which are managed with effective coordination and implementation of surge plans. Plans for ensuring the appropriate management of patients during this period include:

- Extra specialty ward rounds in the first two weeks of January
- Extended Pharmacy hours
- Additional therapies input to ambulatory assessment areas
- Improved patient flow measures including: protected assessment areas, triage away from ED and protection of the minors workflow in ED
- Additional patient transport resource

A range of additional measures have been identified to cope with winter pressures as follows:

Increasing bed capacity to meet demand

- 21 beds - Evergreen – WRH
- Planned pilot with HaCT of 10 additional beds at Princess of Wales Community Hospital
- Wyre Forrest GP Unit re-opening to full capacity (16 beds) from November 2016

The Trust's bed model is currently being refreshed to link the current and surge bed capacity to the expected increased demand during winter months.

Admission avoidance measures

- MDU has become a Theatre Admissions Unit
- Extended Ambulatory Emergency Care (AEC) including
  - Broader scope and more patients seen in AEC at WRH and AGH
  - Consistent implementation of Older Persons Assessment and Liaison service at WRH and introduction at AGH

Improving patient flow and Discharge To Assess (DTA)

- Robust implementation of the SAFER bundle
- Implementation of 'Care Out of Hours' a new approach to clinical task coordination and safety out of hours
- A 'Single Call' triage from wards to the Patient Flow Centre of all complex discharges
- Trial of extended DTA model

5. Advancing seven day services

WAHT has the full range of emergency and urgent acute services operating seven days a week including general, vascular and trauma surgery, A&E services, inpatient services, up to level 3 critical care, and the full range of diagnostic and support services.

6. Workforce

The following additional workforce arrangements are in place over the winter months:

- Increased ED and Acute physician cover evenings and weekends
- Appointment of 2 Physicians Associates in November 2016 and further 2 in January 2017 with potential to appoint further three subject to successful retake of the exams.
- Over recruitment to therapies, nursing and HCA roles
- A review of safer staffing levels ward by ward, supplementing any predicted gaps with corporate and specialist nurses
- Monitoring compliance with E-Rostering to ensure consistent staffing levels
- Focussed management of vacancies and sickness

7. Discharge To Assess

Evidence shows that many patients, particularly the frail elderly have better outcomes and experience when an extended inpatient stay is avoided and when they instead have any essential acute hospital treatment as outpatients, day cases and with appropriate integrated care at home (RCP, Future Hospitals Commission, 2013). Older people who are otherwise independent frequently have an acute illness that needs some diagnosis and treatment in an acute setting, and at this time, their functional independence is challenged and may deteriorate. However, there are risks to this cohort of patients following inpatient admission, they may further decompensate, there is a risk of falls and hospital acquired illness, and unfamiliar settings can exacerbate confusion. The growing support for safely assessing and managing 'frailty' patients in their own environments needs effective coordination between secondary and primary care in delivering an Acute led Discharge To Assess model.

The experience of our 'Buddy Trust' the Oxford University Hospitals NHS Foundation Trust (OUHFT) is that pressure on acute hospital beds is significantly reduced over the Winter months with Acute led DTA including:

- Direct commissioning of nursing home beds for immediate DTA
- An Acute led Liaison hub checking patient wellbeing and providing direct medical, nursing, therapies and Social Work support to nursing homes
- Deployment of rapid diagnostic tests (Point of Care) to support these patients to stay independent
- Improved access to imaging facilities (CT and MRI) on an outpatient basis
- An advanced ambulatory emergency care capability to avoid or minimise acute admissions

The Trust reports a positive balance sheet impact of this initiative (saving approximately £800k by the end of 2016), 76 acute hospital beds were closed, beds occupied by Delayed Transfers Of Care reduced from 14% of bed days to 8%, and 60 patients per month have been successfully discharged. The Trust was able to implement this model from the concept stage in November 2015 to fully operationalizing 130 'transitional care' nursing home beds in December 2015. There are plans to extend the model to include an Acute Hospital at Home scheme in advance of winter 2016, and to close a further 68 beds.

OUHFT has offered its full support for a local implementation of a similar DTA model, including advice, guidance, copies of SOPs, site visits and collaboration on staff development. Working closely with the CCG, a scaled down pilot has been proposed with immediate effect.

CCGs have agreed the following actions as first steps towards a different model:

- Healthcare Assistant social care package pilot
- Access to additional DTA beds in local nursing homes from November 2016 (exact numbers to be confirmed)
- Scoping of centralised stroke rehabilitation service at Evesham

Evaluation and monitoring of the effectiveness of the above interventions will be via the A&E Delivery Board. Via the A&E Delivery Board we will also be seeking an independent post two year evaluation of the effectiveness of the Patient Flow Centre (PFC) focusing on information flows and performance against agreed standards.

8. Severe weather

Plans to assist the Trust during times of adverse weather conditions can be found on the Trust intranet on the Major Incident Response Plans page. The main plans to consider are:

- EPRR Arrangements (Command and Control)
- Severe Weather Plan (Activating Volunteer 4x4 Transport due to adverse weather conditions)
- Business Continuity Plans (Critical services)
- Worcestershire Local Resilience Forum (LRF) Coordination Arrangements in the event of severe cold weather.

Via the Worcestershire Local Resilience Forum, WAHT and Worcestershire County Council have specific operational level plans to reduce the risks to health from cold weather. '*The Cold Weather Plan (CWP) for England Protecting health and reducing harm from cold weather',* sets out public health and wellbeing impacts and what should happen before and during periods of severe cold weather in England. It spells out what preparations both individuals and organisations can make to reduce health risks and includes specific measures to protect at-risk groups.

A cold weather alert service operates in England from 1 November to 31 March. During this period, the Met Office will issue alerts which may forecast periods of severe cold weather, on the basis of either of two measures; low temperatures of 2°C or less; and/or heavy snow and ice. The cold weather alert service comprises five levels (levels 0-4). Each level aims to trigger a series of appropriate actions which are detailed in the operational plans for the NHS and social care.

Figure 3 – Cold Weather Alert levels

Level 0	**Year-round planning** *All year*
Level 1	**Winter preparedness and action programme** *1 November to 31 March*
Level 2	**Severe winter weather is forecast – Alert and readiness** *mean temperature of 2°C or less for a period of at least 48 hours and/or widespread ice and heavy snow are predicted, with 60% confidence*
Level 3	**Response to severe winter weather – Severe weather action** *Severe winter weather is now occurring: mean temperature of 2°C or less and/or widespread ice and heavy snow.*
Level 4	**Major incident – Emergency response** *Central Government will declare a Level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health*

In the event of adverse weather conditions impacting on the Trust's ability to provide normal levels of business, a Command and Control Team linked to the LRF will be established, and will consist of the following individuals during normal working hours:

- Chief Operating Officer and/or Deputy (Chair)
- EPRR Manager
- Divisional Directors of Operations (all divisions)
- Divisional Directors of Nursing (all divisions)
- Head of Estates and Facilities
- Associate Chief Nurse – Infection Prevention and Control
- Minute taker – COO/DDOps to identify

If the effects of adverse weather conditions impact on the Trust out of hours, the on-call Manager, on-call Matrons (all 3 sites) and on-call Executive will hold regular meetings and document decisions and actions taken. The on-call Manager will arrange and attend the first in-hours Command and Control Team meeting post their on-call to provide a situation briefing and handover.

The Command and Control Team above will hold regular meetings (no less than daily and deputised to the on-call Manager, Matrons (all 3 sites) and Executive over the weekend) to discuss and agree coordination of the key areas in the table below as a minimum. It is the responsibility of the Divisional Directors of Operations to ensure that all critical services within their divisions are considered and discussed under each key section below and identify other areas of concern to discuss.

The EPRR Manager is responsible for maintaining regular liaison with WHCT, NHSE and the Local Resilience Forum. He is available for additional support in and out of hours via switchboard on 07775680913.

9. Flu plans

Last year we achieved 58% of staff inoculated for influenza, and we aim to inoculate more this year despite staff concerns about failure of the vaccine last year, and low take up nationally in this season's campaign. As at 24 October 2016 we have achieved 52% and the programme will continue during November and December 2016. Additional efforts to increase take up of the vaccine include establishment of Flu 'Hubs' at all of our sites including regular night shift sessions commencing at 7am. Our flu team have done 'Walk Arounds' targeting high risk groups in A&E, MAU, theatres, paediatrics and oncology. Special sessions have been laid on at Junior Doctors training sessions and senior nurse forums. A free prize draw will take place for all staff who have been inoculated.

10. Communications

WAHT will be working very closely with the CCGs and other healthcare providers to ensure that there is a consistent and clear message being communicated to the population of Worcestershire. This year the main communications winter plan will be formulated around the national communications campaign.

Additional to this, WAHT will also run its own winter communications plan concerned specifically with the pressures experienced at the trust and the trigger points for escalating communications. As with any communications plan it is essential to ensure that all key stakeholders are informed about key messages at the appropriate time. The standard process for communication would be:

1. Staff
2. Communications Concordat – NHSi, CQC, CCGs, WH&CT, FOAHSW
3. Key stakeholders – MPs, media
4. Public

Whenever possible, internal communications should take place before the information is distributed to the media and the public. All messages will be agreed by the COO:

Weekly Update -This routine weekly staff communication channel will be used to provide routine winter plan messages to staff.

Intranet -The staff intranet is one of the most effective routes for staff communication. Updated by the Communications team on a daily basis it can provide real-time information to staff

Staff emails - Where possible the communications team will avoid contacting staff via email with the exception of the daily brief. Staff email

will only be used if either a specific group of staff need to be targeted or there is an urgent communication requiring action

Urgent Communications - Where urgent communication is required, the following channels will be used to communicate to staff: all staff emails, screen savers, intranet.

Plasma screens - There are plasma screens located across the 3 main hospital sites and will be utilized as a communication channel with staff and patients.

Website - The Communications team will work closely with NHS colleagues across the health economy to ensure messages to the public on our website are consistent and coordinated. Bespoke messages pertinent to each hospital site will be used as appropriate.

Social Media - The importance of social media messaging cannot be understated. All media and stakeholder communications will be promoted via WAHT Facebook and Twitter pages.

GP Communications - We will work with communications colleagues within the CCGs to get key Trust messages out to GPs and practice staff. A GP practice distribution list is also available for urgent communication.

Communications direct with the Media - It is vital that information is properly coordinated and shared to avoid the emergence of different or even contradictory messages. All media activity will be coordinated by the Communications team. Messaging will be consistent and in line with health economy colleagues and key site specific messages will be communicated to the media following agreement with the Winter Planning Emergency Lead. Should it be necessary to issue press statements/comments in the absence of the Communication team is important to let everyone know what statements are being made / interviews are being given, preferably in advance of any release to the media.

Communications direct with the Public - Any large emergency will result in widespread public interest and concern and consideration will be given, in conjunction with health economy colleagues to meet the need for additional public information material to address specific issues and support the media communications process. The Communications team will ensure that the Intranet end external websites are updated regularly. These should be used by hospital customer contact centres/switchboards to provide latest information.

11. Elective activity

The Surgery Division will continue with a full programme of elective surgery within available resources over the winter, including the period

between Christmas and New Year. Surgery Division will transfer elective activity off from the Worcestershire Royal site where appropriate to maximise theatre utilisation at KTC, AGH and Evesham; this will release further emergency capacity at Worcester. Theatres maintenance has been scheduled throughout the year and is NOT timed to coincide with the festive bank holidays.

12. Evaluation

Progress on the Winter plan will be monitored at the Finance and Performance Committee, including monitoring of income and expenditure (see Appendix 1), and the effectiveness of interventions. The Trust will undertake an evaluation of the effectiveness of the winter plan and actions taken over the winter in Q1 of 2017/18 to identify lessons learned and to support planning for the following year. The Trust will also contribute to evaluation of the local health economy plan and share the learning from the internal evaluation.

13. Action required

To agree the winter plan, noting the additional expenditure to ensure patient safety in the local health economy.

Date of meeting: 2 November 2016 **Enc D1**

Appendix 1 Finance

Summary financial implications

Winter plan measures (Dec 2016 - March 2017)	Pay £'000	Non Pay £'000	Source of funding
Additional bed capacity			
21 Beds Evergreen WRH	(500)	(100)	
Admission avoidance/ambulatory			
Additional Physio/OT	(147)		
Improved patient flow			
Additional specialty ward rounds	(13)		
Increased patient escorting (2 HCAs)	(40)		
Subtotal	**(800)**		Winter pressures reserve
Patient transport Support (Oct 16 -Mar17)		(120)	Within current forecast
Total	**(920)**		

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2 November 2016 **Enc D2**

Report to Trust Board

Title	**Trust Management Group (TMG)**
Sponsoring Director	**Chris Tidman** Chair of the Trust Management Group
Author	**Kimara Sharpe** Company Secretary
Action Required	The Board is requested to: • Approve the terms of reference • Note the monitoring work being undertaken on medical vacancies • Note the progress on out of hours care • Note the report
Previously considered by	*N/A*

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances
Legal Implications or Regulatory requirements	

Title of Report	**Trust Management Group**
Name of director	**Chris Tidman**

Date of meeting: 2 November 2016 **Enc D2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – NOVEMBER 2016

1. Situation

To inform the Trust Board on the actions and progress of the Trust Management Group (TMG) at its September and October meetings.

2. Background

The Trust Management Group provides assurance to the Trust Board on operational issues. TMG meets monthly.

3. Assessment

3.1 Terms of Reference

These have been approved by the TMG and are presented as appendix 1 for approval by Trust Board.

3.2 Medical Workforce

A significant proportion of time was spent at the October meeting on discussing each vacant medical post. Actions have been agreed to ensure that the vacancy level decreases. TMG will regularly hold to account the divisional leadership teams on this important issue.

3.3 Performance

Approval was given to the introduction of a Performance Assurance Group (PAG), reporting to the Finance and Performance Committee. This is an executive forum which will challenge and manage performance. The first meeting will be held in November.

3.4 Radiology

Progress has been rapid with the work to eliminate the backlog. The Divisional Director of Operations and the Divisional Medical Director gave a presentation showing the lessons learnt and the work that was undertaken to reach this situation.

3.5 Out of hours care

Progress was given by the Chief Nurse on the Out of Hours care project. There are six work streams associated with this programme. A key element of the work is the introduction of the Physician Associate role and work is underway to ensure that this role plays a key part in out of hours care. The introduction of the revised food service times has been as a direct result of the work with night staff to understand their needs better. A comprehensive communication strategy is in place to support this work.

3.6 Local A&E Delivery Board

A summary of the work programme discussed at the September A&E delivery board was discussed. A detailed work plan showing actions against the five work streams was also presented. The five work streams are:

1. A&E streaming at the front door
2. Increasing the %of calls to 111 transferred to a clinician
3. Improved triage and response by ambulance services
4. Improved patient flow
5. Discharge to assess

The local health economy have added a sixth work stream, that of communications.

4 **Recommendations**

The Board is requested to:

- Approve the terms of reference
- Note the monitoring work being undertaken on medical vacancies
- Note the progress on out of hours care
- Note the report

Chris Tidman
Chair of the Trust Management Group

Title of Report	**Trust Management Group**
Name of director	**Chris Tidman**

Date of meeting: 2 November 2016 **Enc D2**

Worcestershire NHS
Acute Hospitals NHS Trust

Terms of Reference

Trust Management Group

Version: 1.1

Terms of Reference approved by:

Date approved:

Author: **Company Secretary**

Responsible directorate: Chief Executive

Review date: March 2017

Title of Report	**Trust Management Group**
Name of director	**Chris Tidman**

Date of meeting: 2 November 2016 **Enc D2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Trust Management Group

Terms of Reference

1. Introduction

This Group will act as a subcommittee of the Trust Board and is set up to drive the operational agenda for the Trust. The Committee will ensure that the operational risks for the Trust are identified and mitigated as well as ensuring that the Trust achieves its performance targets.

2. Membership

Chief Executive
Director of Finance
Director of Strategic Development
Director of HR and OD
Chief Operating Officer
Chief Nursing Officer
Chief Medical Officer
Director of Communications
Director of Planning and Development
Divisional Medical Directors
Divisional Nurse Directors
Divisional Directors of Operations
County Cancer Lead
Director of Asset Management and Facilities

In attendance:
Company Secretary
Improvement Director
Deputy COO
Head of Information

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

3 Arrangements for the conduct of business

3.1 Chairing the meetings

The Chief Executive will chair the meetings. In the absence of the Chief Executive, the Chair will be the Chief Operating Officer.

3.2 Quorum

The Group will be quorate when one third of members are present including two non-clinical members of the Executive Management team and three clinicians.

3.3 Frequency of meetings

The Group will meet monthly.

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.

4 Authority

The Group is authorised by the Trust Board.

5 Purpose and Functions

5.1 Purpose

The purpose of the Group is to drive the operational agenda for the Trust. The Group will ensure that the operational risks for the Trust are identified and mitigated as well as ensuring that the Trust achieves its performance targets.

5.2 Duties

In discharging the purpose above, the specific duties of the TMG are as follows:

5.2.1 Strategy development

- To develop the annual business plan for presentation to the Trust board
- Monitoring the overall performance of the annual Business Plan including the quality, financial and workforce performance

5.2.2 Performance management

- To ensure compliance with performance targets
- Monitoring and ensuring delivery of the PCIP

5.2.3 Risk Management

- To identify the risks to the delivery of the operational objectives and ensuring mitigation of those risks
- To ensure that risks to patients are minimised through the application of a comprehensive risk management system including, without limitation:
    - to review the trust's risk management strategy prior to its presentation to the trust board for approval;
    - to ensure that processes are in place to ensure the escalation of risks from divisional risk registers to the corporate risk register and receive reports from the trust's risk executive forum

5.2.4 Emergency planning

- To ensure that the Trust has robust plans in place to respond to emergencies and meets the appropriate statutory legislation

5.2.5 Health and Safety

- To ensure that the Trust meets its obligations for Health and Safety
- To approve the annual report for health and safety for presentation the at the Trust Board

5.2.6 Information Governance

- To ensure that the Trust's responsibilities for information governance are discharged appropriately, in line with relevant legislation and the Information Governance toolkit
- To embody the principle of 'right first time', and champion data quality within the Trust. In particular, to ensure compliance with False or Misleading Information legislation.

5.2.7 External assessments (including the CQC)

- To ensure that the Trust adequately plans for external inspections
- To respond to inspection reports as appropriate

5.2.8 Cancer board

- Oversee the development and implementation of the cancer strategy

5.2.9 Children's services

- to ensure that the all Children's services meet the minimum requirements

5.2.10 Workforce

- To ensure that the Trust has a workforce fit for purpose

- To oversee the development and implementation of the that the Organisational Development Strategy

5.2.11 Health Records

- To ensure the safe management of health records, electronic and paper.

6. Relationships and reporting

6.1 The Group is accountable, via the Chief Executive, to the Trust Board. TMG will report after each meeting to the Trust Board.

6.2 The sub groups accountable to the TMG are as follows:

- Risk Executive Group
- Emergency Planning
- Workforce Operational and Assurance Group
- Preparing for Inspector meetings (task and finish)
- Children's Trust-wide group
- Health and Safety
- Information Governance
- Health Records
- Divisional Management Group
- Operations Executive group
- Cancer Board

These groups will provide regular reports to the TMG, frequency TBA.

7 Review of the Terms of Reference

These Terms of reference will be reviewed by March 2017.

KS/ToR TMG (corpgovtor)

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 2 November 2016 **Enc E1**

Report to Trust Board

Title	**Quality Governance Committee – report to Trust Board**
Sponsoring Director	**Dr Bill Tunnicliffe, Associate Non-Executive Director, Chair**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is requested to: • Note the never event • Receive assurance in respect of the management of VTE prevention • Note the lack of assurance in respect of the time to theatre for patients who had suffered a fracture neck of femur and primary mortality reviews • Note the lack of assurance in relation to the workforce information governance processes • Receive the Dementia update and note the amount of work being undertaken • Note the report
Previously considered by	Not applicable

Priorities (√)

Investing in staff	
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	

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 29 September and 20 October 2016.

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

Date of Trust Board: 2 November 2016 **Enc E1**

REPORT TO TRUST BOARD – 2 NOVEMBER 2016

1. Situation

This report provides the Board with key quality issues and risks discussed at the QGC's meetings held on 29 September and 20 October 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 Clinical Governance Group

It is now evident that the new governance structure is proving a valuable assurance mechanism for the Committee. The work undertaken by the CGG enables the Committee to gain assurance from the Chief Nurse and Chief Medical Officer in relation to clinical governance matters. The Committee have been concerned about the lack of development for staff involved in clinical governance activities and have received assurance that this is being addressed as part of the organisational development programme.

The Committee were informed about a never event that took place in September. The event was a wrong site block. The patient was unharmed. The investigation is underway and in concentrating on the lack of adherence to the processes in place.

The Committee also received the Cervical Cytology Annual Report.

3.2 Venous Thrombolytic Embolism (VTE) prevention

The QGC received a report from the Chief Nurse on the progress with ensuring all eligible patients have a recorded assessment in relation to VTE prevention. This was requested by the Audit and Assurance Committee as the Trust has had two qualified audits in relation to the Quality Account. Assurance was gained with respect to the actions being put into place.

3.3 Divisional reports

The reports from the divisions have noticeably improved with the clinical discussion held at the CGG. However, assurance was not gained with respect to the grip on the performance for patients needing surgery following a fractured neck of femur. Assurance was also not received on the number of primary mortality reviews. The Committee understood the actions being taken for the latter including the revision of the form and the consideration of linking appraisal to the completion of the reviews.

3.4 Avoidable Mortality

This are of work continues to be of concern. HSMR and SHMI continue to be an outlier and analyses have shown that the coding of comorbidities and

palliative care are unlikely to be major contributing factors. The main factor appeared to be the deteriorating patient.

3.5 Patient Engagement Strategy

The Committee were informed of the work being undertaken to develop this strategy which will be launched after the CQC visit.

3.6 Workforce information

The Committee wishes to raise with the Trust Board that clarification is required in relation to the governance processes around the triangulation of workforce information which is presented to QGC as risks and/or mitigation. QGC would also like to raise awareness with the Board that workforce information is not part of the information department so has separate quality assurance processes in place.

3.7 Radiology

Assurance has been received that there have been no harm events as a result of the backlog.

3.8 CQC preparation

The Committee are assured of the work being undertaken to prepare for the CQC inspection on 22 November. This includes Clinical Fridays and the development of a briefing pack for Board members.

3.9 Dementia update

As requested by the Trust Board, the Committee reviewed the Trust's approach to Dementia. The Dementia Lead, Donna Kruckow attended the October meeting. She was obviously very enthusiastic in relation to the developments. She outlined the new strategy which will be launched shortly and will address the Prime Minister's challenges for 2020. She also informed the Committee that the digital reminiscent therapy units had just been delivered. A video will be made of the working of this state of the art equipment. She is also working with the estates department and Evergreen Ward and Ward 12 have both been refurbished to be 'dementia friendly'.

She also reported that dementia friendly clocks and signage were being put in place.

3.10 Breach analysis – two week waits

The Interim COO presented to an analysis of harm events to the September meeting. No patient has come to harm from the delays incurred. Agreement had now been reached with the endoscopy consultants and this backlog should be cleared by the middle to end September.

3.11 Stroke services

The Committee heard that a new consultant had commenced within the stroke service which would ensure a more stable service. A county wide strategy was being developed to ensure that the service was attractive to potential recruits.

3.12 Clinical Effectiveness Annual Report

Title of report	Quality Governance Committee
Name of director	Bill Tunnicliffe

The Committee approved the Clinical Effectiveness Annual Report. During the year, there had been a concentration on ensuring that the audits were effective and were of high quality which is why the number had decreased from the previous year.

3.13 Board Assurance Framework

The Committee expressed concern about the lack of update in respect of BAF 2790 (high occupancy). Reassurance was given that the risk would be updated by the incoming Interim COO.

4 Recommendation

The Board is requested to:

- Note the never event
- Receive assurance in respect of the management of VTE prevention
- Note the lack of assurance in respect of the time to theatre for patients who had suffered a fracture neck of femur and primary mortality reviews
- Note the clarification required in relation to the workforce information governance processes
- Receive the Dementia update and note the amount of work being undertaken
- Note the report

Dr Bill Tunnicliffe
Chair – Quality Governance Committee

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 02 November 2016 **Enc E2**

Report to Trust Board in Public

Title	Patient Care Improvement Plan (PCIP)
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 latest published PCIP report and to support the further actions described to ensure that satisfactory progress is made.
Previously considered by	Combined Quality Improvement Review Group (QIRG) – CQC, NHSI, NHSE, CCGs))

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	

Related Board Assurance Framework Entries	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	Subject to satisfactory improvement, the CQC has included conditions on the Trust's registration relating to the time to initial assessment in the Emergency Department and reporting in Radiology
Glossary	NHSI – NHS Improvement NHSE – NHS England CQC – Care Quality Commission CCG – Clinical Commissioning Group PMO – Programme Management Office

Key Messages

The Patient Care Improvement Plan (PCIP) is central to the Trust being able to demonstrate sustainable change and improvement in key areas of Trust operations, governance and safety systems in response to external scrutiny.

The Trust has received additional support from NHSI to strengthen the governance of the PCIP and a PCIP progress report is provided as at end September 2016. There are 7 PCIP programme areas and some good examples of improvement activity and programme development/delivery. Programme areas that now have dedicated project /programme management or external support are on the whole making greater progress. The Urgent Care and Patient Flow PCIP programme presents the greatest risk in terms of governance and delivery. These issues have been compounded by wholesale changes in the Medicine Division management team. However, as a result of these changes there is greater capacity and programme and project support in place which, going forward should provide greater resilience to the plan and its delivery. Meanwhile, there are intensified operational controls in place to support patient flow.

Title of report	Patient Care Improvement Plan
Name of director	Sarah Smith, Director of Planning and Development

Date of meeting: 02 November 2016 **Enc E2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – NOVEMBER 2016

1. Situation

This paper presents the latest published version of the Trust Patient Care Improvement Plan (PCIP) as presented to the combined Quality Improvement Review Group (QIRG) in October 2016. The QIRG, which meets monthly, comprises the CQC, NHSI, NHSE and the CCGs and, as the Trust is in special measures, is responsible for the oversight of the Trust's required improvement plans.

2. Background

The Patient Care Improvement Plan (PCIP) is the mechanism through which the Trust is addressing the key areas of improvement identified from the CQC Chief Inspector of Hospitals Inspection visit in July 2015; in addition to previous safety concerns raised following unannounced CQC visits to the Trust's emergency departments in March 2015. The Trust received a further unannounced visit to the Radiology Department in August 2016 and this is the subject of a separate improvement plan.

Currently there are seven programme areas in the PCIP:

- Urgent Care and Patient Flow
- Reducing Mortality
- OD and Staff Engagement
- HDU Review
- Governance and Safety
- Outpatients
- RTT and Waiting Times

Reducing Mortality will form part of the new Caring Safely programme along with work streams around (a) eliminating harm and the (b) developing the Trust Improvement Faculty. Caring Safely will be launched formally on November 16th 2016.

3. Assessment

3.1 Key risks and controls

Across the 7 PCIP programme areas there are some good examples of improvement activity and programme development/delivery.

The Urgent Care and Patient Flow PCIP programme presents the greatest risk in terms of governance and delivery. These issues have been compounded by wholesale changes in the Medicine Division management team.

However, as a result of these changes there is greater programme and project support in place which going forward should provide greater resilience to the plan and its delivery.

Title of report	Patient Care Improvement Plan
Name of director	Sarah Smith, Director of Planning and Development

Programme areas that now have dedicated project/programme management or external support are on the whole making greater progress. These include:

- Reducing Mortality/ Caring Safely
- Governance and Safety
- Outpatients

Additional programme support has been in place for between 3-4 months and these programmes are starting to show returns in terms of approach, strengthened governance arrangements and improvement activity.

Their still remains a gap in terms of measuring improvement and the metrics associated with each programme are being reviewed as part of the strengthened PCIP governance arrangements described below.

3.2 Gaps in controls and mitigation

The Trust has received additional support from NHSI to strengthen the governance of the PCIP. Each programme area is being reviewed in a 'Star Chamber' meeting to discuss progress and evidence, identify priority actions and, where necessary, to review the programme objectives and reset the plans appropriately. Escalation of issues is via Trust Management Group.

The Star Chamber also serves to identify where there are additional resource requirements including project management and improvement resource. This process is running alongside but aligned with the weekly preparation for inspection meetings (PIMS).

As part of the strengthened PMO approach each work programme is being reviewed weekly to address issues around project management, governance, reporting and measurement.

4 Recommendation

The Board is asked to receive the latest published PCIP report and to support the further actions described to ensure that satisfactory progress is being made.

Sarah Smith
Director of Planning and Development

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 02 November 2016 **Enc E2**

WAHT Patient Care Improvement Plan
September 2016 Update

Programme	Workstream	Deliverables	Progress Rating		
			Sep-16	% Complete	Finish
Urgent Care & Patient Flow	SAFER bundle	Introduce best practice ward round (Medicine)		100%	Jun-16
		Engage all clinicians across sites (Medicine)		80%	Jun-16
		Train all staff in SAFER practice (Medicine)		100%	Jul-16
		Implement SAFER bundle across Trust		30%	Jan-17
		Workstream evaluation		25%	Jun-17
	ED/Acute Care	To implement a permanent AEC service on both acute sites (Mon-Fri 8-8)		50%	Dec-16
		Increase number of patients seen per day in AEC (15) / increase clinic slots		50%	Dec-16
		To ensure MAU functions consistently at both sites (60% ambulatory)		20%	Dec-16
		Ensure that 55% of GP referrals are seen in speciality clinics		20%	Dec-16
		Ensure 75% of patients referred to specialty doctors are seen within hour		50%	Dec-16
		Ensure that 95% of ambulance patients are handed over within 15 minutes		75%	Dec-16
	Patient Flow Centre	Electronic referral process in place with accurate reporting for receipt		100%	Jun-16
		Hosting of PFC to be transferred to WAHT		20%	Dec-16
		Integrated multi agency discharge support in place		50%	Sep-16
		Pathway 1 increased capacity to meet demand (Pathways 2/3 integrated)		10%	Sep-16
		Team of discharge liaison nurses established to support all discharges		75%	Sep-16
	Frailty Service	Implement an OPAL service on WRH and Alex sites operating 5/7		30%	Dec-16
		Close Elderly Medicine Ward in Aconbury East		100%	Jun-16
		To ensure service reviews 5 patients per day and discharge 80% of patients		20%	Sep-16
		Establish a new Silver Ward on MSSU at WRH		100%	Jun-16
		Establish an OPAL service at AGH		0%	Oct-16
		Liaise and integrate ED GP into OPAL service		0%	Nov-16

Date of meeting: 02 November 2016 **Enc E2**

Programme	Workstream	Deliverables	Progress Rating		
			Sep-16	% Complete	Finish
Caring Safely Programme		Combining four mortality reduction work streams below with two additional programme areas (Elininating Harm and Improvement Faculty) **DUE FOR LAUNCH NOVEMBER 2016**			
Mortality Reduction	Management of Sepsis	Identified medical clinical lead in all key areas		100%	Sep-16
		Ward based sepsis champions for each clinical area		50%	Dec-16
		Sepsis screening process for all patients with a NEWS score of 5 / PARS 3		75%	Dec-16
		Antibiotic Administration system for all patients with positive screening		50%	Dec-16
		Three day antibiotic review process for all confirmed sepsis patients		25%	Dec-16
	Mortality Reviews	Trust Mortality Review Documentation		50%	Nov-16
		Agree process for notification and investigation of all adult patient deaths		50%	Nov-16
		Primary Review dissemination process implemented		100%	Jun-16
		Primary Review investigation and review process		50%	Nov-16
		Secondary Review investigation and review process		0%	Nov-16
	Fractured NoF	Implement 'Golden Patients'	**Project reset underway with new dedicated project support from 10/10/16**		
		Dedicate first slot on trauma list to # NOF (unless required for more urgent			
		Schedule Daily trauma lists to meet demand requirements			
		Dedicated Trauma Anaesthetist provision			
		Allocated trauma bed base			
	NEWS	NEWS integration to all relevant paperwork		100%	Sep-16
		Training Programme delivered		100%	Sep-16
		Implemented audited escalation approach		75%	Nov-16
		Trust Launch of NEWS		100%	Sep-16
		Communications Plan Implemented (align with Sepsis work)		75%	Nov-16

Date of meeting: 02 November 2016 **Enc E2**

Programme	Workstream	Deliverables	Progress Rating		
			Sep-16	% Complete	Finish
OD & Staff Engagement	Leadership	Complete a training needs analysis for all senior leaders/managers		100%	Sep-16
		Implement a Trust Board Leadership Plan		25%	Mar-17
		Develop and implement a Board Development Programme		10%	Sep-17
		Develop a Talent Management Strategy		100%	Sep-16
		Implement 360 degree appraisals for all senior leaders		25%	Dec-16
		Develop "Understanding your Trust Programme		90%	Sep-16
		Develop a coaching culture for leaders/managers		80%	Dec-16
		Develop and implement a clinical leadership programme		25%	Dec-16
	Workforce Plan	Tactical plan to reduce agency spend / medical recruitment plans		100%	Sep-16
		Nurse recruitment and retention intiatives to include new roles		100%	Sep-16
		Plan for increased student mentorship /student nurses /recruitment		100%	Sep-16
		Plan for recruitment of Physicians Associates		100%	Sep-16
		2 - year Workforce Plans developed by end of November 2016		25%	Nov-16
	Policies / Standards	Review and develop key Policies and Procedures.		100%	Sep-16
		Strengthen and equip the HR Advisory Team.		75%	Dec-16
		Strengthen and equip Line Managers.		25%	Mar-17
		Reduce timelines of Formal Case Management.		100%	Sep-16
		Develop better KPI monitoring of Case Management.		100%	Sep-16
	Engagement & Communications	Introduce and implement Chat-back internal staff opinion survey		100%	Jun-16
		Introduce and implement Listening into Action Programme		100%	Jun-16
		Increase effective use of social media.		100%	Jun-16
		Review Trust Induction process and programme.		100%	Sep-16
		Set up staff engagement group		100%	Jun-16
		Implement programme of health and wellbeing events for staff.		50%	Mar-17
		Implement programme of Staff reward and recognition events.		100%	Sep-16

Date of meeting: 02 November 2016 **Enc E2**

Programme	Workstream	Deliverables	Progress Rating		
			Sep-16	% Complete	Finish
Governance and Safety	Complaints & Serious Incidents	Design and implemented a new user led complaints process		80%	Nov-16
		Implementation of a robust SI process (meets best practice standards)		80%	Sep-16
		Established trajectories to achieve agreed timescales for SI's /Complaints		80%	Sep-16
		Staff are trained and confident to investigate complaints and SI's		70%	Oct-16
		Design of a framework for ensuring lessons are learned		30%	Nov-16
	Governance Capacity & Capability	Review of the clinical governance structure and ways of working		100%	Sep-16
		Trained and competent professionals at corporate and Divisional level		20%	Jan-16
		Support Divisional Management team around assurance and escalation		40%	Dec-16
		2016/17 Governance Work plan		90%	Nov-16
	Ward to board quality reporting	Line of sight reporting from ward to board utilising exception reporting		60%	Nov-16
		Enable automatic data entry and minimise preparation time.		25%	Dec-16
		Develop a phased plan to deliver new improved line of sight		100%	Aug-16
	Risk Management	85% of risk assessments reviewed within the set periods		76%	Oct-16
		85% of risks have actions within the due date		74%	Jan-17
		The corporate risk register reflects the organisation's risks		50%	Oct-16
		Effective management of risks by Divisions and escalation as required		50%	Oct-16
		Implement Ward Risk Register reporting process at Ward Manager level.		48%	Nov-16
		Deliver practical risk management / Datix training to 75% risk owners.		80%	Oct-16
		Implement a 'stubborn risk' peer-review process		0%	Mar-17
		Executive oversight group (REG) to be implemented		25%	Nov-16
HDU Review	HDU Improvement Plan	HDU audit of acuity		100%	Jun-16
		Nurse training and competence – commences September 2016		30%	Dec-16
		HDU Governance		80%	Oct-16
		ICNARC data collection		80%	Nov-16

Date of meeting: 02 November 2016 **Enc E2**

Programme	Workstream	Deliverables	Progress Rating		
			Sep-16	% Complete	Finish
Outpatients	Outpatient environment	Standardise available information for patients in waiting rooms		90%	Sep-16
		Produce a standardised communications folder across each outpatient site		100%	Aug-16
		To develop generic and consistent cleaning schedules for clinical areas		100%	Aug-16
		To notify patients of clinic delays in real time; displayed on whiteboards		100%	Aug-16
		Provide adequate signage for patients or carers suffering with dementia		100%	Sep-16
		Provide appropriate and applicable information to patients across all TVs		95%	Sep-16
	Standards & operating procedures	Devise and implement a standard operating procedure for all nursing staff		50%	Nov-16
		Devise and implement a standard operating procedure for reception staff		50%	Nov-16
		Engage and obtain support from medical and surgical Clinical Directors		35%	Nov-16
		Standardisation of working practices for reception staff		35%	Dec-16
	Clinic room scheduling & utilisation	Develop a countywide tool to standardise and manage room utilisation		15%	Feb-17
		Devise and implement a standard operating procedure for room scheduling		35%	Dec-16
		Develop a scheduling dashboard in conjunction with the information team		15%	Dec-16
		Develop training materials and guidance for tool and process change		0%	Dec-16
	Efficiency and productivity	Increase the usage of SMS Text appointment reminders by specialties		40%	Dec-16
		Reduce the number of late clinic starts		15%	Mar-17
	Strategy	Develop a forward look for outpatients, referral and booking service		30%	Dec-16
RTT and waiting time management	Oasis Clinic Management	Devise and implement a standardised process for clinic set-up on Oasis		10%	Dec-16
		Draft and implement a standard operating procedure with supporting KPI's		15%	Dec-16
		Upskill all appropriate staff via training sessions to support standardisation		0%	Dec-16
		Instruct a system data cleanse that removes all obsolete clinics		10%	Dec-16
	Oasis Clinic Outcomes	Implement a generic outcome form for all specialties		35%	Feb-17
		To reduce the number of RTT outcomes available on Oasis from 130 to 12		25%	Oct-16
		Improve data quality and accuracy of RTT outcomes currently recorded		10%	Mar-17
		Provide training and guidance on the Do's and Don'ts on RTT rules		15%	Mar-17
		Deliver training to all relevant staff on generic outcome form		5%	Jan-17
	Referral and Booking Management	Devise and implement a standardised booking process for new referrals		10%	Mar-17
		Implement a standardised waiting list management process		5%	Mar-17
		Identify KPI's to monitor the booking and waiting list process		5%	Mar-17
		Develop a booking governance framework that is formally signed off		0%	Mar-17
		Produce an Access Policy underpinned by the governance framework		15%	Dec-16

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2 November 2016 **Enc F1**

Report to Trust Board in public

Title	Medical Workforce Report
Sponsoring Director	Denise Harnin Director of Human Resources & Organisational Development
Author	Deborah Evans. Human Resources Manager Rainy Faisey, HR Consultant – Medical Staffing
Action needed	The Board is asked to: • Note the current situation regarding medical vacancies and work being undertaken to reduce vacancies across the Trust. • Note the salary issues in relation to the impact of the introduction of the new Junior Doctor Contract. • Note the costs associated with the UKVI CoS price changes in April 2017 and the impact on the Trust's recruitment plans. • Note the establishment of the Central Temporary Medical Staffing service and associated benefits. • Support the introduction of the revised Senior Clinical Leadership arrangements
Previously considered by	Previously monthly reports considered by The Medical Workforce Assurance Group

Priorities (√)

Investing in staff	
Delivering better performance and flow	x
Improving safety	x
Stabilising our finances	**x**

Related Board Assurance Framework Entries	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 to our staff and patients.
Glossary	UKVI CoS UK Visa and Immigration Certificate of Sponsorship wte whole time equivalent

Key Messages

To provide an update to the Board on key medical workforce priorities including medical recruitment, the establishment of a centralised booking service for locum medical staff to enable the Trust to reduce agency expenditure, and an outline of the new senior clinical leadership proposals.

Date of meeting: 2 November 2016 **Enc F1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – November 2016

1. Situation

The Workforce Report is a monthly document previously given to the Workforce Assurance Group, now disbanded. In order to ensure the Board is kept up to date the report is noted below.

2. Background

To provide to the Board a position statement on the progression of medical workforce priorities and to consider the new proposed arrangements for medical leadership.

3. Assessment

3.1 Medical Vacancies

The level of medical vacancies across the Trust has continued to rise from 113.9wte as at 18th January 2016, to 153.3wte at 24th October 2016. Of the current vacancies, the Trust has successfully appointed to 23wte posts (10wte Consultants, 8wte career grade doctors, and 5wte locum appointments for doctors in training), with commencement dates ranging between November 2016 to July 2017.

A summary of the current vacancies, including a divisional breakdown of posts and anticipated dates of commencement for the 23wte posts is available on request.

Regular meetings continue with divisional representatives to progress recruitment and address any delays within the process. In an effort to attract more applicants to our current vacancies a number of Consultant advertisements have been placed in the British Medical Journal and an analysis of the interest and response rate will be undertaken to ascertain whether this has been beneficial. Furthermore, where applicants withdraw from the interview process additional information has being sought to ascertain the reasoning behind this to measure both the reputation of the Trust and ensure it is offering an attractive reward package. Feedback to date has primarily been personal related withdrawals with relocations outside of the county, or applicants no longer able to relocate to the county, however the high level agency rates of pay continue to impact against the career grade recruitment success against national pay scales.

Analysis of the recruitment hotspots/ key areas of risk are available on request.

3.2 Recruitment fill rates

A review of the successful recruitment rates against advertised posts in January 2016 showed a 2:1 success rate, with 134 recruitment rounds and 62 appointments being made over the preceding 12 months. This success rate has now been reviewed, and at October 2016 149 recruitment rounds have been held over the last 12 months and 58 appointments have successfully commenced, providing a decrease in the success rate to 2.5:1. A total of 23 advertisements received no applications. A revised approach to consultant recruitment is being developed.

3.3 Doctors in Training Vacancies

The trainee fill rates for August 2016 ended at 84% with 260 out of 308 posts filled. Local recruitment into the 48 vacancies continues and we have successfully filled 2 posts. Although a number of departments have declined recruitment for these short-term vacancies where the vacancy position is expected to positively change with the next rotation and intake.

3.4 Future risks

UKVI CoS price changes – With effect from 1 April 2017, there will be a change in pricing structure from a one-off £199 application fee to £1000 for each year of the Certificate of Sponsorship. Currently the Trust charges the employee the £199 one-off application fee for the length of the employment contract, ie 1-4 years. The change will mean the Trust may encounter further difficulties in recruiting career grade doctors who are non EEA residents due to this additional annual charge.

Currently the Trust employs 27 doctors under this arrangement of an establishment of circa 75wte i.e. 36%. Whilst other Trusts in the Midlands area do not charge the employee the £199 one-off application fee, benchmarking is underway to ascertain whether this practice will continue once the new charges are in place. If the Trust were to absorb the cost, this could amount to circa £30,000 per year additional cost pressure based on the current number of non EEA doctors employed by the Trust.

New Junior Doctor Contract – The first group of doctors to transition over to the 2016 new Junior Dr contract in December 2016 have now received their new terms and conditions of service. Early indications show that pay protection is applicable to this group of doctors and is in place. The next group of doctors to transfer will be February 2017 and work is underway to prepare their contractual documentation.

3.5 **Salary Update**

3.5.1 **Impact of salary assessment against national terms and conditions**

The Trust meets national guidelines in calculating starting salaries. However, we are recognising an increase in the number of challenges to the starting salary pay calculations. A growing number of doctors who request this calculation prior to accepting offers of employment then indicate that other NHS organisations are prepared to remunerate above the starting salary. This issue is particularly worrying in hard to fill specialties as it is impacting on the Trust's ability to appoint doctors having received offers of employment. We are reviewing current arrangements for calculating starting salaries.

3.5.2 **Impact of New Junior Doctor Contract**

With the introduction of the new Junior Doctor Contract, we are aware that non training grade doctors, i.e. clinical fellows and Trust doctors, currently have their salaries and terms and conditions mirrored against the old Junior Doctor Contract. We have been advised by NHS Employers that doctors in these roles should not be employed under the new arrangements but that local terms and conditions should be introduced. This work will be benchmarked with other local employers and will commence in the New Year.

3.6 **Physician Associate Scheme**

Following a recruitment process, it is anticipated that the first 3 Physician Associates will commence in the first week in December, 2016, with five commencing in January 2017.

The Physician Associates will commence within ENT, then rotate in General Surgery and Trauma and Orthopaedics to complete the three 4 month placements.

3.7 **Central Temporary Medical Staffing Service**

The centralisation of the booking system went live on the 17th October 2016 with a phased roll out plan commencing in the Medicine Division. The final phase of the roll-out will conclude w/c 31 October 2016.

In January 2017 the Centralised Temporary Medical Staffing Team will be further developing a locum bank for medical staff within the Trust to reduce the expenditure on Agency locums.

3.8 **Senior Clinical Leadership Arrangements and Proposals**

In order to meet the demands of the Trust, the current Clinical Leadership arrangements have been reviewed and as a result, a number of changes are needed to ensure the senior clinical leadership structure is fit for purpose. The detail of these changes

are available on request and recruitment to the senior posts will be complete by April 2017.

The Proposed Structure Senior Clinical Leadership is as follows and will include:

- Chief Medical Officer - Board Appointment
- Divisional Medical Directors
- Deputy Medical Director (Governance lead)
- Associate Medical Directors
    - Education
    - R&D
    - Appraisal/Revalidation
- Divisional Governance leads

4 **Recommendations**

The Board is asked to:

- Note the current situation regarding medical vacancies and work being undertaken to reduce vacancies across the Trust.
- Note the salary issues in relation to the impact of the introduction of the new Junior Doctor Contract.
- Note the costs associated with the UKVI CoS price changes in April 2017 and the impact on the Trust's recruitment plans.
- Note the establishment of the Central Temporary Medical Staffing service and associated benefits.
- Support the introduction of the revised Senior Clinical Leadership arrangements

Denise Harnin
Director of HR and OD

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: November 2016 **Enc F2**

Report to: Trust Board

Title	**Nursing and Midwifery Workforce Report**
Sponsoring Director	**Jan Stevens, Chief Nursing Officer**
Author	**Sarah Needham, Associate Director**
Action Required	To receive the report and actions being taken to assure safe workforce
Previously considered by	N/A

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

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	NWAG – Nursing workforce assurance group NMC – Nursing Midwifery Council

Key Messages

- Slight improvements in recruitment continue to be seen across the qualified and unqualified workforce. However, the Trust continues not to make any significant pace in reduce the figures.
- Slight improvements in our retention rates can be seen but assurance and further work to improve these will be monitored by the NWAG group.
- Staff achieved recognition for the quality of mentoring at the Trust by the University and our recent NMC inspection.
- Over the last 16 months agency spend has reduced by nearly 50%. However, bank and agency spend are anticipated to rise in order to support winter pressures and additional capacity.

Date of meeting: November 2016 **Enc F2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

1. Situation

This paper presents an update on the Nursing and Midwifery Workforce Action group, including the identification of key risks and mitigation plans. Compliance information on safer staffing levels at ward and site level is also presented along with the Trusts position on recruitment and retention. An update is also provided on our local challenges for nursing recruitment.

2. Background

In November 2013 The National Quality Board 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.

3. Current Position

To address our current recruitment challenges against a back drop of a national shortage of nurses, we are undertaking the following;

- A nursing workforce strategy is being developed and will be presented to the Board in early 2017 We are doing this because we want to provide the highest quality care to our patients and this requires the right number of staff who are motivated, engaged and highly skilled across the spectrum of services we provide .
- In line with good practice we are undertaking a review of the current nursing establishments. This review uses a nationally agreed approach including Shelford Tool, review of ward quality metrics and professional judgement between October and December 2016. A paper will be presented to the Board in 2017 regarding the outcomes and recommendations.
- Proactive recruitment including
  - Return to practice campaign
  - Proactive recruitment of Student nurses and offering their final placements in the areas where they have been appointed at job.
  - Quarterly job fairs at the Trust
  - Internal transfer process for all internal staff
- To optimise the care contact time nurses have we are implementing new roles and new ways of working. This includes
  - Ward Administrator
  - Ward house keeper
  - Introduction of Band 4 Nursing Associates

4 Recruitment

The tables below show the vacancies over a period of time

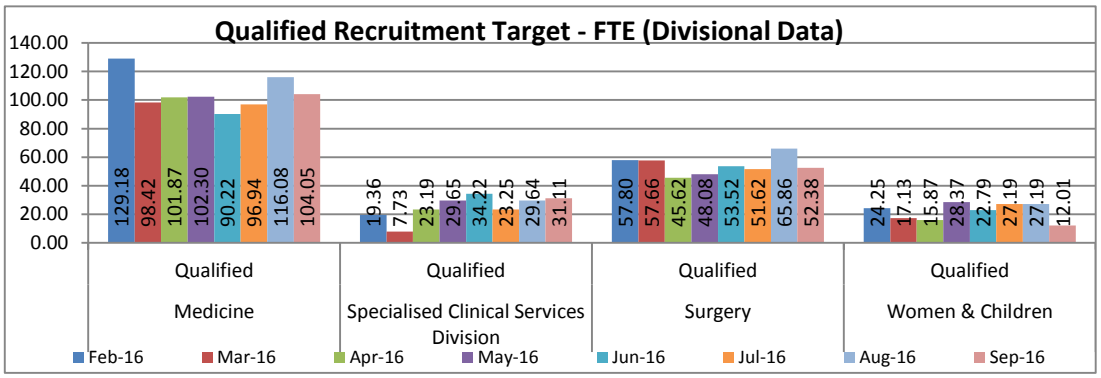
Overall Summary

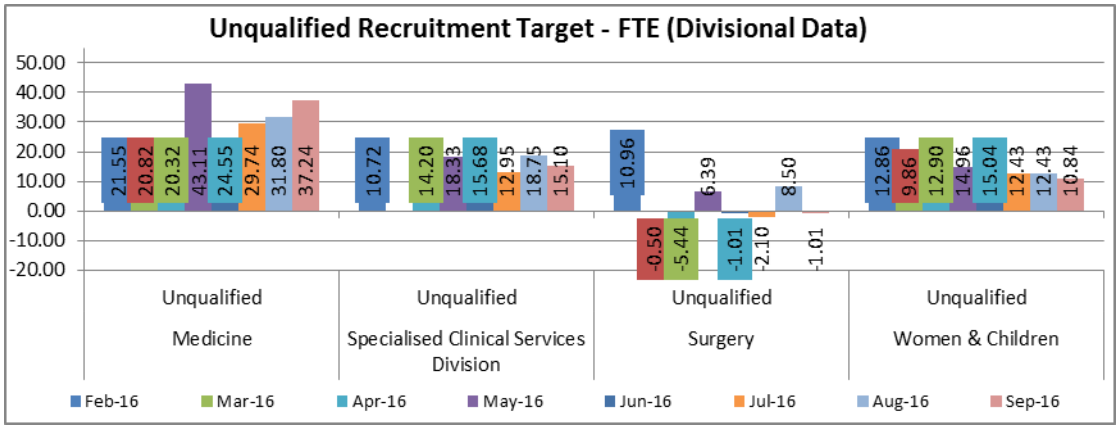
The current total number of qualified nurse vacancies in the Trust is at 199.5 WTE and 63.18 WTE for unqualified staff. The increase in unqualified relates to increasing

capacity for winter and additional panels have been organised to address the gap.

The areas with the highest number of vacancies are;
MAU Redditch
Emergency Departments and theatres at Worcester and Redditch
T&O Worcester

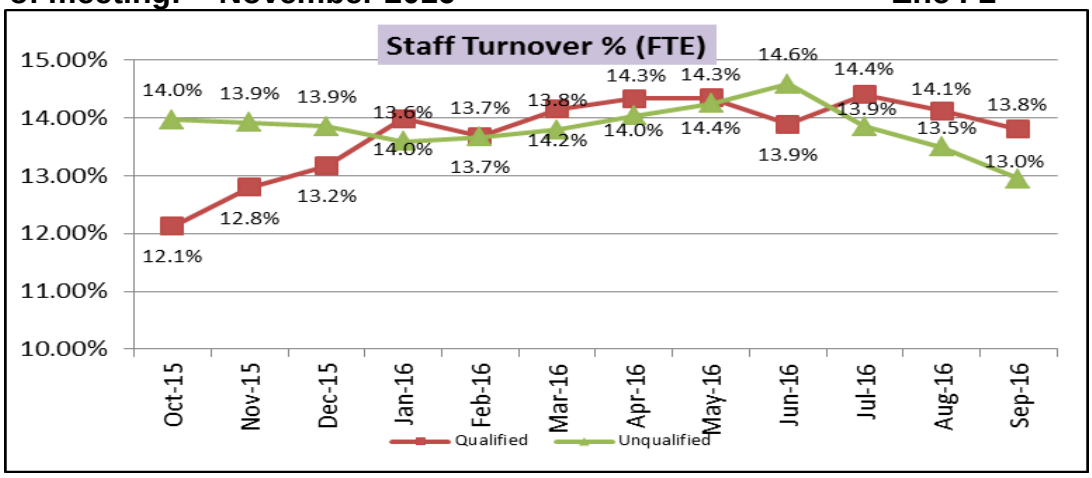
Vacancies and recruitment to areas with high vacancies are managed by Ward managers, Matrons and Divisional Directors of nursing and reviewed at the NWAG.





B **Retention**

Our ambition is that all employees wish to remain and work in the organisation as they experience support from their line managers and are provided with excellent education and training and career development opportunities. Through our Nursing and Workforce Action Group we will be monitoring our compliance against NHS Employers good practice guidance for retaining staff. The table highlights our rates of nursing turnover.



A key component of retention is recognising achievement amongst of workforce and therefore we would like to inform the board of the following achievements.

Mentorship awards took place in partnership with the University of Worcester on 11th October 2016.

The award winners were:

Outstanding Mentor: Nurse - **Rebecca Clarke, Worcestershire Royal Hospital**

Outstanding Mentor: Midwife – **Anna Meredith, Wyre Forest Community Midwives**

Outstanding Mentor: Allied Health Professional – **Angela Goulden, Alexandra Hospital**

Long Service Mentor: **Dr David Jenkins, Worcestershire Royal Hospital**

Outstanding Practice Learning Environment – **Outpatients Department, Kidderminster Hospital and Treatment Centre**

The Trust and the University following the NMC quality review which took place in April 2016 has been awarded the best possible outcome, having achieved the "met" standard across all 5 key areas (resources, practice learning, admission and progression, fitness to practice and quality assurance). Bournemouth University is the only other University in the country to be rated at this highest level

6 Safer staffing fill rates

The Board if required to receive information on fill rates per ward and information is also provided per site for the Trust.

Areas below the 80% (national expected fill rate) are highlighted in red. The impact on the quality and safety of these areas is scrutinized by the DDN's and Matrons. Where fill rates are reported as over 100% this is because unqualified staff are utilised to support and backfill trained staff vacancies. Reviews of the Trusts staffing position takes place three times per day and staff are mobilised from areas with higher staffing levels into areas which require support in order to provide assurance that patients receive safe and quality care.

Date of meeting: November 2016 **Enc F2**

Key

-80%	
80-94.9%	
95% +	

	Day		Night	
Ward name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
Acute Stroke Unit	83.9%	107.5%	93.8%	96.0%
Avon 2- Gastro	96.1%	93.7%	99.2%	129.3%
Avon 3- Infectious Diseases	99.1%	92.5%	73.5%	103.6%
Avon 4	81.9%	123.1%	83.6%	106.1%
Laurel 1 Cardiology-CCU	94.0%	116.1%	95.9%	151.6%
Laurel 2 Resp	93.2%	93.0%	97.9%	104.0%
Medical Assessment Unit WRH	97.5%	111.5%	76.1%	117.7%
Medical High Care and Short Stay	65.2%	86.0%	69.5%	77.4%
Silver Assessment Unit	106.5%	95.0%	102.2%	94.8%
GP Unit WF - ward (TCS)	90.8%	76.3%	100.3%	90.0%
MAU ALX	77.7%	109.3%	82.8%	87.1%
Ward 12 Medicine	72.1%	112.1%	102.6%	102.8%
Ward 2 Specialist Med	94.9%	112.2%	67.7%	123.8%
Ward 6	81.9%	103.5%	100.6%	91.5%
Ward 10	101.1%	113.1%	82.9%	89.1%
Ward 11	88.6%	92.8%	100.0%	97.5%
Ward 16	88.0%	110.8%	99.5%	89.9%
Ward 17	103.2%	102.2%	90.4%	75.1%
Ward 18	84.6%	124.4%	89.8%	103.5%
SCDU & SHDU	102.0%	106.4%	80.8%	100.0%
Beech A	116.1%	113.9%	70.5%	131.3%
Beech B	82.9%	127.1%	96.1%	73.1%
Chestnut	101.0%	88.3%	99.1%	166.7%
Trauma & Orthopaedics	92.0%	122.3%	69.5%	97.8%
Severn Unit & HDU	108.5%	74.2%	95.9%	86.2%
WRH Delivery Suite & Theatre	81.7%	100.0%	85.3%	100.0%
WRH Maternity Triage	94.2%	100.0%	112.9%	93.5%
WRH Meadow Birth Centre	95.0%	100.0%	88.7%	90.3%
WRH Postnatal Ward	87.6%	100.0%	83.9%	74.2%
WRH Riverbank	91.4%	55.9%	86.7%	48.1%
Alex Ward 1	101.2%	95.1%	66.7%	83.9%
WRH Gynaecology - Chestnut Ward	93.5%	96.8%	90.3%	93.5%
WRH TCU Nursery Nurses	16.1%	96.8%	12.9%	100.0%
WRH TCU Midwives	100.0%		96.8%	
WRH Antenatal Ward	84.9%	43.8%	78.2%	58.1%
Laurel 3 WRH	85.8%	85.6%	85.0%	100.0%

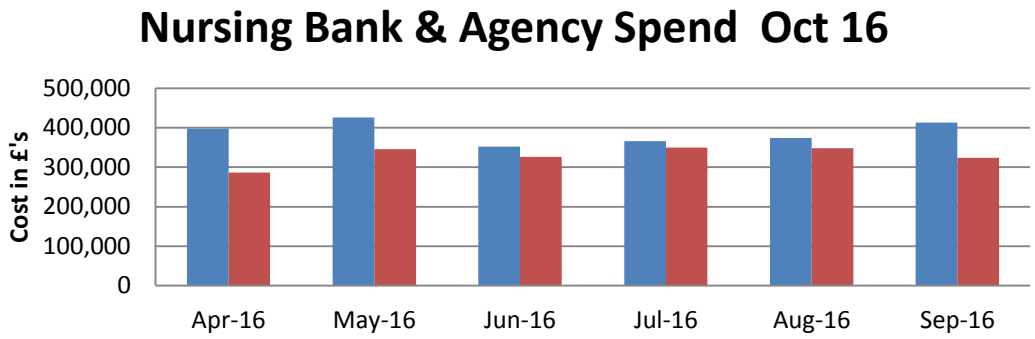
Rationale for the areas reporting less than 70% are for areas where there are small numbers of care staff required per shift and therefore this affects the overall % fill rate.

Date of meeting: November 2016 **Enc F2**

Table below outlines the fill rate by site.

		Day		Night	
Site Code	Site Name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
RWP01	ALEXANDRA HOSPITAL	90.8%	111.5%	91.3%	96.4%
RWP31	KIDDERMINSTER HOSPITAL	90.8%	76.3%	100.3%	90.0%
RWPTC	KIDDERMINSTER TREATMENT CENTRE	100.0%	100.0%	100.0%	100.0%
RWP50	WORCESTERSHIRE ROYAL HOSPITAL	91.9%	100.2%	87.8%	99.3%

7 Agency & Bank spend



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Agency	397,846	426,307	352,086	365,588	373,701	413,340
Bank	286,388	345,440	326,070	349,627	348,237	323,503

Significant reductions in agency spend has been achieved over the last 16 months to a nearly 50% reduction. This has been achieved due to a number of initiatives. These are;

- Price Water house Cooper review of bank and agency controls task and finish group in place to implement action.
- Review of agencies and bought within cap parameters
- Implementation of new KPi's to measure performance of NHSP via the NWAG report.

Recommendation

To receive the report and actions being taken to assure safe workforce

Jan Stevens
Interim Chief Nursing Officer

Title of report	**Nursing and Midwifery Workforce Report**
Name of director	Jan Stevens

Worcestershire NHS
Acute Hospitals NHS Trust

02 November 2016 **Enclosure G2**

Report to Trust Board in Public

Title	Integrated Performance Report (September 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 review the Integrated Performance Report for September 2016; the key performance issues and the mitigating actions
Previously considered by	Finance and Performance Committee

Priorities (√)

Investing in staff	✓
Delivering better performance and flow	✓
Improving safety	✓
Stabilising our finances	✓

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience
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	STF – Sustainability and Transformation Fund

Key Messages

The Trust is facing ongoing performance challenges against the majority of the operational targets and standards that relate to both good patient access and the STF performance fund.

Performance against the 4 -hour emergency access standard (EAS) remains challenging. Increased operational controls are in place to create flow and to release designated assessment area spaces to ensure that patients that are admitted in timely way to the right bed first time.

Performance in respect of the 18 referral to treatment target continued to show a decline in September which remains a concern.

There is evidence of improvement in cancer performance which it is anticipated will be sustained in terms of 2 week waits however planned under performance in 62 – day cancer pathways will continue until the remaining backlog is cleared.

02 November 2016 **Enclosure G2**

REPORT TO TRUST BOARD NOVEMBER 2016

1. Situation

This paper presents an integrated corporate performance report (IPR) for September 2016. This is an exception report based on performance against national and locally agreed targets and standards

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 currently being taken or planned, to address non – compliance.

3. Assessment

The Trust is facing ongoing performance challenges against the majority of the operational targets and standards that relate to both good patient access and the STF performance fund.

Emergency Access Standard

The Trust did not achieve the 95% 4 - hour Emergency Access Standard (EAS) in September 2016. Performance declined further and remained below 95% at 82.8%; a decrease from 83.7% in August 2016. There remain significant pressures in the ED from levels of attendance; over the period September 2013 to September 2016, the Trust has seen an 11% increase in ED attenders, a 25% increase in ambulance conveyances, and a 26% increase in ambulance conveyances for people aged over 75 years. Emergency admissions over the same period are up 11% (21% for over 75 years).

High levels of bed occupancy and high numbers of stranded patients (emergency admissions with length of stay > 7 days) negatively impact on the delivery of this standard causing 'exit block' from the ED on both sites and the Worcester site in particular. A number of initiatives have been implemented in September and October 2016 to improve patient flow through the hospital, including extension of the SAFER bundle rollout, a focus on 'Care AM' on the wards, continued reverse queuing in ED and Ambulatory Emergency Care (AEC) now functioning on both sites, supporting same day discharge for patients whom may otherwise have been admitted. Specifically during October, the Trust with some support from partners in the local health and care system has increased daily operational controls from the executive through all the spans and layers of the organisation, to create flow and reset the system; to release designated assessment area spaces for assessment rather than to accommodate inpatient activity, and to ensure that patients that are admitted to the right bed first time. This was aided by the opening of the Evergreen Ward on the WRH site to provide nurse/therapist led care for patients medically fit for discharge but awaiting a support package in the community. The Trust is looking at a similar development for the Redditch site.

The Trust failed to deliver the national 15 minute standard for assessment in Emergency Department (ED) for the 95th percentile wait however the time to initial assessment improved in month for both ambulance - borne patients (32 minutes in August to 23 minutes in September) and all patients (40 minutes in August to 35 minutes in September). The median wait for treatment in the ED was 59 minutes in August and September 2016, which is just within the national standard of 60 minutes.

18 weeks Referral to Treatment (RTT)
Since February 2016, the Trust has been unable to report compliance with the 92% 18 Week referral to treatment incomplete pathways target. Performance in September 2016 was 86.79%. This is concerning as performance against this target and the recovery trajectory is continuing to decline.

A number of challenged specialties show improvement in performance compared to August however this is offset by further deterioration in other specialties. The balance of performance issues remain weighted towards outpatients. There is one 52+week waiter as at the end of September 2016 in Oral Surgery. Additional activity in house and outsourcing to Independent Sector (Dermatology, T&O and General Surgery) have been stepped up to increase short and medium term capacity. Significant data quality issues remain and clinical and non-clinical waiting list validation is undertaken on a specialty by specialty basis. The total waiting list has reduced in size from August to September by 1444 records which demonstrates that data quality is starting to improve.

Cancer Performance
The 62-day target of 85% for cancer first treatment was not achieved in September 2016; performance was 70.6%, an increase from 65.9% in August 2016. It is anticipated that the performance issue will continue over the next 2-3 months as the Trust works through the remaining backlog of over 62-day waiters. This follows the temporary reduction in capacity at various stages of the 62 day pathways (mainly 2ww and diagnostics) earlier in the year, which has been slow to reset. In September 38% of the 62 –day breaches were in Urology, followed by Lower GI and Breast. Cancer 62-day performance has also been impacted by increases in 2ww referrals (Colorectal, Skin, Breast, Head and Neck, Urology).

Performance in respect of the 2 week wait (2ww) cancer waits (all) continues to recover and was 70.8% in September 2016. The backlog of patients waiting over 14 days has been cleared in most specialties with the exception of a small residual backlog in Colorectal Surgery that will be cleared in October. Forecast performance against the trajectory is a return to historic levels of performance from October onwards (80-85%) and achievement of the 93% standard in the latter part of Quarter 3.

For breast symptomatic patients, 2ww performance in September 2016 recovered to 76.1% compared with 52.0% in August. Forecast performance is achievement of the 93% standard in October 2016.

Diagnostics Waiting Time Standard
In September 2016, the Trust failed achieved the target of < 1% of patients waiting longer than 6 weeks for diagnostic tests however actual performance improved to 2.36% from 3.16% in August. Capacity issues remain in particular in radiology and endoscopy. These are being mitigated by utilising external capacity where available and reviewing radiology capacity countywide.

There are separate Board reports from the Board sub committees relating to quality, and financial performance indicators.

4. Recommendation

The Board is asked to review the Integrated Performance Report for September 2016; the key performance issues and the mitigating actions.

Title of report	Integrated Performance Report
Name of director	Sarah Smith, Director of Planning and Development

Worcestershire NHS
Acute Hospitals NHS Trust

02 November 2016 **Enclosure G2**

Trust Performance Measures by Exception - September 2016

Performance Metric	National Target	Recovery Trajectory –Sep 16	Current reporting month – Sep 16	Previous month reporting- Aug 16	Direction of Travel vs previous month
Key NHS Constitution/ National Performance Standards					
RTT Incomplete	92%	92%	86.79%	87.36%	Declined
Cancer 2WW – Suspected	93%	86%	70.8%	65.9%	Improved
Cancer 2WW - Breast	93%	83%	76.1%	52.0%	Improved
Cancer 62 days	85%	86.1%	70.6%	65.9%	Improved
4 hour EAS	95%	92%	82.8%	83.7%	Declined
Diagnostics	<1%	0.99%	2.36%	3.16%	Improved
Trust Workforce	**Local Standard**				
Staff Turnover	9-11%	12.3%	12.5%	12.6%	Improved
Nursing Turnover Qualified	9-11%	13.75%	13.8%	14.1%	Improved
Nursing Turnover Unqualified	9-11%	13.8%	13.0%	13.5%	Improved
Sickness Absence Monthly	<3.75%	3.75%	3.92%	4.02%	Improved
Appraisal Rates - Medical	85.0%	85.0%	81.1%	81.4%	Declined
Appraisal Rates – Non Medical	85.0%	85.0%	83.4%	82.0%	Improved
Appraisal Rates - Consultants	85.0%	85.0%	86.0%	85.9%	Improved
Mandatory Training rates	>90%	90%	87.1%	87.3%	Declined
Quality and Safety	**Local Standard**				
VTE Risk Assessment	≥ 95%	93%	93.8%	93.9%	Declined
Category 2 complaints response	≥ 90%	65%	51%	68%	Declined
Serious Incidents open > 60d	0	4	4	4	Same
Hip Fractures – Theatre within 36 hours – all patients	≥ 85%	50%	53.4%	47.9%	Improved
Friends & Family - Response Rate Wards	≥ 30%	25%	12.4%	18.2%	Declined
Friends & Family - Response Rate A&E	≥ 20%	13%	8.4%	4.7%	Improved
Mortality – SHMI 12 month rolling	100	N/A	110 (Jun 16)	109 (May 16)	Declined
Mortality – HSMR 12 month rolling	100	N/A	109 (Jul 16)	108 (Jun 16)	Declined
Financial Performance					
At the midway point of the financial year the Trust is recording a year to date deficit of £19.1m. This is £0.9m worse than plan and driven by the failure to deliver the operational performance related metrics of the STF. Further detail is provided in the Finance Performance Report.					

NB: Last month the following performance measures were RAG rated red and are now Amber or Green and therefore not included in this month's report:

- 28 Day Breaches as a % of Cancellations – improved from 22.9% to 10.14%

Title of report	Integrated Performance Report
Name of director	Sarah Smith, Director of Planning and Development

02 November 2016 **Enclosure G2**

Trust data regarding stroke care performance for July, August and September 2016 is not currently reported as it is being validated in line with national dataset definitions.

Sarah Smith
Director of Planning and Development

Worcestershire NHS
Acute Hospitals NHS Trust

2 November 2016 **Enclosure G3**

Report to Trust Board (public)

Title	**Financial Performance – Month 6 2016/17**
Sponsoring Director	**Rob Cooper – Interim Director of Finance & Information**
Author	Haq Khan – Deputy Director of Finance Jo Kirwan - Assistant Director of Finance Katie Osmond – Assistant Director of Finance
Action Required	The Trust Board is asked to note the financial position.
Previously considered by	Finance & Performance Committee

Priorities (√)

Investing in staff	
Delivering better performance and flow	
Improving safety	
Stabilising our finances	✓

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	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. ***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:

I&E POSITION YTD

- At the midway point of the financial year the Trust is recording a YTD deficit of £19.1m. This is £0.9m worse than plan, driven by the failure to deliver the STF trajectories for the operational performance metrics.

- The September (M6) deficit position of £3m is consistent with August (M5). However, the underlying position deteriorated by c.£0.8m, predominately due to reduced levels of **patient care income** and CIP slippage offset by a mid-year review of provisions.

I&E POSITION FORECAST

- The September deficit was £0.4m worse than forecast and increases the YTD forecast variance to £0.9m.

- The Trust continues to report a full year forecast that meets the control target of £34.6m. A mid-year review of the forecast indicates that the level of financial risk has not reduced and if the risks are not mitigated, then the Trust could be facing a deficit ranging from £34.6m to as much as £55m as the Trust could not draw down the financial element of the STF.

- Delivery of the £34.6m deficit requires the Trust to have an average monthly deficit of £2.6m for the second half of the year noting that in September the underlying deficit was £3.8m.

Title of report	Financial Performance – Month 6 2016/17
Name of director	Rob Cooper

INCOME POSITION

- The elective income position has improved but not to the extent required, with T&O and General Surgery continuing to be the main areas of concern. Despite this, there has been an overall deterioration in the income position which is £0.38m worse than the average run rate reported up to August across three key areas:

  - **Emergencies –** £0.37m deterioration was seen across Acute Medicine/MAU and General Surgery across both sites due to increased LOS including a number of long stayer patients.

  - **Paediatrics** – The £0.15m deterioration is reported across three areas:
    - reduced level of neonatal cot day activity related to a reduction in births,
    - YTD adjustment to marginal rate cap
    - reduction in emergencies not deemed to be linked to centralisation - but ongoing monitoring will take place for assurance.

  - **Cardiology Daycases** – these typically deliver to plan but this month show an adverse movement of £0.1m. Referrals have decreased for Acute Coronary Syndrome conditions especially in the North of the county. This is being investigated and the Directorate are exploring other opportunities to increase activity levels.

CAPITAL POSITION

- The capital programme has been reviewed in detail to bring it back within the available resources. The reprioritisation of schemes leaves the Trust with a significant degree of risk in relation to failure of plant and equipment and potentially unsupported clinical IT systems. NHSI has been approached for an emergency loan to fund these urgent requirements as well as the costs already committed to the development of the ASR Outline Business Case.

KEY RISKS

- The key risks requiring the greatest level of management are:

  - **Cost pressures** (**R2) –** These need to be contained within the £1m included in the forecast. The Interim COO to present a proposal to the Executive Team to agree cost pressures by 8th November 2016.

  - **Delivery of agency ceiling (R1a)** – Managing expenditure within the agency ceiling is crucial to delivery of the CIP target. A continuation of the current run rate and cost pressures exceeding forecast levels would result in the ceiling being breached by up to £3m. The Trust has established an executive level Agency Task Force chaired by the Director of Financial Improvement. The first meeting is scheduled for 1st November. Update on key actions will be provided to Executive Team on 8th November.

- **Recovery of contract income** (**R9)** – The divisions have been given specialty level weekly trajectories for elective, daycase and outpatient activity. They have been tasked with formulating plans to deliver the trajectories; triangulated with RTT performance RAPs without incurring additional expenditure. Robust cases will be necessary for any investment required. Divisional delivery plans to be presented to Executive Team by 15th November 2016.

Worcestershire NHS
Acute Hospitals NHS Trust

Finance Report
Month 6

Rob Cooper

Interim Director of Finance

31st October 2016

Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

At the midway point of the financial year the Trust is recording a YTD deficit of £19.1m. This is £0.9m worse than plan and driven by the failure to deliver the operational performance related metrics of the STF. The September (M6) deficit position of £3m is consistent with August (M5) and results in a £0.3m adverse variance against plan. However, the underlying position worsened by c£0.8m - predominately due to reduced levels of patient care income and CIP slippage offset by a mid year review of provisions.

	M6 Actual £m	M6 Plan Variance £m	M6 Forecast Variance £m	YTD Actual £m	YTD Plan Variance £m	YTD Forecast Variance £m	Variance Analysis	Pages
Income	32.0	(1.2)	(1.1)	193.2	(4.4)	(1.9)	**Plan Variance (£1.2m)** - A disappointing month with inpatient activity £1m (EL £0.2m, DC £0.2m, Non EL £0.6m) adverse to plan increasing the YTD under performance to £4.4m (EL £1.8m, DC £0.7m, Non EL £1.8m). Emergency Income variance was £0.4m worse than the monthly average. Elective income has improved but remains below required levels. Continued non compliance against the STP operational performance metrics explains a further £0.3m in month and £1m YTD.	Pages 3, 4 and 6
Expenditure	(35.0)	0.9	0.7	(212.3)	3.5	0.9	**Plan Variance £0.9m** - A mid year review of provisions released £0.8m into M6 reducing the underlying expenditure position in month. The impact of CIP slippage of £0.3m against the theatres improvement project was limited by non clinical vacancies and reduced marginal costs due to activity performing below contracted levels. Vacancies across non clinical and ST&T staff groups contribute £1.5m towards the YTD favourable variance with the remainder due to lower than planned levels of activity. The underlying level of underspend will reduce with the inclusion of cost pressures and the ramp up of the CIP target .	Page 3, 4 and 11-12
Total	**(3.0)**	**(0.3)**	**(0.4)**	**(19.1)**	**(0.9)**	**(1.0)**		
Non Rec	(0.8)						M6 non recurrent items - Mid year review of provisions .	
Underlying position	**(3.8)**							

Values are net of non PbR pass through movements

At the end of September the Trust continues to report a full year forecast that meets the control target of £34.6m. A mid year review of the forecast indicates that the level of financial risk has not reduced and if the risks identified are not mitigated, then the Trust could be facing a deficit ranging from £34.6m to as much as £55m.

Financial Performance

Worcestershire NHS
Acute Hospitals NHS Trust

Ref		Risk or Opportunity	Pages
R1a	**Pay Expenditure** - Pay costs overall remained flat at £20.9m and were within £30k of the forecast. Additional sessional expenditure reduced by £59k from £372k to £313k. Bank also reduced from £701k in August to £648k in September. The effect of these decreases on the bottom line were offset by increased agency costs. Agency costs continue to increase rising by £125k from £2,030k in August to £2,155k in September. Non clinical increased by £74k and nursing £40k. The total agency costs exceeded the September forecast by £200k . If agency expenditure were to remain at September levels, then the Trust would exceed its agency ceiling by £1.5m. The Trust needs to ensure that its agency expenditure does not exceed a monthly average of £1.9m for the second half of the year.	Risk	Pages 11-12 Page 5
	Non Pay Expenditure – (excluding non PbR drugs and devices) decreased from £9m in August to £8.7m in September (note August included £0.3m PFI credit note). A mid year review of provisions improved the non pay position which supported the overall position in month. Non pay reports a favourable in month variance of £0.3m.		
	Income - YTD income reports an adverse variance of £4.4m against plan which has worsened by £1.2m in September. This decline was also consistent with the variance against forecast. Inpatient activity represents £1m of the in month adverse variance with electives and day case combined accounting for £0.4m and non electives £0.6m. Electives have improved in month but are still below where they need to be. The Emergency position worsened in Acute Med and General Surgery across both sites. An increased length of stay (LOS) and a deterioration in A&E performance supports the reduced patient flow experienced in September. Paediatrics emerged as an issue with an unlikely link to the centralisation of inpatient services but on-going monitoring will take place for assurance. The refreshed forecast assumes that elective and day case activity recover broadly to plan. At the end of September Elective activity is under performing significantly against plan (£1.8m) and is also lower than the comparable period last year (partly due to reduced use of additional activity sessions and the independent sector). Specialty level plans are being developed to ensure in-house delivery of elective activity at contracted levels. Any outsourcing must be done above contracted levels to preserve planned margins.	Elective opportunity now classified as a risk as included within forecast	Pages 6 and 14-16
R2	**Cost Pressures –** The value of cost pressures stands at £3.6m with £1m factored into the forecast. It is therefore imperative that an urgent assessment of the risks is undertaken to ensure that cost pressures do not exceed this limit.	Risk	
R3	**CIP** – The remaining gap for the second half of the year totals £3.9m across the Divisions following the addition of non recurrent savings from non clinical vacancies. M6 CIP delivery is £0.3m behind target due to the Theatres Improvement Project. This position will continue to worsen over the remainder of the year unless firm plans are formulated to address the gap.	Risk	Page 8
R4	**CQUINs** – Total CQUIN is worth £7.6m. Currently, £5.2m is risk rated Green, £0.6m is rated Amber and £1.8m is Red. Stronger performance in Q2 has seen CQUIN risk decrease from £3.3m to £2.5m.	Risk	
R5	**Sustainability Transformation Fund –** at M6 the forecast has been revised with the Interim COO and now assumes that the Trust receives £12.3m of the £13.1m. This revision assumes that an element of the YTD under performance will be recovered in future months. • Finance – Green £10.2m - Q1 actuals reported within finance element consistent with NHSI reporting. • RTT- Red £0.6m • A&E 4 hour target – Red £1.2m • 62 day cancer waits – Red £0.3m	Risk	
R9	**Capital –** The capital programme has been reviewed in detail to bring it back within the available resources. The reprioritisation of schemes leaves the Trust with a significant degree of risk in relation to failure of plant and equipment and potentially unsupported clinical IT systems. NHSI has been approached for an emergency loan to fund these urgent requirements as well as the costs already committed to the development of the ASR Outline Business Case.	Risk	Page 9

Trustwide Position

Worcestershire NHS
Acute Hospitals NHS Trust

Table 1

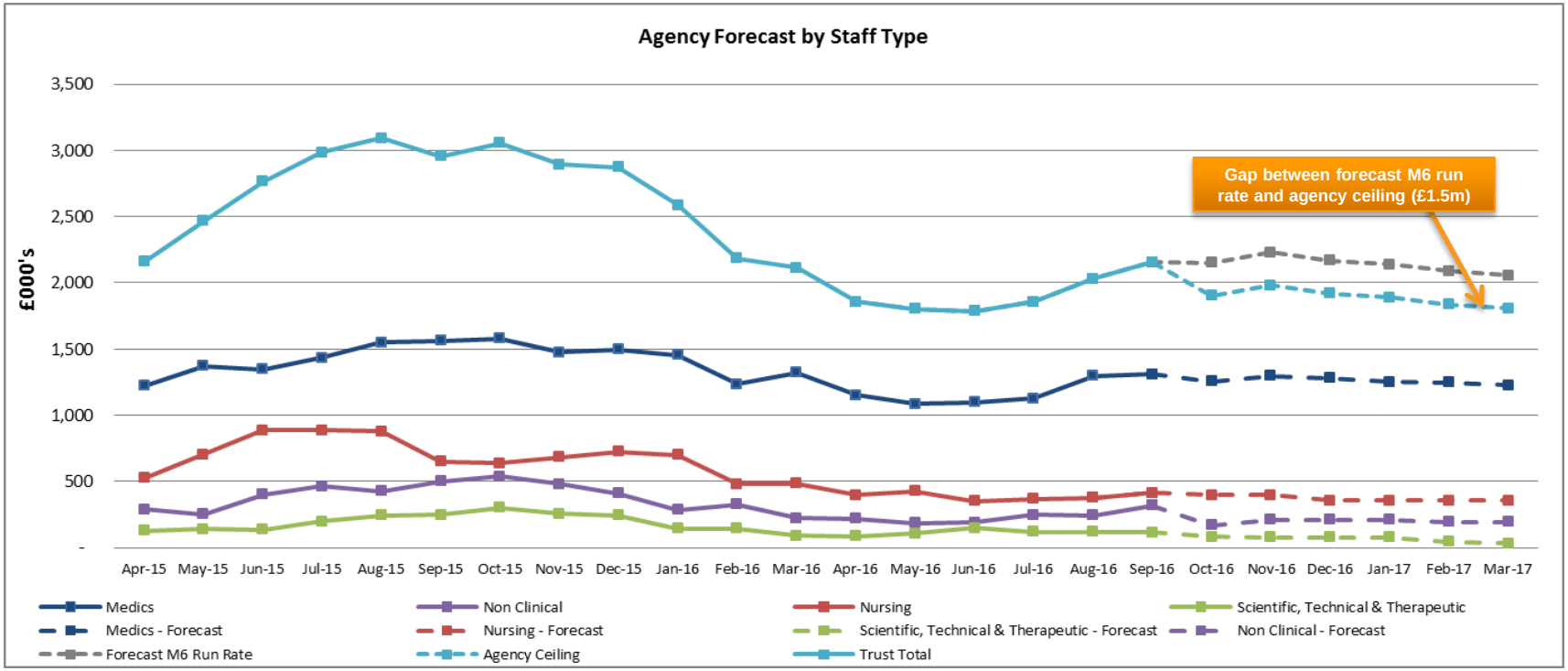
September 16 (Month 6)

Income & Expenditure	Current Month			Year to Date			Full Year		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Revenue & Income									
Patient Care Revenue	26,657	25,635	(1,022)	159,642	155,818	(3,825)	317,598	316,559	(1,039)
Other Operating Income	2,213	2,374	162	13,069	13,512	443	26,542	26,623	81
Non PBR Drugs & Devices	3,260	3,260	0	18,297	18,297	0	37,070	37,069	(0)
STF	1,092	764	(327)	6,550	5,568	(982)	13,100	12,254	(846)
Total Operating Revenue	**33,222**	**32,034**	**(1,187)**	**197,558**	**193,194**	**(4,364)**	**394,310**	**392,506**	**(1,804)**
Operating Expenses									
Pay	(21,456)	(20,850)	606	(127,248)	(124,195)	3,053	(251,816)	(250,974)	842
Non Pay	(9,058)	(8,743)	315	(57,435)	(57,035)	400	(115,011)	(113,334)	1,677
Non PBR Drugs & Devices	(3,260)	(3,260)	(0)	(18,297)	(18,297)	0	(37,070)	(37,069)	0
Total Operating Expenses	**(33,774)**	**(32,853)**	**921**	**(202,979)**	**(199,526)**	**3,453**	**(403,897)**	**(401,378)**	**2,519**
EBITDA *	**(553)**	**(819)**	**(266)**	**(5,422)**	**(6,333)**	**(911)**	**(9,587)**	**(8,872)**	**715**
EBITDA %	-1.7%	-2.6%		-2.7%	-3.3%		-2.4%	-2.3%	
Depreciation	(903)	(903)	0	(5,218)	(5,218)	0	(10,044)	(10,545)	(501)
Net Interest, Dividends & Gain/(Loss) on asset disposal	(1,209)	(1,246)	(37)	(7,617)	(7,617)	0	(15,024)	(15,238)	(213)
Reported Total Surplus / (Deficit)	**(2,665)**	**(2,968)**	**(303)**	**(18,257)**	**(19,168)**	**(911)**	**(34,655)**	**(34,655)**	**0**
Less Impact of Donated Asset Accounting	6	6	0	36	36	0	72	72	0
Surplus / (Deficit) against Control Total	**(2,659)**	**(2,962)**	**(303)**	**(18,221)**	**(19,132)**	**(911)**	**(34,583)**	**(34,583)**	**0**
Surplus / (Deficit) %	-8.0%	-9.2%		-9.2%	-9.9%		-8.8%	-8.8%	

- Overall, the Trust is £0.3m over plan in month and £0.9m YTD largely driven by non achievement of the operational performance element of the STF.
- At month 6 the revised forecast remains in line with the planned deficit of £34.6m taking into consideration the risks set out on page 4 and 5.
- YTD patient care revenue is £3.8m under plan due to under performance against activity plans (£2.8m) and the impact of fines and contractual issues (£1m). Improvement of income performance against the plan requires a significant increase in elective activity and day case activity.
- YTD operating expenditure is £3m under spent on pay. This is mostly due to below plan expenditure on non-clinical staff (£1.2m) and lower than planned levels of activity (£1.1m). Increased agency costs continue to impact the rate of under spending and this is expected to reduce further as the CIP target ramps up and following the cost pressures kick-in.

Agency Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust



Staff Group	Actuals							Q2 Forecast							Full Year Control Total	FOT Var against Control Total
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	*YTD Actual*	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	FY Forecast		
Medics - Agency	1,153	1,086	1,096	1,127	1,297	1,310	*7,069*	1,254	1,297	1,282	1,253	1,245	1,224	14,625		
Non Clinical - Agency	219	186	190	247	*243*	*317*	*1,401*	169	210	210	210	194	194	2,588		
Nursing - Agency	398	426	352	366	*374*	*413*	*2,329*	398	398	353	353	353	355	4,539		
ST&T - Agency	87	106	149	119	*117*	*115*	*693*	81	75	75	75	45	33	1,077		
TOTAL	**1,857**	**1,804**	**1,787**	**1,858**	***2,030***	***2,155***	***11,492***	**1,903**	**1,980**	**1,920**	**1,891**	**1,837**	**1,806**	**22,829**	**22,940**	**111**
Plan	*1,925*	*1,951*	*1,895*	*1,914*	*1,913*	*1,907*		*1,890*	*1,907*	*1,914*	*1,904*	*1,896*	*1,858*	*22,874*		

** Forecast is inclusive of the £3.2m reduction above.*

- Agency expenditure increased by £0.1m compared to August, exceeding the September forecast by £200k. In month increases can be seen across non clinical (£74k) and nursing (£40k).
- The Trust needs to ensure that its agency expenditure does not exceed a monthly average of £1.9m for the second half of the year
- If agency expenditure continued at current levels the Trust could exceed its agency ceiling by £1.5m. It is imperative that agency expenditure is tightly managed and that the Trust rapidly recruits to clinical vacancies to ensure agency expenditure can be maintained within the agency ceiling. Increased use of bank staff is also essential.
- The recent communication from NHSI titled 'Taking further action to reduce agency expenditure' should support the Trust in delivering this reduction .

Income by Point of Delivery

Worcestershire NHS
Acute Hospitals NHS Trust

	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	Forecast £'000	Var £'000	% £'000
Elective	2,416	2,220	(196)	(8%)	14,056	12,238	(1,818)	(13%)	27,293	27,293	27,113	(180)	(1%)
Daycase	2,983	2,756	(228)	(8%)	17,331	16,626	(705)	(4%)	35,063	35,063	35,848	786	2%
Non Elective - Emerg	7,454	6,820	(634)	(8%)	45,013	43,181	(1,832)	(4%)	88,795	88,795	85,963	(2,831)	(3%)
Non Elective - Other	130	149	20	15%	818	818	(0)	(%)	1,610	1,610	2,523	913	57%
Total Inpatients	**12,983**	**11,945**	**(1,038)**	**(8%)**	**77,217**	**72,863**	**(4,355)**	**(6%)**	**152,760**	**152,760**	**151,448**	**(1,312)**	**(1%)**
Outpatients New	1,716	1,725	9	1%	9,938	9,607	(331)	(3%)	19,953	19,953	19,231	(722)	(4%)
Outpatients F Up	1,680	1,642	(38)	(2%)	9,594	9,367	(228)	(2%)	19,312	19,312	18,866	(446)	(2%)
Outpatients Procedure	735	665	(70)	(9%)	4,241	4,276	35	1%	8,525	8,525	8,901	376	4%
Total Outpatients	**4,131**	**4,033**	**(99)**	**(2%)**	**23,773**	**23,250**	**(523)**	**(2%)**	**47,790**	**47,790**	**46,999**	**(791)**	**(2%)**
ED Attendances	1,403	1,361	(41)	(3%)	8,341	8,457	116	1%	16,645	16,645	16,971	326	2%
Community MIU	182	205	24	13%	1,080	1,188	108	10%	2,155	2,155	2,366	211	10%
Total ED/MIU	**1,584**	**1,567**	**(17)**	**(1%)**	**9,421**	**9,644**	**224**	**2%**	**18,800**	**18,800**	**19,337**	**537**	**3%**
Maternity - Delivery	1,067	1,066	(1)	(%)	6,987	6,289	(698)	(10%)	13,267	13,267	11,939	(1,328)	(10%)
Maternity Ante Natal	769	774	5	1%	4,394	4,369	(25)	(1%)	8,625	8,625	8,567	(57)	(1%)
Maternity Post Natal	138	123	(14)	(11%)	815	725	(90)	(11%)	1,598	1,598	1,421	(177)	(11%)
Total Maternity	**1,979**	**1,966**	**(13)**	**(1%)**	**12,230**	**11,396**	**(834)**	**(7%)**	**23,555**	**23,555**	**21,954**	**(1,601)**	**(7%)**
Paed - Daycase/Elective	20	26	5	27%	128	117	(10)	(8%)	250	250	225	(25)	(10%)
Paed - Non Elective	407	370	(37)	(9%)	2,466	2,463	(2)	(%)	5,527	5,527	5,499	(28)	(1%)
Paed - Outpatient	223	224	1	1%	1,298	1,349	51	4%	2,645	2,645	2,765	119	5%
Paed - BPT, Drugs, CQUIN	123	47	(75)	(61%)	707	714	7	1%	1,501	1,407	1,511	104	7%
Paed - Neonatal Cot Days	354	310	(44)	(13%)	2,125	1,940	(185)	(9%)	4,250	4,250	3,897	(353)	(8%)
Total Paediatrics	**1,127**	**977**	**(150)**	**(13%)**	**6,723**	**6,584**	**(140)**	**(2%)**	**14,174**	**14,080**	**13,896**	**(183)**	**(1%)**
Chemotherapy Delivery	**310**	**364**	**55**	**18%**	**1,892**	**2,023**	**131**	**7%**	**3,828**	**3,828**	**4,018**	**190**	**5%**
Drugs PBR Excluded	2,415	2,415	0	%	12,368	12,368	0	%	25,700	25,040	25,040	0	%
Critical Care ITU/HDU	854	782	(71)	(8%)	5,121	4,720	(402)	(8%)	10,242	10,242	9,444	(798)	(8%)
Other Contract Income	4,960	4,996	36	1%	29,633	30,130	497	2%	60,663	59,378	60,082	704	1%
Total Other Contract Income	**8,228**	**8,193**	**(35)**	**(%)**	**47,122**	**47,218**	**95**	**%**	**96,605**	**94,660**	**94,566**	**(94)**	**(%)**
Non Elective - Emerg Threshold	0	0	0		0	0	0		0	0	0	0	
Financial Sanctions	0	(93)	(93)		0	(650)	(650)		0	0	(1,318)	(1,318)	
Contractual Risk	(135)	(200)	(65)		(812)	(1,113)	(301)		(1,624)	(1,624)	(3,132)	(1,508)	93%
Contractual Deductions/Penalties	**(135)**	**(293)**	**(158)**	**117%**	**(812)**	**(1,763)**	**(951)**	**117%**	**(1,624)**	**(1,624)**	**(4,450)**	**(2,826)**	**174%**
Commissioner QIPP	(417)	0	417		(2,500)	0	2,500		(5,000)	(5,000)	0	5,000	(100%)
Non Contract Income	392	409	16	4%	2,859	2,886	28	1%	7,970	5,818	5,859	41	1%
Phasing Adj	(266)	(266)	0	%	13	13	0	%	0	(0)	(0)	0	
Pre STP Total	**29,917**	**28,895**	**(1,022)**	**(3%)**	**177,939**	**174,114**	**(3,825)**	**(2%)**	**358,859**	**354,668**	**353,629**	**(1,039)**	**72%**
STF	1,092	764	(327)	(30%)	6,550	5,568	(982)	(15%)	0	13,100	12,254	(846)	(6%)
	31,009	**29,659**	**(1,350)**	**(4%)**	**184,489**	**179,682**	**(4,807)**	**(3%)**	**358,859**	**367,768**	**365,884**	**(1,884)**	**(1%)**

Key Activity/Income Messages

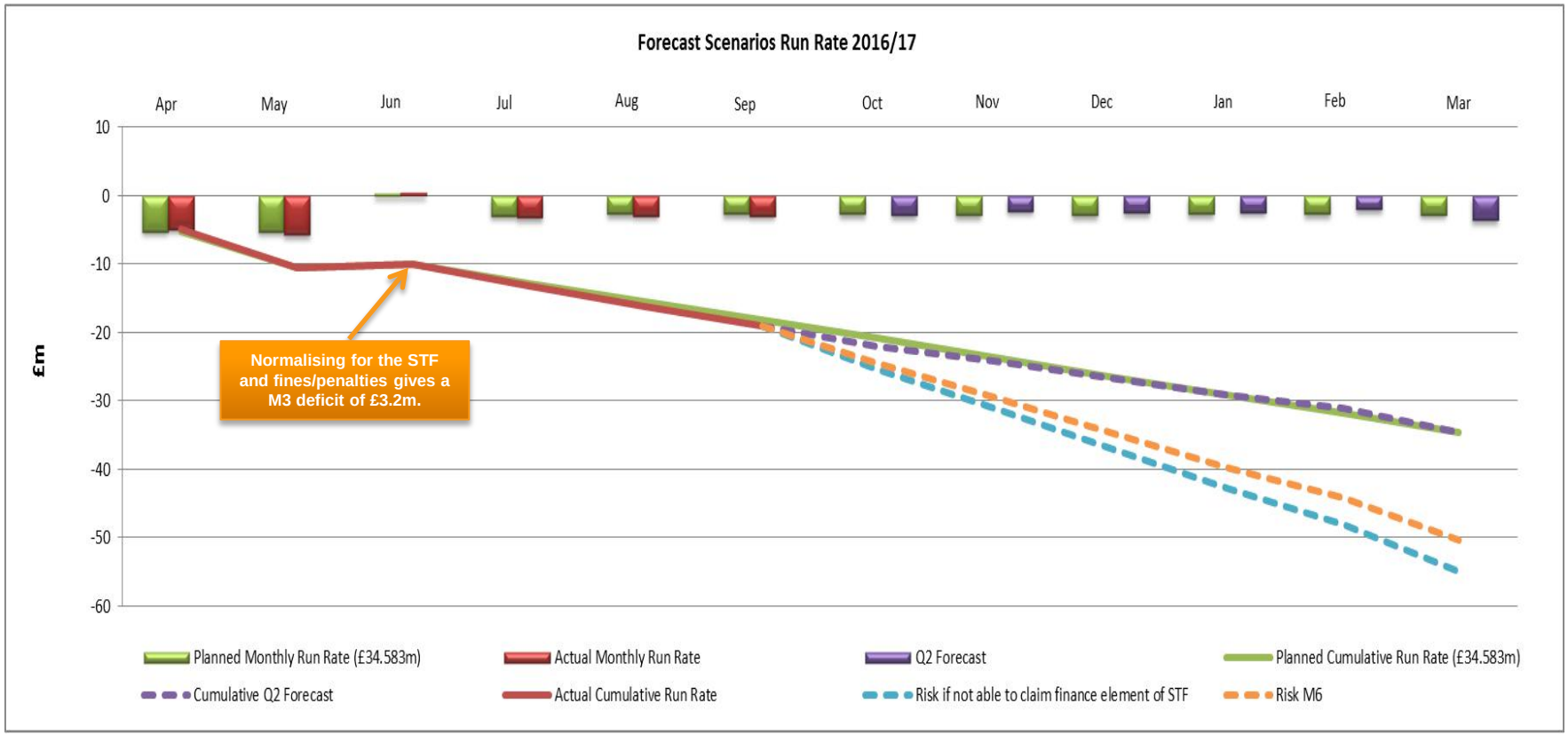
- In September pre STF the position was £1,022k below plan mainly driven by an under performance on inpatients activity. At September the YTD position pre STF was £3,825k and post £4,807k below plan.
- Inpatients position has got materially worse due to Emergency and Daycase underperformance. However, Electives have picked up but not to the level required. Outpatients continue to underperform and Paediatrics have emerged as an issue in-month.
- The Trust has achieved the Financial Control Target earning 70% of the available STF funding for September, but the RTT, A&E and Cancer 62 day waits standards were non-compliant. This creates a £327k under performance in month and £982k YTD. There is an opportunity to recover the shortfall via achieving Q3 and Q4 targets for A&E and RTT as the targets are cumulative but the 62 Day cancer target is quarterly and cannot be clawed back.

Financial Forecast- Month 6 update

Worcestershire NHS
Acute Hospitals NHS Trust

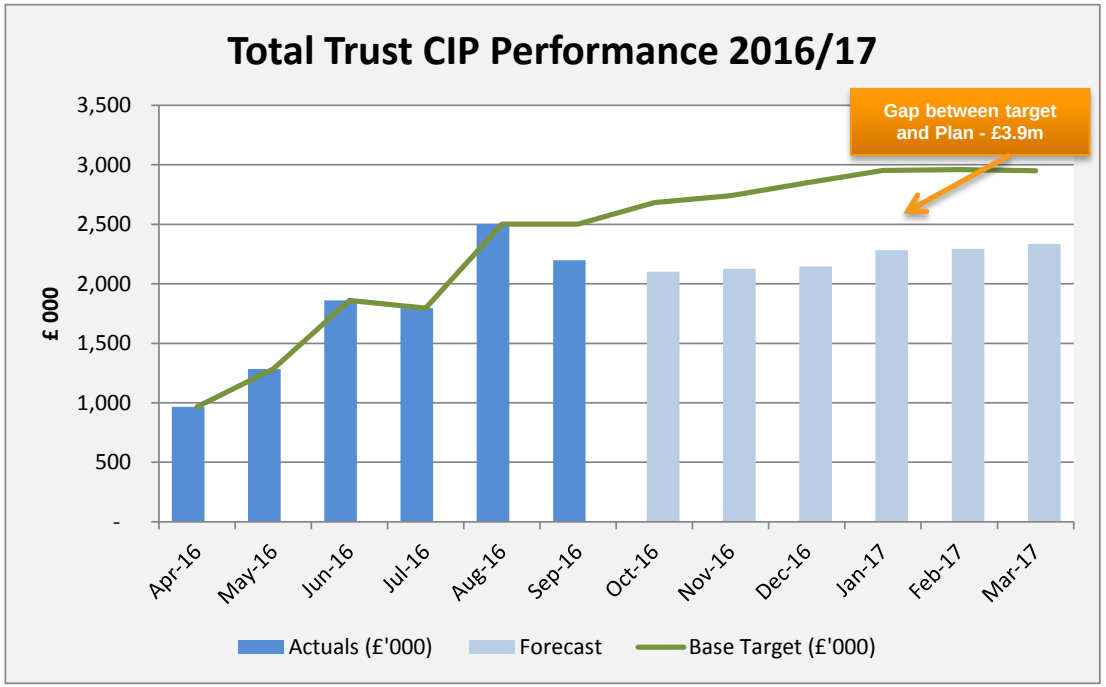
The run rate chart below shows that the base full year forecast remains in line with the £34.6m planned deficit requiring delivery of average monthly deficits of £2.6m.

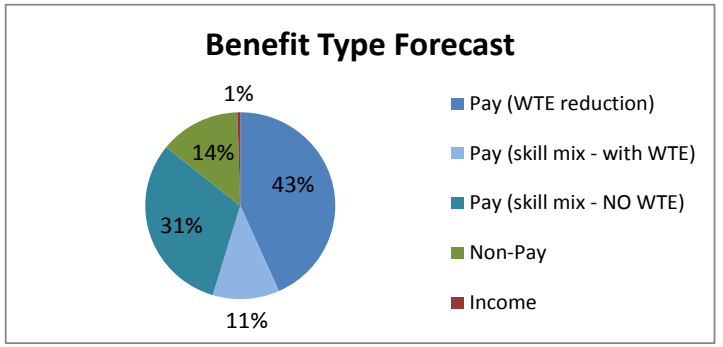
A forecast deficit of £34.6m is a challenging forecast position for the Trust, particularly with the activity recovery assumption, full CIP delivery and maintaining agency expenditure within the agency ceiling. If the assumptions don't hold, the Trust could face a deficit of £55m (risk total £15.8m plus the inability to claim STF financial element estimated at £4.6m).

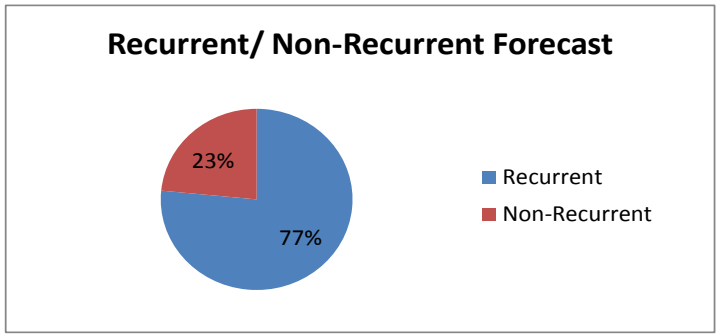


CIP – Target £28m

Worcestershire NHS
Acute Hospitals NHS Trust







Month	Base Target (£'000)	Actuals / Forecast (£'000)	Actual v Target (£'000)	Plan v Target (£'000)
Apr-16	967	967	0	
May-16	1,284	1,284	0	
Jun-16	1,860	1,860	0	
Jul-16	1,795	1,795	0	
Aug-16	2,502	2,502	0	
Sep-16	2,502	2,197	-305	
Oct-16	2,683	2,102		-581
Nov-16	2,740	2,125		-615
Dec-16	2,849	2,145		-704
Jan-17	2,952	2,281		-671
Feb-17	2,959	2,293		-666
Mar-17	2,950	2,334		-616
	28,043	23,885	-305	- 3,853

At the end of September the Trust is reporting a £0.3m adverse variance against the CIP target predominately due to slippage in the Theatres improvement Programme. The Forecast assumes full delivery.

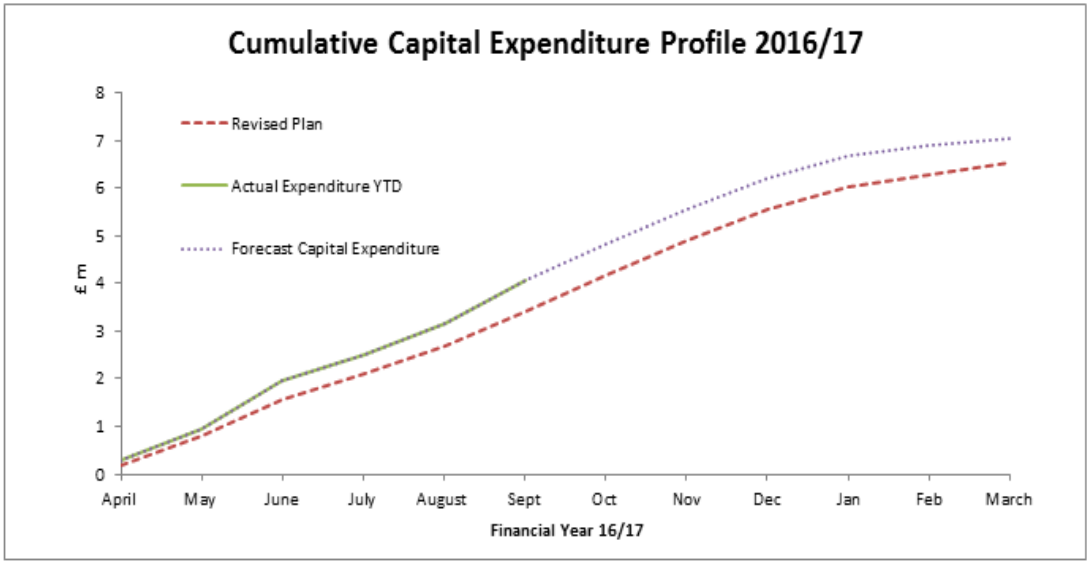
As the table on the left highlights, the monthly targets increase from August with the inclusion of the £3.7m of additional CIP related to the agreement of the control total and continue to increase due to phasing of key schemes such as the Theatres Improvement Programme.

Without firm plans the Trust is at risk of undershooting the CIP target by £3.9m. The size of the gap reduced in month following the inclusion of non recurrent vacancies that have been held YTD. This gap is to be delivered through a combination of savings from the Theatres Improvement Programme and reductions in agency expenditure.

Plans to deliver the Theatres element are encompassed within the Specialty plans to recover elective and day case activity whilst agency expenditure reductions will form part of the agency reduction work stream – see risk R1 slide 4.

Capital Programme 16/17 – M6 Position

Worcestershire NHS
Acute Hospitals NHS Trust



The YTD £647k overspend includes £165k expenditure associated with the ASR OBC. This will form part of the Emergency Capital loan request. There is an expected additional expenditure of £135k on the ASR OBC due by the end of December with further expenditure taking the total to £500k by the end of the financial year. If the emergency loan is not approved the Trust will have £500k unfunded ASR capital expenditure, which will have to be prioritised over other capital schemes.

A list of prioritised schemes has been produced for Executive Team approval. The remaining expenditure will be managed within the available funding in line with the agreed schemes.

There is a risk that failure of plant or equipment may require a further re-prioritisation.

		£000's	In Month			YTD			Full year			
Workstream	Source of Funding	Highlevel Summary	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Expenditure Details
Development	Trust Funded	ED Expansion	(112)	(112)	(0)	(1,386)	(1,386)	0	(1,786)	(1,786)	0	Main capital expenditure YTD relates to the ED department. ED is expected to overspend by £400k. The ASR OBC costs YTD are £165k and expected to be between £300k and £500k FY.
	Emergency Loan	*ASR OBC*	0	(165)	(165)	0	(165)	(165)	0	(500)	(500)	
Development Total			(112)	(277)	(165)	(1,386)	(1,551)	(165)	(1,786)	(2,286)	(500)	
Property and Works	Trust Funded	Routine Works/Backlog Maintenance	(82)	(43)	39	(356)	(353)	3	(935)	(935)	0	Replacement of RO plant KTC £156k, Kings Court and Aconbury Decant costs £149k, General fire safety £50k, and electrical tesing £11k, KTC Steam Condenser replacement £25k, Project Management staffing costs £53k, Water Safety and Legionella £49k, CQC works £13k and lifecycle painting £55k. Service Block roof repairs £15k
		Regulatory Standards/Requirements	(45)	(82)	(37)	(221)	(167)	54	(465)	(465)	0	
		Clinical Developments / Strategic Schemes	0	(18)	(18)	0	(185)	(185)	(220)	(220)	0	
		Staffing/Project Costs	(1)	(11)	(10)	(6)	(53)	(47)	(17)	(17)	0	
Property and Works Total			(128)	(154)	(26)	(583)	(758)	(175)	(1,637)	(1,637)	0	
Equipment	Trust Funded	Equipment	(169)	(169)	0	(175)	(175)	0	(400)	(400)	0	Two Echocardiogram Ultrasound Machines & Probes inc TOE probe
Equipment Total			(169)	(169)	0	(175)	(175)	0	(400)	(400)	0	
ICT	Trust Funded	Systems & Infrastructure	(40)	(49)	(9)	(185)	(324)	(139)	(354)	(354)	0	YTD is £307k overspent relating to EPR actual expenditure £302k, NHS Mail £155k expenditure and other inflight projects.
		EPR	(62)	(20)	42	(130)	(302)	(172)	(270)	(270)	0	
		Data Centre	(200)	(199)	1	(900)	(900)	0	(1,800)	(1,800)	0	
		Hardware and Peripherals	(9)	23	32	(57)	(40)	17	(119)	(119)	0	
		Additional Schemes	(10)	(16)	(6)	(10)	(23)	(13)	(180)	(180)	0	
ICT Total			(321)	(261)	60	(1,282)	(1,589)	(307)	(2,723)	(2,723)	0	
Total Expenditure			(730)	(862)	(131)	(3,426)	(4,073)	(647)	(6,546)	(7,046)	(500)	
Alex Land Sale			0	0	0	0	0	0	0	0	0	
Grand Total			(730)	(862)	(131)	(3,426)	(4,073)	(647)	(6,546)	(7,046)	(500)	

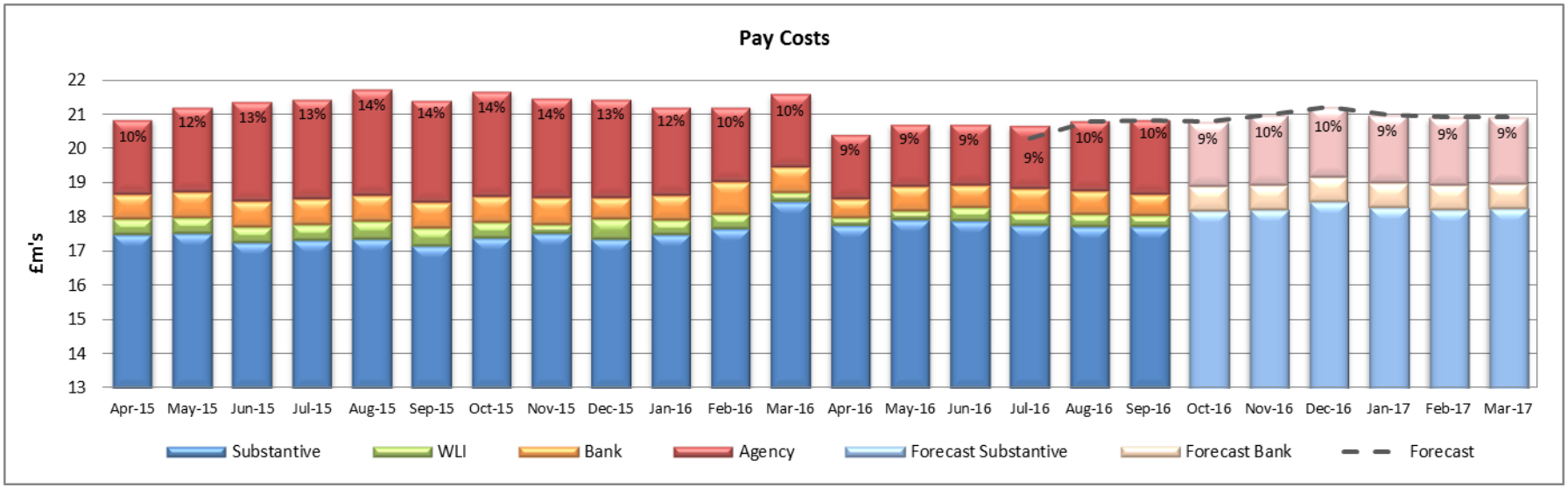
Worcestershire NHS
Acute Hospitals NHS Trust

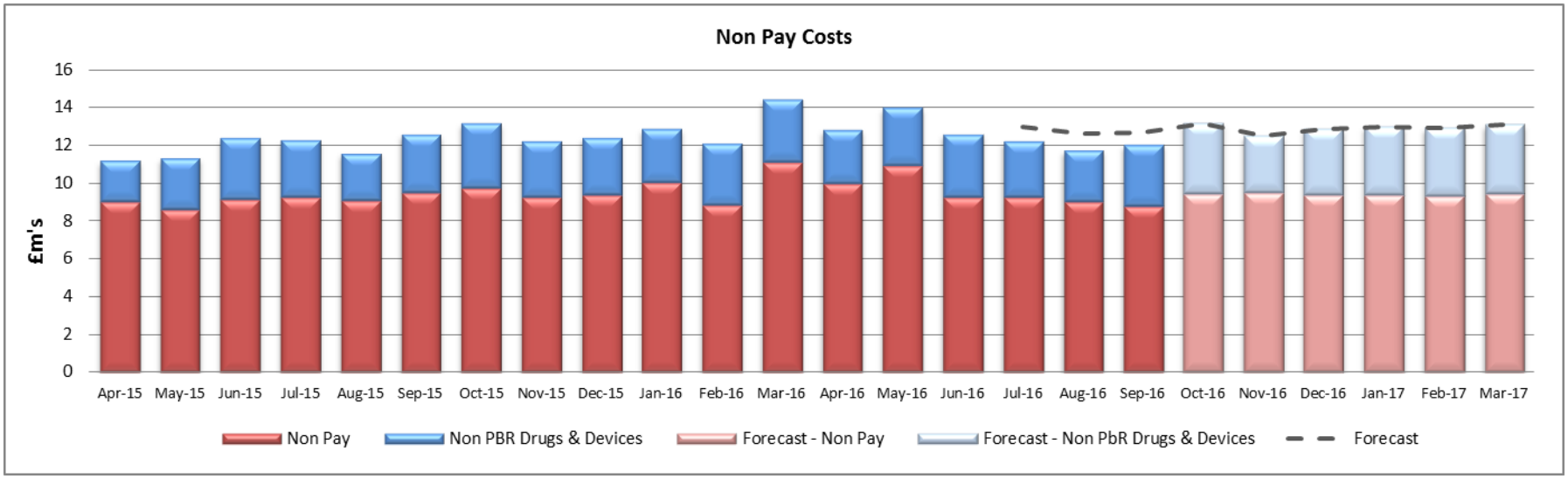
Appendices

Pay & Non Pay Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust

Percentages shows proportion of agency spend against total spend.

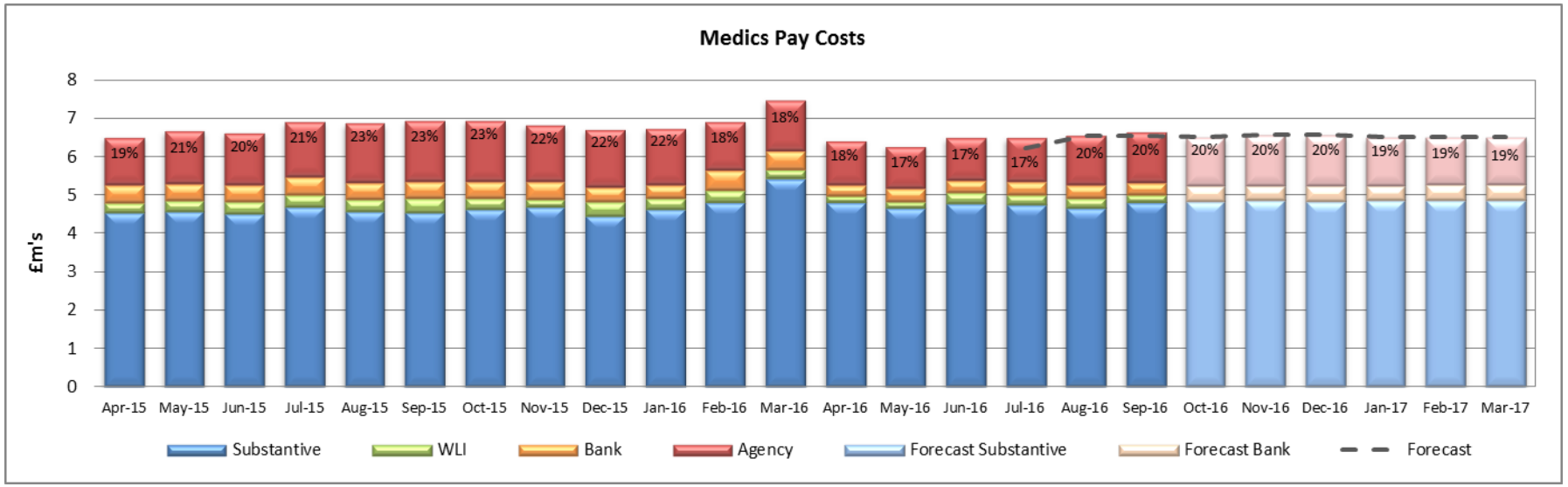


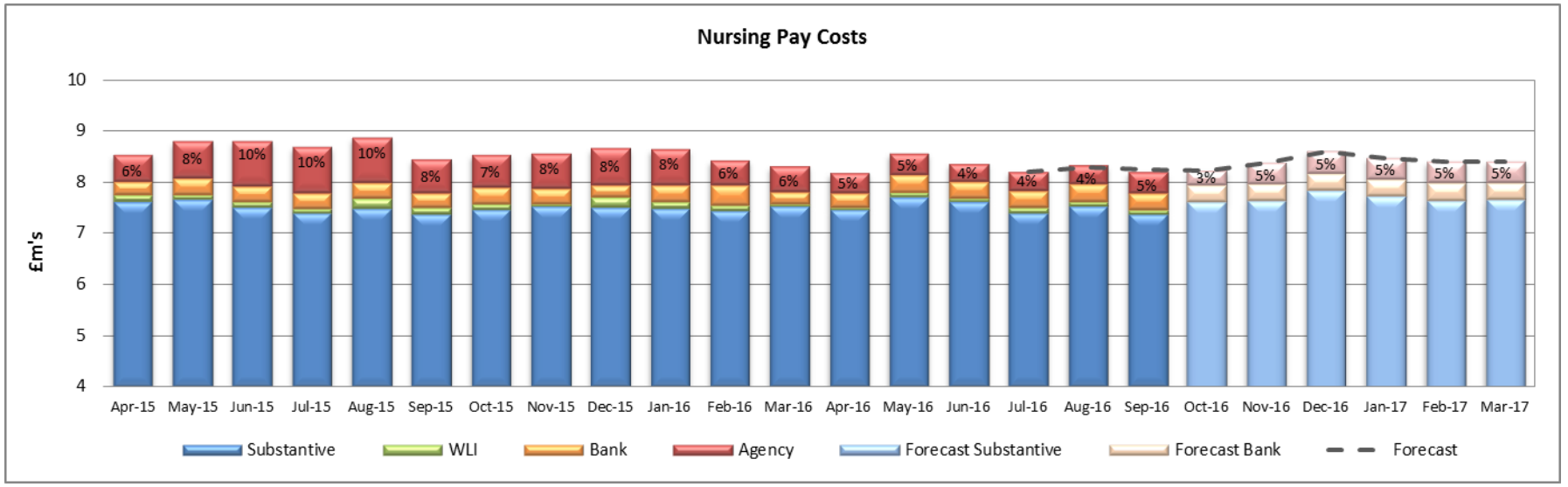


Medics & Nursing Pay Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust

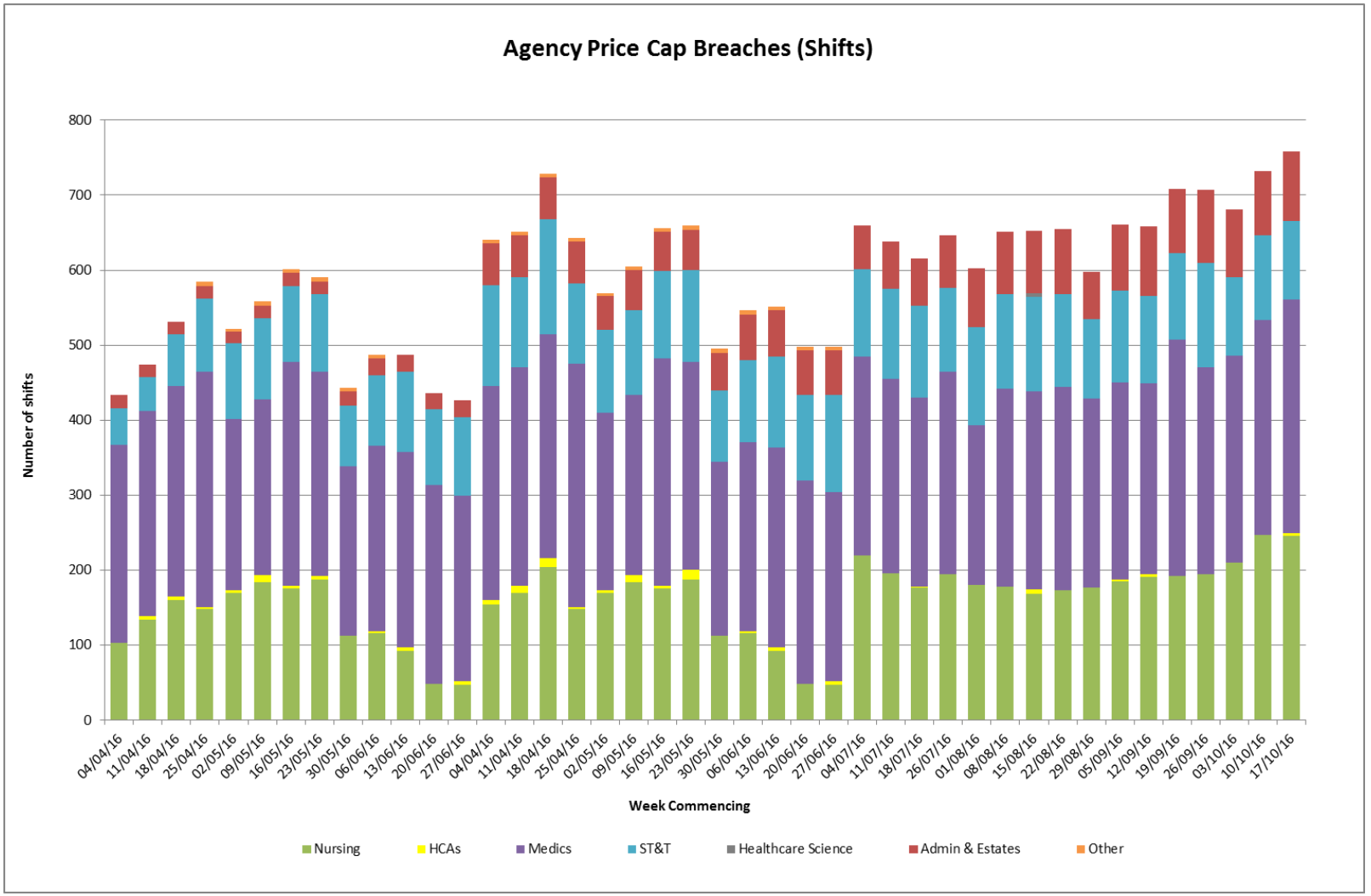
Percentages shows proportion of agency spend against total spend.





Agency Cap Breaches

Worcestershire NHS
Acute Hospitals NHS Trust



NHS Improvement agency performance is measured against price caps, framework breaches and wage caps. The chart above includes price cap performance only.

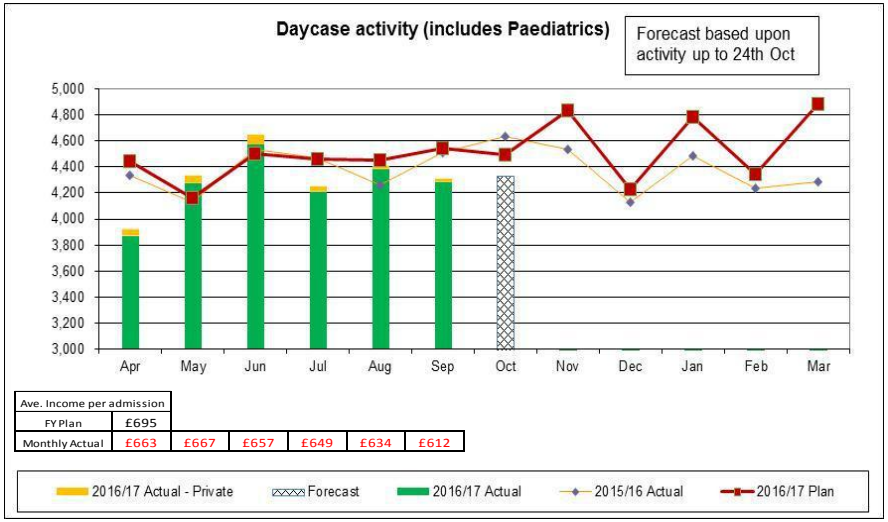
Activity

Worcestershire NHS
Acute Hospitals NHS Trust

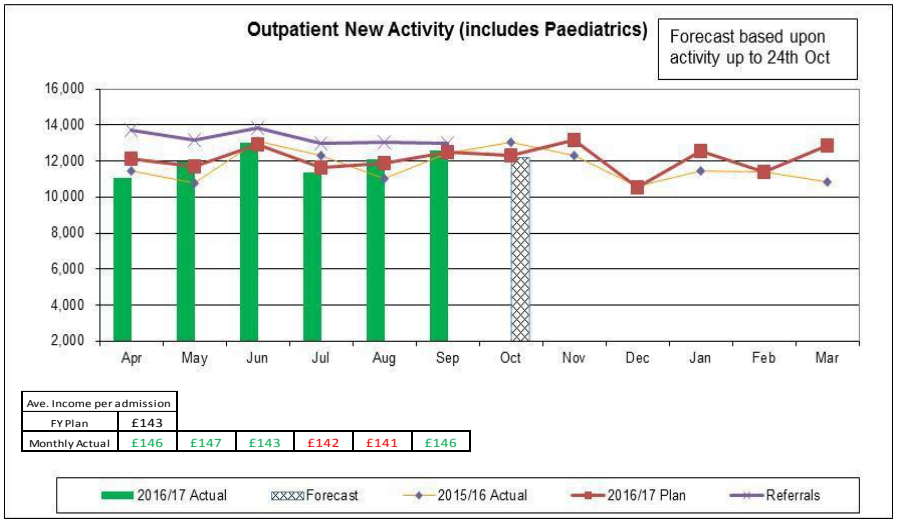
	In Month				YTD				Full Year				
	Plan	Actual	Var	%	Plan	Actual	Var	%	Initial Plan	Current Plan	Forecast	Var	%
Elective	844	755	(89)	(11%)	4,977	4,271	(706)	(14%)	9,679	9,679	9,202	(476)	(5%)
Daycase	4,514	4,272	(242)	(5%)	26,379	25,708	(671)	(3%)	64,901	53,771	55,658	1,887	4%
Non Elective - Emerg	3,596	3,298	(298)	(8%)	21,326	20,950	(376)	(2%)	42,403	42,403	41,974	(430)	(1%)
Non Elective - Other	47	59	12	27%	293	341	48	16%	575	575	1,063	488	85%
Total Inpatients	**9,001**	**8,384**	**(617)**	**(7%)**	**52,975**	**51,270**	**(1,705)**	**(3%)**	**117,559**	**106,429**	**107,897**	**1,469**	**1%**
Outpatients New	11,904	12,144	240	2%	69,352	68,310	(1,042)	(2%)	138,738	138,738	136,444	(2,294)	(2%)
Outpatients F Up	21,049	21,118	69	%	121,039	120,907	(132)	(%)	243,400	243,400	244,035	634	%
Outpatients Procedure	4,199	3,832	(367)	(9%)	24,263	24,308	45	%	48,800	48,800	50,329	1,528	3%
Total Outpatients	**37,152**	**37,094**	**(58)**	**(%)**	**214,654**	**213,525**	**(1,129)**	**(1%)**	**430,939**	**430,939**	**430,807**	**(132)**	**(%)**
ED Attendances	12,873	12,504	(369)	(3%)	76,551	77,557	1,006	1%	152,768	152,768	155,621	2,852	2%
Community MIU	3,079	3,480	401	13%	18,309	20,129	1,820	10%	36,539	36,539	40,108	3,569	10%
Total ED/MIU	**15,951**	**15,984**	**33**	**%**	**94,860**	**97,686**	**2,826**	**3%**	**189,307**	**189,307**	**195,728**	**6,421**	**3%**
Maternity - Delivery	473	475	2	%	3,078	2,797	(281)	(9%)	5,845	5,845	5,328	(517)	(9%)
Maternity - Non Delivery	188	180	(8)	(4%)	1,192	1,016	(176)	(15%)	2,312	2,312	1,951	(361)	(16%)
Maternity - Outpatient	3,893	3,826	(67)	(2%)	21,827	22,361	534	2%	44,112	44,112	44,500	388	1%
Maternity Ante Natal	534	523	(11)	(2%)	3,052	3,003	(49)	(2%)	5,989	5,989	5,899	(90)	(2%)
Maternity Post Natal	499	448	(51)	(10%)	2,957	2,617	(340)	(12%)	5,802	5,802	5,128	(675)	(12%)
Total Maternity	**5,587**	**5,452**	**(135)**	**(2%)**	**32,106**	**31,794**	**(312)**	**(1%)**	**64,061**	**64,061**	**62,806**	**(1,254)**	**(2%)**
Paed - Daycase/Elective	32	39	7	22%	198	184	(14)	(7%)	415	415	355	(60)	(14%)
Paed - Non Elective	531	470	(61)	(12%)	3,220	3,117	(103)	(3%)	7,220	7,220	7,013	(207)	(3%)
Paed - Outpatient	1,352	1,318	(34)	(2%)	7,901	8,150	249	3%	16,080	16,080	16,710	630	4%
Paed - BPT, Drugs, CQUIN	18	0	(18)	(100%)	111	0	(111)	(100%)	270	221	0	(221)	(100%)
Paed - Neonatal Cot Days	736	556	(180)	(24%)	4,419	3,746	(673)	(15%)	8,816	8,838	7,573	(1,264)	(14%)
Total Paediatrics	**2,670**	**2,383**	**(287)**	**(11%)**	**15,849**	**15,197**	**(652)**	**(4%)**	**32,801**	**32,774**	**31,652**	**(1,122)**	**(3%)**
Chemotherapy Delivery	**1,024**	**1,060**	**36**	**4%**	**5,138**	**5,823**	**685**	**13%**	**11,130**	**11,130**	**11,988**	**858**	**8%**
Drugs PBR Excluded	0	0											
Critical Care ITU/HDU	806	744	(62)	(8%)	4,837	4,600	(236)	(5%)	9,673	9,673	9,227	(446)	(5%)
Other Contract Income	0	0											
Total Other Contract Income	**806**	**744**	**(62)**	**(8%)**	**4,837**	**4,600**	**(236)**	**(5%)**	**9,673**	**9,673**	**9,227**	**(446)**	**(5%)**
Non Contract Income													
Phasing Adj													

Elective, Day Cases & Outpatients New

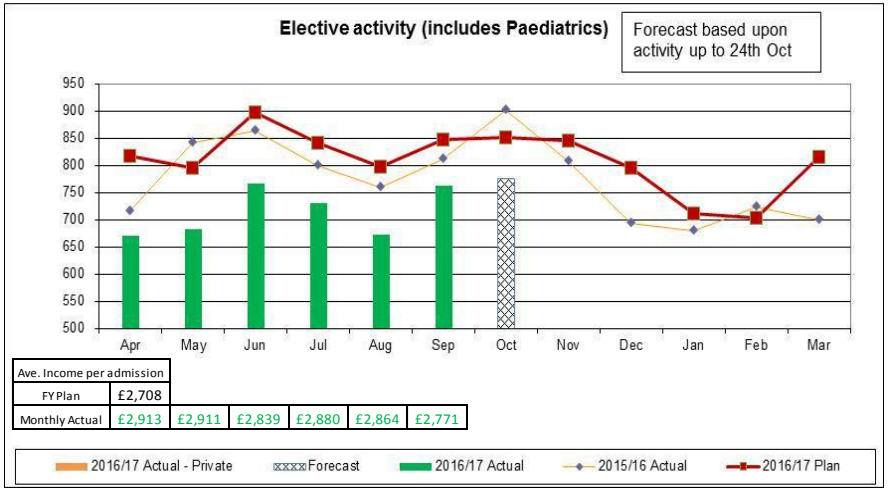
Worcestershire NHS
Acute Hospitals NHS Trust



Ave. Income per admission						
FY Plan	£695					
Monthly Actual	£663	£667	£657	£649	£634	£612



Ave. Income per admission						
FY Plan	£143					
Monthly Actual	£146	£147	£143	£142	£141	£146



Ave. Income per admission						
FY Plan	£2,708					
Monthly Actual	£2,913	£2,911	£2,839	£2,880	£2,864	£2,771

Activity performed within Trust and sent Private				
	Daycase		Elective IP	
	Trust	Private	Trust	Private
Apr	3,876	50	670	0
May	4,275	50	682	0
Jun	4,576	71	768	0
Jul	4,209	48	737	0
Aug	4,384	31	670	0
Sep	4,284	26	763	0
Oct	0	0	0	0
Nov	0	0	0	0
Dec	0	0	0	0
Jan	0	0	0	0
Feb	0	0	0	0
Mar	0	0	0	0
YTD	25604	276	4290	0

Outsourcing Plan

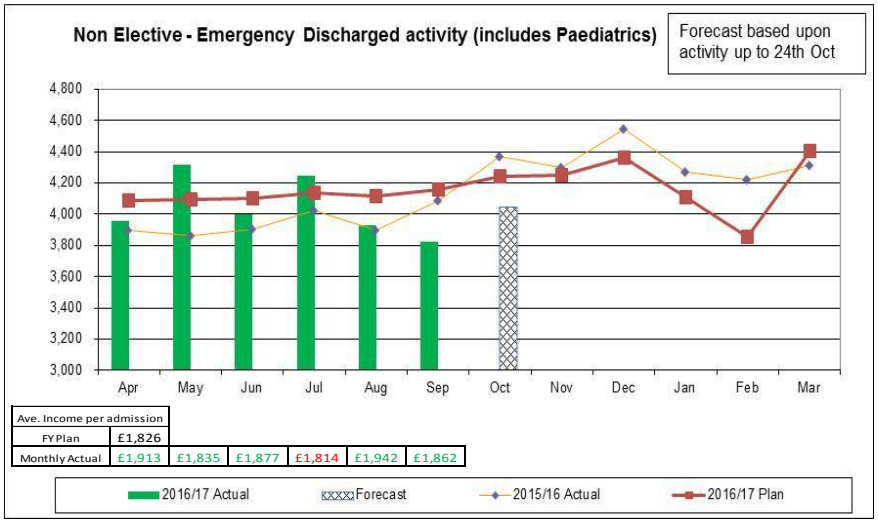
The Trust has agreed to outsource activity in a few specific areas where there are exceptional capacity pressures. This is on the basis that rates are at or below tariff.

At August agreed areas are:

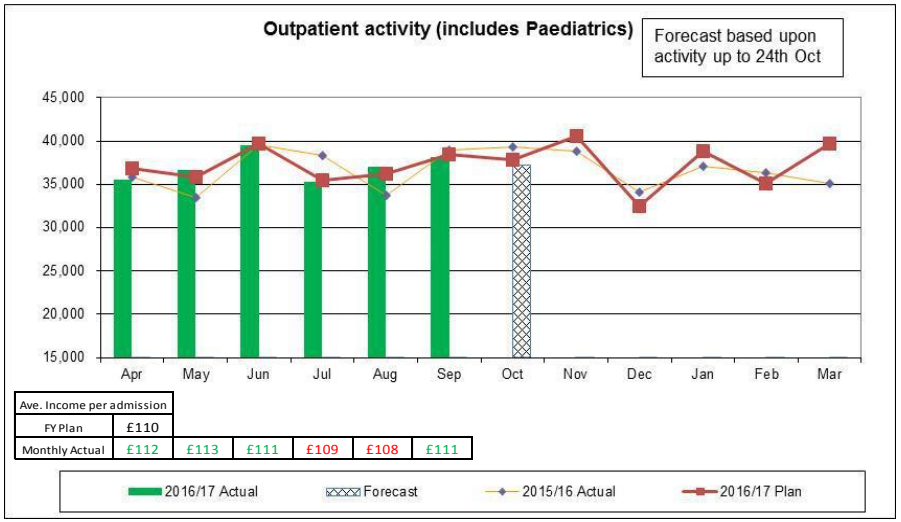
- Dermatology (via third party subcontractor)
- Endoscopy
- Radical Prostatectomies
- T&O – maximum of 27 cases pm as agreed with CCGs
- General Surgery – maximum of 20 cases pm

Outpatients, Non Elective and A&E

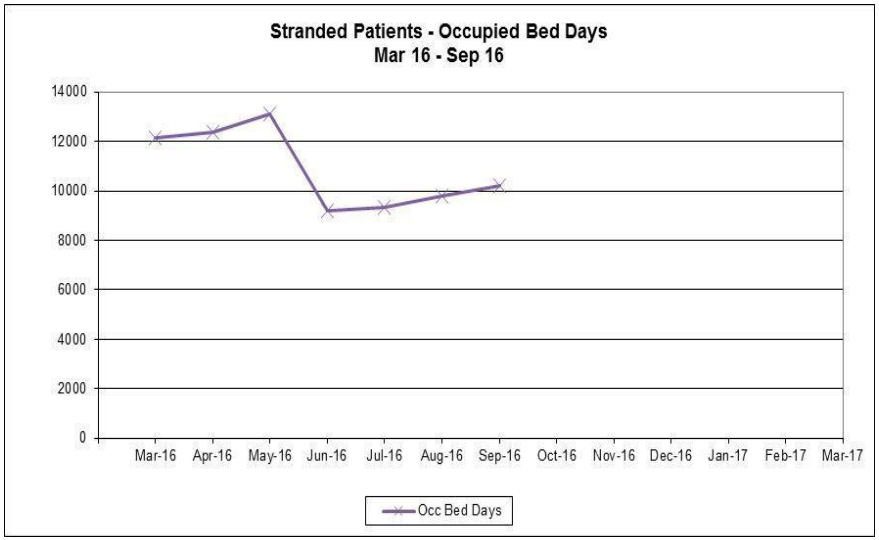
Worcestershire NHS
Acute Hospitals NHS Trust

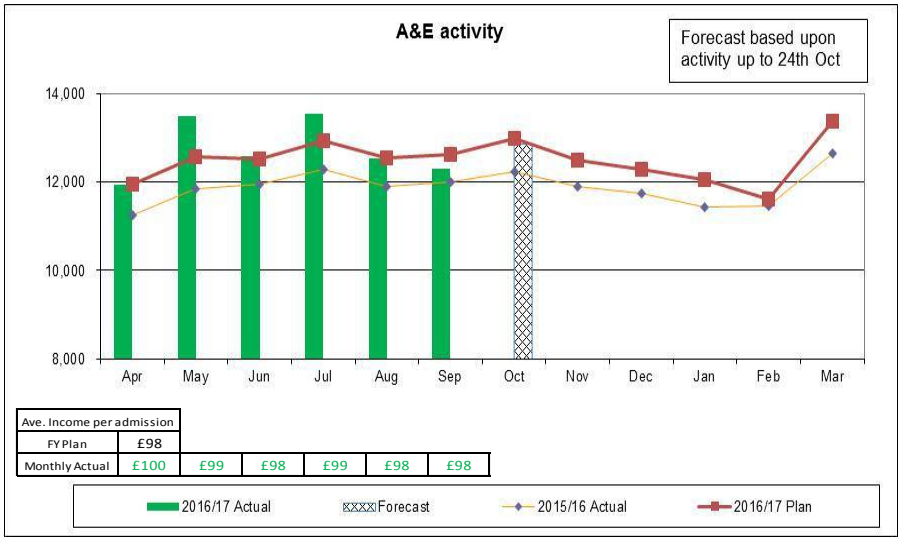


Ave. Income per admission						
FY Plan	£1,826					
Monthly Actual	£1,913	£1,835	£1,877	£1,814	£1,942	£1,862



Ave. Income per admission						
FY Plan	£110					
Monthly Actual	£112	£113	£111	£109	£108	£111





Ave. Income per admission						
FY Plan	£98					
Monthly Actual	£100	£99	£98	£99	£98	£98

Stranded Patients – there was a reporting issue for Feb to May 2016, which has been corrected from June onwards.

Balance Sheet

Worcestershire NHS
Acute Hospitals NHS Trust

				Full Year			
Balance as at 31 August 2016	Balance as at 30 September 2016	Movement in Month	Balance Sheet	Annual Plan	Forecast 31st March 2017	Variance from Plan	Balance at 31st March 2016
£000s	£000s	£000s	**ASSETS, NON CURRENT**	£000s	£000s	£000s	£000s
249,290	249,216	(74)	Property, Plant and Equipment and intangible assets, Net	270,605	253,444	(17,161)	250,590
3,913	4,359	447	Other Assets, Non-Current	3,238	3,388	150	1,669
253,203	**253,575**	**372**	**Assets, Non-Current, Total**	**273,843**	**256,832**	**(17,011)**	**252,259**
			ASSETS, CURRENT				
8,029	7,885	(144)	Inventories	5,800	5,506	(294)	7,081
12,424	10,024	(2,400)	Debtors	15,121	10,718	(4,403)	25,823
14,504	11,503	(3,001)	Cash and Cash Equivalents	1,900	1,900	0	1,474
34,957	**29,412**	**(5,545)**	**Assets, Current, Total**	**22,821**	**18,124**	**(4,697)**	**34,378**
288,160	**282,988**	**(5,172)**	**ASSETS, TOTAL**	**296,664**	**274,956**	**(21,708)**	**286,637**
			LIABILITIES, CURRENT				
1,936	**968**	(968)	PFI leases, Current	1,936	**1,941**	5	1,936
37,160	**32,664**	(4,496)	Creditors < 1 Year	38,367	**25,454**	(12,913)	48,270
39,096	**33,632**	**(5,464)**	**Liabilities, Current, Total**	**40,303**	**27,395**	**(12,908)**	**50,206**
(4,139)	**(4,220)**	**(81)**	**Net Current Assets/(Liabilities)**	**(17,482)**	**(9,271)**	**8,211**	**(15,828)**
			LIABILITIES, NON CURRENT				
125,410	127,863	2,453	Creditors > 1 Year	153,031	143,424	(9,607)	95,757
71,248	72,055	807	PFI leases, Non-Current	70,058	70,114	56	72,055
0	0	0	Other Liabilities, Non-Current	0	0	0	0
196,658	**199,918**	**3,260**	**Liabilities, Non-Current, Total**	**223,089**	**213,538**	**(9,551)**	**167,812**
52,406	**49,438**	**(2,968)**	**TOTAL ASSETS EMPLOYED**	**33,272**	**34,023**	**751**	**68,619**
£000s	£000s		**FINANCED BY :- PUBLIC EQUITY**	£000s	£000s	£000s	£000s
184,564	184,564	0	Public Dividend Capital	184,564	184,564	(0)	184,564
54,320	54,320	0	Revaluation reserve	54,320	54,320	0	54,320
(861)	(861)	0	Other reserves	(861)	(861)	0	(861)
(185,618)	(188,585)	(2,968)	I&E Reserve	(204,751)	(204,000)	751	(169,404)
52,406	**49,438**	**(2,968)**	**TOTAL PUBLIC EQUITY**	**33,272**	**34,023**	**751**	**68,619**

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2nd November 2016 **Enc**

Report to Trust Board in Public

Title	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR)**
Sponsoring Director	Jan Stevens, Interim Chief Nursing Officer
Author	Wendy Huxley Marko, Interim 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 sufficient progress has been made
Previously considered by	Appropriate committees

Priorities (√)

Investing in staff	√
Delivering better performance and flow	√
Improving safety	√
Stabilising our finances	√

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 NHS Improvement. 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 - an information tool that allows for detailed analysis of all strategic risks which could impact on the Trust achieving its objectives CRR – Corporate Risk Register - contains those risks which have the potential to impact on the organisation as a whole & exceeds the risk appetite for that category of risk.

Key Messages

This paper provides Trust Board with the quarterly update of the full BAF and full Corporate Risk Register.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2nd November 2016 **Enc**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – November 2016

1. Situation

The Trust Board is provided with the Board Assurance Framework and Corporate Risk Register for assurance.

2. Background

NHS Trusts are required to have a Board Assurance Framework. Trust Board review the Board Assurance Framework and Corporate Risk Register in full quarterly.

3. Assessment

3.1 Board Assurance Framework (BAF)

The risks recorded on the BAF have been reviewed by the responsible Executive Directors, and action plans updated.

- Two risks have been closed and replaced by new risks which reflect the 2016/17 financial situation.
- The ratings of three risks have reduced.
- There are seven risks where the risk rating has remained the same for the past 12 months (five of these for 18 months).

The risk tracking report indicates where these changes have occurred.

An Assurance Summary has been provided with this report for the first time. In order for the assurance framework to be able to provide the Board with full information on the management of risks it is important that actual evidence of assurances are identified, including negative assurance.

This will provide the Board with more meaningful information with which to challenge how well the risk is being managed and agree if the risk rating is correct. Not all BAF risks will have had any actual assurances.

3.2 Corporate Risk Register (CRR)

There are 26 risks recorded on the Corporate Risk Register, with 10 at a rating of high. The summary sheet provided shows the executive lead and monitoring committee of each. Risks are reviewed by the responsible Executive Directors, and action plans updated.

The risk tracking index shows that in the last quarter:

- Five risks were closed
- Two risks were added (one new, one escalated)

- The ratings of three risks have reduced

4 Recommendation

Trust Board is asked to:

- Note the changes to the BAF & CRR
- Review risk ratings, controls, assurance and mitigating actions and consider if sufficient progress has been made

Jan Stevens
Interim Chief Nursing Officer

Title of report	Board Assurance Framework (BAF) and Corporate Risk Register (CRR)
Name of director	Interim Chief Nursing Officer

BAF Risk rating tracking report

BAF Risk		Jul-15	Oct-15	Jan-16	Apr-16	Jul-16	Oct-16	Notes	Change over 12 months
2665 If we do not redesign services in a timely way we will have inadequate numbers of clinical staff to deliver quality care		20	20	20	20	20	9	Rating reduced as the FoAHSW proposal has been ratified by the external clinical services review panel	↓
2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels		20	20	20	20	20	16		↓
2790 As a result of high occupancy levels, patient care may be compromised		20	20	20	20	20	20		→
2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability		16	20	20	20	20	closed	Replaced by 3291	
2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services		12	12	16	20	20	20		↑
2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity and missed opportunities		12	12	12	20	20	20		↑
3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care		16	16	16	16	16	12	Rating reducedfollowing introduction of weekly sitrep and quality dashboards	↓
2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service		9	12	16	16	16	closed	Replaced by 3290	
3193 If the Trust does not achieve patient access performance targets, there will be significant impact on finances		new			16	16	16		→
2894 Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems		15	15	15	15	15	15		→
2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience		16	16	12	12	12	12		→
2902 If the Trust does not achieve safety targets, it will fail to reduce avoidable harm & reported mortality rate to expected levels		12	12	12	12	12	12		→

2904 If there is inadequate culture and staff development for improvement, the Trust will not be able to continuously improve		12	12	12	12	12	12		→
3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected		12	12	12	12	12	12	managed as risk 2903 until Jan 2016	→
3290 If plans to improve cash position fail the Trust will be unable to pay creditors impacting on supplies to support services		new					9		
3291 Deficit is worse than planned and threatens the Trust's long term financial sustainability		new					15		
2889 Sufficient access to capital to achieve change and conduct backlog maintenance		15	15	de-escalated				Covered by risk 2888, and managed at CRR level via risk 2856 (rating now 20)	↑
2900 If the Trust does not expand renal services, patients will have to travel further and experience fragmented care		12	12	12	de-escalated			being managed within Medicine Division (no change to risk rating since)	→
2899 Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, reduced clinical outcomes		12	12	12	de-escalated			moved to Corporate risk register (no change in rating since then)	→
2891 If the Trust does not implement mortality review trust-wide then we will have fewer opportunities to improve patient care		16	16	16	closed			closed as it is captured within BAF risk 2902	
2666 Inability to secure sufficient income placing the financial position at further risk and affecting long term sustainability		16	16	closed				closed, merged with 2888	
2667 If expenses are not sufficiently contained and reduced there will be a serious impact on financial position & cash availability		16	16	closed				closed, merged with 2888	
2898 Poor communication with patients resulting in reduced quality of patient experience, complaints and reputation damage		12	12	12	closed			closed, merged with risk 2898	
2905 Failure to create capacity and capability for transformation, resulting in inability to deliver required improvement		12	12	12	closed			closed, risk merged with risk 2665 March 2016	

Board Assurance Summary

Introduction:

This document is intended to be dynamic. Each potential risk is given a risk rating that is derived from the consequences of the risk in respect of potentially not achieving our objective(s) and the likelihood of the risk arising. 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 target risk level is calculated, which reflects the level of risk posed to the achievement of the objective once the actions are completed.

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). 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.

Assurances:

In order for the assurance framework to be able to provide the reader with full information on the management of risks it is important that actual evidence of assurances are identified, including negative assurance.

This will provide the reader with more meaningful information with which to challenge how well the risk is being managed and agree if the risk rating is correct.

Key:

Risk Rating	
1-6	Risk is within tolerance
8-10	
12-15	Risk Exceeds tolerance
16-25	

Assurance Rating	
	Minor or no concerns / significant assurance / standard achieved
	Issues of concern / moderate assurance / standard partly achieved
	Serious concerns / limited assurance / standard not achieved

Board Assurance Summary

Objective:	**1. Investing in Staff**
SRO:	**Director of Human Resources**
NED:	**John Burbeck**
Committee:	**Workforce Assurance Group**
Date:	

Key Risks & Mitigation			
ID	**Risk**	**Level**	**Progress**
2893	Failure to engage and listen to staff leading to low morale, motivation, and productivity (DoHR)	**20**	Quarter 1 Chatback survey results shared with divisions to develop action plans.
2678	If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels	**16**	A review of medical workforce vacancies has been completed – to be reported to November Trust Board with plan to address the vacancies.
2894	Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems	**15**	There has been a delay in commencing the Aspirant Leaders programme.
SRO	**Chief Executive**	**NED**	**Chairman**
2932	Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services	**20**	NHSI have agreed to staggering Board members terms of office with one NED extended to June 2017 and another to December 2017.

Sources of Assurance (internal, external)		
	Assurance	**Results**
Q1	Chatback survey	Improved engagement score
Q2		
Q3		
Q4		
Q1		
Q2	Report to TMG on medical workforce vacancies	Current vacancy position of 125 wte (18% of consultants)
Q3		
Q4		
Q1	Chatback survey	Improved engagement score
Q2		
Q3		
Q4		
Workforce Assurance Group		
Q1		
Q2	NHSI have completed a Board Capability & Capacity review in line with the special measure regime	Assurance on interim arrangements whilst recommending a move to permanent appointments.
Q3		
Q4		

Board Assurance Summary

Objective:	**2. Delivering better Performance and Flow**
SRO:	**Director of Strategy & Planning**
NED:	**Andrew Sleigh**
Committee:	**Finance and Performance Committee**
Date:	

Key Risks & Mitigation			
ID	**Risk**	**Level**	**Progress**
2665	If we do not redesign services in a timely way we will have inadequate numbers of clinical staff to deliver quality care (CMO)	**9**	Paediatric services centralised. Good consultant recruitment into maternity, gynaecology and paediatrics.
2904	If there is inadequate culture and staff development for improvement, the Trust will not be able to continuously improve (DoHR)	**12**	
3140	If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected (DoC)	**12**	

Sources of Assurance (internal, external)		
	Assurance	**Results**
Q1		
Q2	NHSE external clinical services review panel	FoAHSW proposal ratified
Q3		
Q4		
Q1		
Q2		
Q3		
Q4		
Q1		
Q2		
Q3		
Q4		

Board Assurance Summary

Objective:	**3. Quality and Safety**
SRO:	**Chief Medical Officer and Chief Nursing Officer**
NED:	**Bill Tunnicliffe**
Committee:	**Quality Governance Committee**
Date:	

Key Risks & Mitigation			
ID	**Risk**	**Level**	**Progress**
2790	As a result of high occupancy levels, patient care may be compromised and access targets missed (COO)	20	
2902	If the Trust does not achieve safety targets, it will fail to reduce avoidable harm & reported mortality rate to expected levels	12	

Sources of Assurance (internal, external)		
	Assurance	**Results**
Q1		
Q2		
Q3		
Q4		
Q1		
Q2	Internal Audit – Serious Incidents	The timeliness of incident reporting, review and closure still requires improvement. Staff completing reviews are still not fully trained in the RCA process
Q2	Divisional Quality Dashboards	
Q2	Internal - Mortality report to CGG	The Trusts HSMR & SHMI indicators put WAHT in an 'outlier' position. Completion of mortality reviews and the capture of improvement opportunities is at a low level
Q3		
Q4		

3038	If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care	**12**	
2895	If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience	**12**	

Q1		
Q2	Peer Review - Clinical Friday Reviews	Some good practice but many areas where improvement required including learning from incidents, complaints.
Q3		
Q4		
Q1		
Q2	Review of formal complaints that were upheld or partially upheld by the Parliamentary and Health Services Ombudsman.	From 01/01/16 to 08/09/2016, 1 complaint upheld and 3 partially upheld c/w 4 partially upheld in 2015.
Q3		
Q4		

Board Assurance Summary

Objective:	**4. Stabilising our finances**
SRO:	**Director of Finance**
NED:	**Andrew Sleigh**
Committee:	**Finance and Performance Committee**
Date:	

Key Risks & Mitigation			
ID	**Risk**	**Level**	**Progress**
3291	Deficit is worse than planned and threatens the Trust's long term financial sustainability	15	The Trust reported a Year to Date (YTD) adverse variance of £0.3m at Month 4. Delivery of the CIP target, contracted levels of activity and agreed performance trajectories are crucial to delivering the planned financial position.
3290	If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service	9	The Trust is able to manage the cash impact of the £15m risk to the planned £34.6m deficit if it does not receive further cash to cover this.
3193	If the Trust does not achieve patient access performance targets there will be significant impact on finances (COO)	16	

Sources of Assurance (internal, external)		
	Assurance	**Results**
Q1	External Audit – Value for Money audit	Improvement required – CIP & workforce planning & recovery plan
Q2	PWC – Workforce savings report	Of £28m saving required, £10m already delivered
Q3		
Q4		
Q1	Internal Audit – Treasury Management audit	Existing processes to manage cash are sound
Q2	External - DH Letter	Letter of confirmation regarding availability of cash if required
Q3		
Q4		
Q1		
Q2		
Q3		
Q4		

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	Continuously improve our services to provide the best outcomes and experience for our patients
Strategic objective(s)	Delivering better performance and flow
Initial Risk Level	Major Almost certain 20 High

Director/Committee	Chief Medical Officer / Trust Management Group
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 TMG Future of Acute Hospital Services in Worcestershire (FOAHSW) Project established Sustainability sub-committee of Programme Board Project management contractors employed to support delivery FOAHSW Implementation Group (FIG) established Centralisation of Paediatric Services
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 - Sep 2016 FoAHSW proposal ratified by the external clinical services review panel

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 Moderate Possible 9 Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Planned consultation and engagement during the public consultation on reconfiguration	Andrew Short Consultant Paediatrician	13/01/2017	Public consultation contingent on endorsement by clinical senate and NHSE. Due date changed again to reflect time required for consultation. June 2016 update: Now scheduled to start in October 2016, due date updated.	
ASR Project developing	Chris Tidman	31/01/2017	Due date updated as a result of delays in	

detailed business case(s) for interim and permanent solutions.	Acting Chief Executive		endorsement for the model. 09/09/16 - The Strategic Outline Case was agreed by the Trust Board in June 2016 and the outline business case will be finalised in January 2017. Due date updated to reflect this change.	
Develop and gain endorsement for model of reconfiguration	Andrew Short Consultant Paediatrician	15/07/2016	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. May 2016 update: two meetings of clinical senate have taken place, with third to occur on 16th May. Due date updated to July 2016. 14/09/16 - Outline Business Case submitted for approval October 2016.	15/09/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	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 Assurance. May 2016 Draft clinical senate report received, supporting reconfiguration plans June 2016 Paper requesting emergency centralisation of inpatient paediatric services approved at Trust Board. Draft Clinical Senate report has been shared and fully supports proposed model. Due to be published 7th July 2016. 14/09/16 - Current Risk Rating reduced as outline business case submitted and the FoAHSW proposal has been ratified by the external clinical services review panel.

Next Review Date 02/11/2016

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)	Investing in 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-NWAG report on nursing workforce recruitment, medical staffing management - report via TMG to the Board. Oct 2016 - Current medical staffing vacancy position of 125 wte (18% of consultants). Internal Audit-Temporary Staff Booking Process Audit Internal reports to the Board-Monthly divisional nurse recruitment strategies report via NWAG

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
Recruitment of Physician Associate posts.	Sandra Berry Training Manager WRH	31/12/2016	Posts agreed and recruitment commenced. To be completed by 31.12.16.	
Create Workforce Development Plan and implement new roles. Maximising internal Bank recruitment	Denise Harnin Director of HR & OD	30/06/2016	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. April 2016 update: The Divisions have prepared the first draft workforce plans for years 1 - 3 and these are being progressed with a proposed completion date of 30 June 2016 Update 09/09/16 - Final Divisional workforce plans in progress. New roles developed and implementation commenced to support workforce gaps.	30/06/2016

Establish a group to address agency spend.	Denise Harnin Director of HR & OD	31/10/2016	September 2016 update: Task and Finish Group established early August and meeting fortnightly. Task & Finish Group to be established to reduce agency spend on medical and nursing vacancies.	26/09/2016
Recruitment processes and recruitment packages to be reviewed.	Denise Harnin Director of HR & OD	31/10/2016	Recruitment Policy reviewed. Individual recruitment strategies developed through NWAG and Medical Staffing. Further review undertaken by new Medical Staffing leads by October 2016, hence extension of due date. Update 20.10.16 - Review of medical workforce vacancies complete and outcome to be reported to Board 02.11.16	20/10/2016

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 24/11/2016

BAF Risk Report

Risk	**2790 As a result of high occupancy levels, patient care may be compromised**
Date opened	02/02/2015
Strategic goal	Continuously improve our services to provide the best outcomes and experience for our patients
Strategic objective(s)	Quality and Safety
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	31/12/2016	The actions within the Patient Care Improvement Plan (PCIP) are tracked at UrCOT.	

Target Risk Level Minor Unlikely 4 Very Low

BAF Risk Report

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 02/11/2016

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)	Investing in 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 Staff Engagement Group commenced.
Sources of Assurance	Management Assurance-Workforce Assurance Group reporting Management Assurance-Chatback Survey - Q1 showed an improved engagement score. Independent Assurance-Staff Opinion Survey

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
Measure second quarter Chatback results for improvement.	Sandra Berry Training Manager WRH	14/11/2016	Results expected 31.10.16	
Develop new infrastructure for delivery of engagement plan	Lisa Thomson Director of Communications	15/07/2016	Plan is contained within Improvement Priority Plan (PCIP). Staff Engagement plan agreed & Staff Engagement Group developed and commenced.	15/07/2016
Share Chatback survey results	Lisa Thomson Director of Communications	03/10/2016	First quarter chatback survey results shared with divisions to develop appropriate action plans.	03/10/2016

Medical engagement plan to be implemented.	Lisa Thomson Director of Communications	30/09/2016	Medical Engagement programme & action plan developed & agreed.	24/10/2016

Target Risk Level Moderate Unlikely 6 Very Low

Progress	Annual staff survey underway. Awaiting results for an updated staff engagment score.

Next Review Date 24/11/2016

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) Investing in 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 Internal reports to the Board-Delivery of Leadership programme schedule Management Assurance-Leading Into Action workstream project summaries Management Assurance-Quarterly reports on the Chatback initiative - Q1 shows an improved engagement score Review-External-Annual Staff Opinion Survey

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
Implement Organisational Development Strategy	Denise Harnin Director of HR & OD	31/12/2016	Update September 2016 : OD Strategy and Action Plan being reviewed by Executive Team. Draft Medical Leadership Programme completed to be agreed by CMO with potential start date of November 2016. Medical Engagement Events held and action plan developed. Update April 2016: The initial strategy presented to WAG 21st March 2016. A communications plan and staff leaflet to be developed to include the Trust Values and	

			additional actions agreed to support the strategy focusing on Staff Engagement including Chatback, Listening into Action. And a range of workforce metrics has been developed to support the OD Strategy.
Develop aspirant leaders development programme	Denise Harnin Director of HR & OD	31/01/2017	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. Update September 2016 : TNA Scoping completed by OD consultant and programmes for all senior leaders drafted to be agreed with Executive Team in September 2016 with planned delivery to commence October 2016. Due date updated to reflect this. Update Oct 2016: Delay in commencing programme - due date updated to reflect this.

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 07/12/2016

BAF Risk Report

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)	Quality and Safety
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
Complaints Policy and processes to be revised to better reflect My Expectations guidance and user feedback	Tessa Mitchell Associate Director of Patient Experience	31/10/2016	The Trust is working with a Consultant to revise and review our Complaints processes and policy. Workshops took place in July and August and a new process has been drafted and is currently being adopted divisionally. This will now form the basis of our new revised Complaints Policy which we plan to launch in October.	

Regular audits of complaints processes and learning by CCG colleagues and internal audit to ensure process being followed and is effective	Tessa Mitchell Associate Director of Patient Experience	30/12/2016	The CCG have scheduled a programme of regular audits to review our complaints handling and arrangements for shared learning. They will undertake this work with Divisional Quality Governance Leads. An internal audit of complaints has also been scheduled for January 2017.	
Utilise DATIX as the Complaints reporting and management system for the Trust	Tessa Mitchell Associate Director of Patient Experience	30/12/2016	Significant work has taken place on revising DATIX to mirror our complaints Investigation template and to deliver realtime reporting functionality. The datix manager, Complaints officer and Informatics Officers are working collaboratively on this and it is now being rolled out Divisionally following the complaints workshop in July. further tweaks and revisions will be needed but it is now live and useable.	
Trust to complete Collaborative Pairs Programme with Kings Fund	Tessa Mitchell Associate Director of Patient Experience	14/07/2017	Patient and staff member identified. Area of work identified - Outpatients Improvement Plan. Initial meeting held 9th August. Programme commences in September 2016	
Development of Outpatient Strategy to incorporate outpatient feedback from National Survey 2015 and quick wins	Tessa Mitchell Associate Director of Patient Experience	15/08/2016	An Outpatients Group has been established to develop Strategy. Sabrina Brown is co-ordinating a range of workstreams to improve outpatients and this includes patient representatives. The Trust has also obtained a place on The Kings Fund Collaborative Pairs programme starting in September. The patient and staff member involved will be working on outpatients initiatives and looking at how to bring collaborative working and co-production back into the organisation to change culture and practice to be more patient centered.	16/08/2016
Undertake Complaints users survey 2015-16 and use feedback to inform new policy / procedure	Tessa Mitchell Associate Director of Patient Experience	30/09/2016	The Survey is being collated into a report and the findings will be incorporated into the new policy / procedure. Survey Report presented to PCEC in September and findings incorporated into new policy / procedure.	26/09/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	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 02/11/2016

BAF Risk Report

Risk	**2902 If the Trust does not achieve safety targets, it will fail to reduce avoidable harm & reported mortality rate to expected levels**
Date opened	21/05/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Quality and Safety
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 Governance Committee Structure and reports on key subjects from committees - Mortality report Oct 2016 to CGG - remain an outlier Internal Audit-Internal audit of Risk Management and Serious Incident processes - Moderate assurance 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 Clear definition and description of safety metrics - check inclusion in reporting processes Performance management processes that include these.

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Implement Safer Care Campaign	Jan Stevens Interim Chief Nursing Officer	31/03/2017	Safer Care campaign has been designed and ready to launch (September 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	Improvement Plan in place with KPIs. Refer to this for detail on actions and performance. Governance & Safety Patient Care Improvement Plan has been revised into a different format which includes the actions related to patient safety. A separate programme PCIP exists for mortality and also has a set of actions included. The action can therefore be closed with follow up through the PCIP review programme.	26/07/2016
Check definitions of patient safety targets / metrics and inclusion in the Divisional Quality Governance Report / Dashboards	Chris Rawlings Head of Clinical Governance & Risk Management	31/08/2016	Review of Divisional Quality Governance Report on 1st April. New dashboard produced to replace the Divisional Governance Report as part of a packages that will change quality performance reporting based on exception reporting through a new CLinical Governance Committee. The definitions are being checked as part of the dashboard construction and development. This new initiative will take place over the several months but the definitions will be completed by the end of August. The action has therefore been moved to this date. New Divisional clinical governance dashboards are now in place and working to an initial 9 week reporting cycle. The indicators have been taken from the Quality Account/Improvement Programmes, contract and other sources to provide an initial set.Definitins are confirmed for each indicator and are being made consistent across all dashboards as part of this process.	31/08/2016
Launch safety culture campaign with highlighted themes	Lisa Thomson Director of Communications	02/11/2016	A new safety campaign is being developed with input of the CNO which will encompass safety culture and the major elements of the Governance and Safety action plan. 26/07/2016 Work has commenced on elements of the safety campaign, including hand washing and sepsis. The full launch will be tied into the safety strategy once all areas of activity are confirmed. 14/09/16 - The Caring Safely Programme was approved at TMG and terms of reference will be agreed on 19/09 with a launch date of 31/10/16. Replaced by Safer Care action - initiative led by CNO and CMO	24/10/2016

Target Risk Level	Major	Possible	12	Moderate

Progress	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. 1st April - review of Divisional Quality Governance 'deep dive' report at OGM after first cycle of reports. Trajectory set for mortality review performance at QGC in April 2016 Update June 2016: PCIP work progressing. CNO recruiting external support and getting input

	from Oxford University Hospitals NHS Foundation Trust. August 2016: New safty improvement plan in development. Changes to the Governance and committee structure.

Next Review Date 02/12/2016

BAF Risk Report

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	Continuously improve our services to provide the best outcomes and experience for our patients
Strategic objective(s)	Delivering better performance and flow
Initial Risk Level	Major Possible 12 Moderate

Director/Committee	Director of Human Resources / Trust Management Group
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 Management Assurance-Implementation of Learning Into Action projects

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
Develop Improvement Technique training	Sandra Berry Training Manager WRH	02/12/2016	Schedule of Leadership/Improvement Development programmes being developed to include improvement technique training. LIA programmes also include improvement projects.	
Implement OD and engagement improvement plan	Denise Harnin Director of HR & OD	31/12/2016	Updates captured within the Trust Improvement Programme (PCIP) for Organisational Development & staff engagement	

Target Risk Level Major Unlikely 8 Low

Progress	April 2016: Resource plan for organisational development being developed

Next Review Date 07/12/2016

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)	Investing in 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, the Trust being placed in Special Measures, recruitment difficulties and historical 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 five Non-Executive Directors (NEDs) including a newly appointed Chair, one Associate NED and a Board Advisor; 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 December 2016. This creates a business continuity risk for the governance of the organisation. 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 NHSI who are responsible for the appointments and this is being considered. Furthermore, as a result of the departure or absence of several Executive Directors, the five voting Executive posts are either acting or 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 and experienced acting or interim staff, endorsed by NHSI Clear deputizing arrangements in operation, and or swift action to bring in interim support where required 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 Additional Associate NED support sourced from neighbouring Foundation Trust to support transitional period Clear deputizing arrangements in operation, and or swift action to bring in interim support where required Terms of Office for NEDs are staggered.
Sources of Assurance	Management Assurance-Acting Chief Executive ensuring and reviewing business continuity through the Exective Management Team (EMT) Independent Assurance-NHSI have completed a Board Capability & Capacity review in line with the special measure regime - this has given assurance on interim arrangements whilst recommending a move to permanent appointments.

BAF Risk Report

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
Gaps in Assurance	The Trust is not presently aware of the NHSI'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	30/12/2016	Strong interim posts in place for 2016. Executive recruitment commencing with CEO process in September 2016. This action will take some months to complete	
Develop a NED recruitment programme	John Burbeck Interim board chair	15/07/2016	Associate NEDs appointed to supplement Board capacity through transition period. Former NED role extended as Board Advisor.	27/06/2016
Following recruitment of new chair, Chairman to discuss with NHSI, agreeing appointment programme and business continuity arrangements for Trust Board		30/09/2016	NHSI have endorsed new NED appointments and are considering proposal to extend some existing NEDs into 2017 for business continuity. 11/10/16 - NHSI have endorsed proposal to extend some NED terms of office into 2017	30/09/2016

Target Risk Level Major Unlikely 8 Low

Progress	Plans are in place to commence recruitment of key Executive posts, following the appointment of a new Chair. In the meantime, the Executive will remain in place, providing continuity and stability through the transition period. 08/09/16 - New Chair in post with effect 12/09/16 11/10/16 - NHSI have agreed to staggering Board members terms of office with one NED extended to June 2017 and another to December 2017.

Next Review Date 09/11/2016

BAF Risk Report

Risk	**3038 If the Trust fails to improve performance, strengthen governance and patient safety it will not address CQC inspection concerns**
Date opened	12/10/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Quality and Safety
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Nursing Officer / Trust Management Group
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. This risk assessment covers the Trust's need to improve performance, strengthen governance and patient safety or it will not address CQC inspection concerns and remain in special measures.
Key Controls	Policies covering the Trust's quality and business activities, monitoring these and taking action to improve compliance Clinical Governance structures and processes Clinical Audit Incident management processes and monitoring Improvement programmes and Boards for: Reducing Avoidable Mortality; Workforce & OD; Urgent Care & Patient Flow; Outpatients; Governane & Safety PIMS meeting to monitor and guide preparations for the CIH re-inspection including testing of 'must-do's' and 'should-do's'
Sources of Assurance	Internal Audit-Review of CQC related processes Self-assessment against standards-Mock inspections Management Assurance-Quality dashboards Review-Internal-Clinical Friday - reviews. Sep 2016 moderate assurance

Performance Monitoring	Dashboards in development which will be presented in CQC domains and reported through a new quality reporting framework. Weekly Sitrep reports delivered and being further developed to maintain focus on the key areas of incidents, risks and complaints management.
Gaps in Control	Not all key corporate and clinical systems and processes are subject to an assessment of compliance with the standards Ability to review performance in context of domains and ward to board reporting
Gaps in Assurance	

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop and implement a new clinical governance reporting framework that will provide ward to board reporting	Chris Rawlings Head of Clinical Governance & Risk Management	31/03/2017	First dashboard developed and produced. Exception based reporting promoted with suitable tools developed. Workshops held but more required. Reporting framework to be discussed at the QGC in August and agreement sought. First cycle commenced with report to Board in November.	
Ensure that the "must do's" contained within the Final Report are acted on.	Lisa Miruszenko Deputy Chief Nursing Officer	31/10/2016	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	09/08/2016

			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). June 2016 update: due date extended to capture continued work of Improvement Board in addressing the Must Do's. August 2015 - PIMs meeting initiated to prepare for the assessment. This will monitor the ,ust and should dos and ttest evidence. Action deadline extended to allow this group to gather evidence and confirm that these have been satisfactorily addressed.	
Implement changes outlined in the review of quality	Chris Rawlings Head of Clinical Governance & Risk Management	30/09/2016	Associate Director post being advertised in December 2015. Structural changes will be implemented when this post commences. Initial review of committees completed, more detailed review of aims and objectives, chairmanship, membership and reporting commenced. March 2016 - Deputy Director post offered with an expected start date in June. Deadline date moved to end of June to allow for this. Change in direction - Deputy Director post not filled. A review of clinical governance arrangements commenced using an external governance advisor. Other assistance also sourced to develop the PCIP / Improvement plans and other element. The closure date has been extended bearing in mind these developments and the action / risk assessment will be further reviewed in light of this. Action closed as it has been superseded by subsequent actions	19/08/2016
Establish a new Clinical Governane Group to oversee performance which reports to the TMG and QGC within the new quality reporting framework	Chris Rawlings Head of Clinical Governance & Risk Management	30/09/2016	ToRs, membership and content developing. Plan to meet 6th September 2016	06/09/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	Must do's and selected should do's are incorporated into the PCIP, which is being monitored by the Improvement Board. Divisional Quality Dashboards in development which will be presented in CQC domains and reported through a new quality reporting framework. Weekly Sitrep reports delivered and being further developed to maintain focus on the key areas of incidents, risks and complaints management.

Next Review Date 04/11/2016

BAF Risk Report

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)	Delivering better performance and flow
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 and any changes made under emergency measures
Sources of Assurance	Review-External-NHSI and CCG Communications teams provide assurance regarding the communications strategy and approach

Performance Monitoring	Yearly stakeholder survey to be initiated. Media monitoring (including social media) 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
Public Board to include 1 hour Q&A session with the public as part of the Public and Patient Engagement Strategy	Lisa Thomson Director of Communications	02/11/2016		
Ensure partners are aligned with the Trust for support with comms.	Lisa Thomson Director of Communications	31/03/2017	Ask partner agencies such as Buddy Trusts to provide independent support for changes.	
Conduct the first annual stakeholder survey	Lisa Thomson Director of Communications	16/05/2016	Survey drafted for consideration by the executive team	16/05/2016
Implement Media Policy	Lisa Thomson Director of Communications	15/07/2016	Developed, tested and approved	31/05/2016
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.	15/06/2016
Test staff advocate programme	Lisa Thomson Director of Communications	15/07/2016	Testing in progress. The Trust is using Listening into Action to deliver a staff advocate approach which includes using Twitter – to support this we	03/10/2016

			have trained/advised the LiA sponsor group on using Twitter and set up accounts for them to promote the work they are doing and the work of the Trust.	
Target Risk Level	Minor	Unlikely	4	Very Low

Progress	
Next Review Date	09/11/2016

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 sustainable and financially viable and makes the best use of resource
Strategic objective(s)	Stabilising our finances
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
Urgent Care and Patient Flow Trust Improvement Programme contains the full action plan for this risk	Rab McEwan Chief Operating Officer	31/12/2016		
Implement training and development for staff and a validation resource for RTT data	Inese Robotham Deputy COO	15/06/2016	Delivered in June 2016	15/06/2016
Centralise pathology services to improve efficiency of diagnostics	David Burrell Divisional Director of Operations	15/06/2016	Up-date 24/6/16 - Complete. Most pathology services were already centralised. Histopathology was centralised at WRH from 8 June 2016. This was a financial and quality initiative. Data will be monitored to determine if this initiative has improved turnaround times.	24/06/2016

BAF Risk Report

Introduce outsourced support for imaging to enable a 24/7 service	David Burrell Divisional Director of Operations	31/07/2016	Up-date 24/6/16 - Radiology overnight reporting was outsourced from 11 April 2016. This has provided additional reporting sessions per week, however the improvement expected in reporting times has been negated by Consultant Radiologists leaving the service or reducing hours. The outsourcing initiative will be reviewed in 3 months' time. Expected completion date – 31 July 2016	31/07/2016

Target Risk Level	Moderate	Possible	9	Low

Progress	

Next Review Date 07/10/2016

BAF Risk Report

Risk	**3290 If plans to improve cash position fail the Trust will be unable to pay creditors impacting on supplies to support services**
Date opened	17/08/2016
Strategic goal	Ensure the Trust is sustainable and financially viable and makes the best use of resource
Strategic objective(s)	Stabilising our finances
Initial Risk Level	Moderate Possible 9 Low

Director/Committee	Director of Resources / 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 NHS Improvement (NHSI). 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
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 Independent Assurance-Letter of confirmation from DH regarding availability of cash

Performance Monitoring	Financial reports to Finance & Performance and Trust Board
Gaps in Control	Confirmation of capital cash availability to meet needs of Trust.
Gaps in Assurance	

Current Risk Level Moderate Possible 9 Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Seek urgent resolution to 14/15 and 15/16 issues with local commissioners.	Rob Cooper Director of Finance	31/10/2016	Discussions taking place at Director level with CCGs.	
Continue monthly cash forecast processes	Rob Cooper Director of Finance	31/07/2016	Monthly cash flow forecasts are prepared and reviewed by the Deputy Director of Finance.	31/07/2016
Submit monthly cash draw down requests	Rob Cooper Director of Finance	31/07/2016	Requests have been submitted and cash has been received up to the end of August 2016.	31/07/2016

Target Risk Level Moderate Possible 9 Low

Progress	17/08/16 The Trust has an agreed loan facility up to the end of August 2016. For future months the process for accessing additional cash has not been notified by DH but the Trust expects to have cash support to cover the planned deficit. The Trust is able to manage the cash impact of the £15m risk to the planned £34.6m deficit if it does not recieve further cash to cover this, though performance against the Better Payment Practice Code (BPPC) would deteriorate.

Next Review Date 25/11/2016

BAF Risk Report

Risk	**3291 Deficit is worse than planned and threatens the Trust's long term financial sustainability**
Date opened	17/08/2016
Strategic goal	
Strategic objective(s)	Stabilising our finances
Initial Risk Level	Catastrophic Possible 15 Moderate

Director/Committee	Director of Resources / 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. Key risks centre around delivering planned levels of income and keeping expenditure within budgeted levels. This includes delivering CIP targets, ensuring CQUIN achievements, minimising fines and securing the STF. 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 2015/2016 carrying over into 2016/2017. 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 NHS Improvement (NHSI) - 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 CIP plans signed off and divisional performance reviews Monthly review of CIP plan delivery by PMO with divisions and escalation of issues to Finance & Performance Committee Monthly CIP update to Finance & Performance Committee Expenditure controls Executive accountability 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 Review-External-PWC Opportunities Report External Audit-Value for Money Audit - highlights areas for improvement regarding VFM Workforce planning, CIP planning over a longer period of time & develop a recovery plan. Internal Audit-Financial Management Arrangements & Reporting Audit Review-External-PWC Workforce Savings report - of £28m saving required, £10m already delivered

Performance Monitoring	Monthly and quarterly performance reviews. Financial reports to Finance & Performance Committee and Trust Board
Gaps in Control	Staff capacity and capability to deliver CIP The performance management system requires strengthening Finalised project plans for all material elements of the CIP programme Ability to realise savings in the face of operational pressures including safety issues and delayed discharges
Gaps in Assurance	Agree a longer term CIP plan (2 to 3 years) Agree Medium Term Financial Strategy Agree Sustainability and Transformation Plan (STP) Plan that demonstrates achievability of sustainable financial balance

Current Risk Level Catastrophic Possible 15 Moderate

Action Plan

Action	Responsibility	Expected	Progress	Date Done

		Completion		
Seek resolution on additional WMAS costs related to paediatric emergency centralisation	Rob Cooper Director of Finance	30/12/2016	CCG CFOs/Trust DoF met w/c 22 Aug 16. Will progress to formal arbitration in the event that agrement cannot be reached by 31 Oct 16.	
Identify key risks to delivery of planned position	Rob Cooper Director of Finance	31/07/2016	Key risks presented to FPC	29/07/2016
Develop mitigation plans for key financial risks	Rob Cooper Director of Finance	05/09/2016	A Financial Risk Management Plan is presented to each FPC and Board meeting.	05/09/2016
Develop a recovery plan	Rob Cooper Director of Finance	30/09/2016	Align recovery plan with STP development plans. 17/08/16 - Updated version of STP to be submitted end of September. 29/09/16 - Updated STP financial schedules were submitted on 16 Sep 2016. The recovery plan will be enacted through the 2 year plan submisisons to NHSI supported by 2 year contracts with commisisoners in line with the recently published national planning guidance.	29/09/2016
Develop robust medical workforce plans to support recruitment as well as managing temporary costs	Denise Harnin Director of HR & OD	17/10/2016	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.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. September 2016 update: Recruitment strategies completed in consultation with divisions by end February 2016. Workforce plans first draft were planned to be developed by end of October 2016 but delayed by FoASHW business case and Divisional Development Plans not being finalised. HEWM workforce planning process has been delayed until end of December 2016 to enable STP plans to be included. Centralising medical locum coordinators to be phased in with one final appointment to be made for Medicine. Planning to implement an all staff bank as part of Temporary and Agency staff Task and Finish Group. October 2016 update: Baseline medical workforce vacancy data agreed with Finance Dept and Divisions.HR working with Divisionson recruitment strategies to be completed by end Nov 2016. centralised Locum co-ordinators go live date was	17/10/2016

17/10/16.

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	17/08/16 - The Trust reported a Year to Date (YTD) adverse variance of £0.3m at Month 4. Delivery of the CIP target, contracted levels of activity and agreed performance trajectories are crucial to delivering the planned financial position.

Next Review Date 25/11/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Enc H1
Attachment 2

Corporate Risk Register Summary

24th October 2016

ID	Opened	Title	Executive Lead	Monitoring Committee	Rating (current)	Risk level (current)
3289	16/08/2016	If there is insufficient medical,nursing and physical capacity within gynae we will be unable to meet contracted activity.	Chief Operating Officer	Trust Board	20	High
3252	06/07/2016	Reduced Cons & middle grade stroke drs in post; reduced emerg & routine stroke work will occur impacting on care delivery	Chief Operating Officer	Directorate governance meeting, Divisional governance meeting, Trust Management Group	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	Trust Management Group	20	High
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	Urgent Care Oversight Team (UrCOT)	20	High
3079	23/11/2015	Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care	Chief Medical Officer	Workforce Assurance Group	16	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	Directorate governance meeting, Divisional governance meeting, Operational Executive 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	Divisional governance meeting, Trust Management Group	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	Trust Management Group, Workforce Assurance Group	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	Trust Management Group	16	High
2649	11/04/2014	Workforce shortages affecting the consultant on-call rota for emergency surgery at AGH	Chief Operating Officer	FoAHSW - Sustainability Subcommittee, Trust Management Group, Divisional governance meeting	16	High
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	Operational Executive Group	15	Moderate
2662	22/04/2014	Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT	Chief Operating Officer	Trust Management Group	15	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
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	Safe Patient Group	12	Moderate
2908	28/05/2015	Use and release of information which is inaccurate, false or misleading resulting in patient harm, reputation and legal damage	Director of Resources	Data Quality 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	Trust Management Group	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	Patient Harm Group, Safe Patient Group	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
2856	07/04/2015	Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury	Chief Executive		12	Moderate
2774	15/01/2015	Failure to provide resilient IT infrastructure resulting in system unavailability which negatively impacts patient care	Director of Resources	Trust Management Group	12	Moderate
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	Operational Executive Group	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, Trust Management Group	12	Moderate
2736	13/10/2014	Lack of Section 12 approved doctors to act as Responsible Clinician prevents legal detentions under Mental Health Act	Chief Medical Officer	Trust Management Group	9	Low
2396	15/01/2013	Poor quality clinical record keeping may lead to a variety of harms to patients and organisation	Chief Medical Officer	Electronic Patient Record Programme Board (HRC)	8	Low
933	01/10/2003	Potential harm due to delay in reporting Radiology examinations,which could impact on timely diagnosis and subsequent treatment	Chief Operating Officer	Trust Management Group	8	Low

Date Generated: 24/10/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

CRR Risk rating tracking report								
CRR risk	**Jul-15**	**Oct-15**	**Jan-16**	**Apr-16**	**Jul-16**	**Oct-16**	**Notes**	**Change over 12 months**
3252 Reduced Consultant & middle grade stroke doctors in post; reduced emergency & routine stroke work will occur impacting on care delivery	escalated					20		↑
3289 If there is insufficient medical ,nursing and physical capacity within gynae we will be unable to meet contracted activity.	new					20	Replaces seven previous risks relating to capacity in gynae	
2664 Insufficient out of hospital capacity to meet the needs of patients with on-going healthcare needs	20	20	20	20	20	20		→
3041 If the Trust does not increase efforts to save money, it may not realise the CIP target, worsening the financial position	15	15	20	20	20	closed	Included in risk 3291	
1941 Lack of available bed capacity may cause overcrowding in ED which can lead to suboptimal care & a poor patient experience	escalated		20	20	20	20		→
2856 Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury	escalated		20	20	20	12		↓
3097 If managers do not adhere to financial controls, there will be excess expenditure and financial recovery plan not met	new		20	20	20	closed	Included in risk 3291	
2908 Use and release of information which is inaccurate, false or misleading resulting in reputational and legal damage	16	16	16	16	16	12		↓
2791 If the Medicine Division is unable to sustain appropriate staffing levels it will be unable to provide safe patient care	16	16	16	16	16	16		→
2746 If W&C Division are unable to sustain safe staffing levels it will be unable to provide safe patient care at all sites	16	16	16	16	16	closed	Closed following centralisation of paediatric services	
2711 Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	12	12	16	16	16	16		→
3079 Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care	new		16	16	16	16		→
3078 Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner	new		16	16	16	16		→
2709 Risk to critically ill patients having delayed admission to ITU due to lack of bed spaces (spaces occupied by wardable patients)	16	16	16	16	16	12		↓
2661 Increased pressure in emergency demand may impact on the safety of patient care & failure to meet performance standards	16	16	16	16	16	16		→

Date Generated: 24/10/2016

2649 Workforce shortages affecting the consultant on-call rota for emergency surgery at AGH	20	20	16	16	16	16		→
2396 Poor quality clinical record keeping may lead to a variety of harms to patients and organisation	20	20	15	15	15	8		↓
3018 As a result of the care models on the Wyre Forest GP unit, medicines are not managed safely	12	15	15	15	15	15		→
2736 Lack of Section 12 approved doctors to act as Responsible Clinician prevents legal detentions under Mental Health Act	15	15	15	15	15	9		↓
2662 Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT	15	15	15	15	15	15		→
3019 As a result of the care models on Ward 1, medicines are not managed safely resulting in sub-optimal care	new	15	15	15	15	closed		
933 Potential harm due to delay in reporting Radiology examinations, which could impact on timely diagnosis and subsequent treatment	escalated					8	Although escalated to CRR the risk rating has reduced in Q2.	↓
2995 If Patient Safety Incidents are not managed in a timely way there will be missed learning and preventable harm	new	16	12	12	12	12		→
2857 Failure to manage water system resulting in transmission of harmful pathogens to patients or staff	15	15	15	16	12	12		↓
2774 Failure to provide resilient IT infrastructure resulting in system unavailability which negativity impacts patient care	12	12	12	12	12	12		→
2663 If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets.	12	12	12	12	12	12	Replaced risk 1800	→
3044 If the Trust does not manage CCG QIPPs the financial plan will not be realised	new	12	12	12	12	closed	Due to the nature of the 2016/17 contract this is no longer a risk .	
2994 Failure to meet the NHS England Serious Incident Framework resulting in failure to learn and potential regulatory action	new	15	12	12	12	12		→
2864 Failure to follow pressure ulcer prevention procedures (risk assessments, position changes, correct equipment) resulting in harm	escalated		12	12	12	12		→
2899 Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, poor clinical outcomes	de-escalated from BAF			12	12	12	Moved from BAF to CRR in March 2016	→
2372 Failure to address the causes of falls resulting in patient harm and financial penalties	12	12	12	12	de-escalated to SPG			→
2463 Failure to reduce number of preventable cases of C.difficile due to lapses in care, resulting in adverse patient outcomes	12	12	16	12	de-escalated to TIPCC		Now rated 9	↓
2747 Failure to prepare for serious new or emerging pathogens (eg Ebola, MERS) leading to exposure	20	16	12	9	de-escalated to TIPCC			↓

of public, patients and staff.							
2565 Delay or failure to act upon clinical diagnostic test results leading to patient harm	12	9	9	9	de-escalated to SPG		→
2461 Problems with the functionality, reliability and timeliness of eznotes system, negatively impacting patient care	12	9	9	9	de-escalated	Manged by EPR Programme Board	→
2732 If the Trust does not adequately prepare for emergencies, there may be an uncoordinated response and subsequent adverse events	20	20	12	8	de-escalated	Managed by Emergency Planning, Resilience and Response group	↓
2770 If a staff member uses an overdue key document, patients may not receive best practice care, or corporate process not followed	12	12	8	8	de-escalated		↓
2957 Breaching hygiene code due to inadequate or ineffective assurance around environmental cleaning	20	20	12	6	de-escalated to TIPCC & PEOG		↓
2464 Risk of Norovirus outbreaks resulting in adverse patient outcome and impact on patient flow	20	20	12	6	de-escalated to TIPCC		↓
2462 Failure to prevent MRSA bacteraemia due to lapse in care resulting in adverse patient outcomes and reputational damage	6	6	12	6	de-escalated to TIPCC		↓
2764 Fire Code non-conformance potentially resulting in reduced capability to achieve timely progressive horizontal evacuation	20	20	5	5	de-escalated	Related to WRH site - managed by E&F risk register	↓
2554 Insufficient staff and fire compartmentation to safely evacuate silver ward resulting in patient/staff injury	12	12	15	closed		Avon 5 closed Feb 2016 risk removed	
2822 As a result of the care models on ward 1 and the GP unit, medicines are not managed safely resulting in suboptimal care	15	closed				GP unit closed, so new risk created just for Ward 1	
2730 If the structure for managing patient property is not robust patients may lose valuables & the trust is financially liable	9	closed				Risk closed following implementation of controls	
2433 Increases in emergency demand may compromise capacity and flow resulting in poor patient experience & failing the 4hr standard	16	closed				Closed as covered by risks 2661 and 1941	

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 933 Potential harm due to delay in reporting Radiology examinations,which could impact on timely diagnosis and subsequent treatment

Date opened 01/10/2003

Strategic goal

Strategic objective(s) Develop and sustain safe services

Initial Risk Level Catastrophic Likely 20 High

Director/Committee	Chief Operating Officer / Trust Management Group
Description/Impact	Over recent years there has been a rise in unreported plain films due to increased numbers of plain film and all other modality referrals and increased vacancies (both radiologists and reporting radiographers). This may lead to delay in diagnosis of patients and potential for delay in treatment. Background: From 1st January 2016 up to and including 27th July 2016 there were 11,722 plain films waiting to be reported by radiology (5% of the annual total of plain films), including work in progress (under two weeks old). At 1st August 2016 additional reporting and validation had reduced the number to 9,625 plain films of which 6,318 were classed as backlog (over two weeks), the remainder being work in progress (3,307 films requested in the previous two weeks). 3,792 of the plain films in the backlog were chest x-rays, and there were a further 50 chest x-rays from earlier than January 2016. Currently data estimates around 500 - 700 unreported radiographs per month. There had been 11 radiographer posts vacant. 8 posts were recruited in May 2016. Historically - In July 2013 it was identified that 166,300 plain films had not been reported by radiology. In 2015 this number had reduced to 4,539.
Key Controls	Prioritisation of reporting all chest x-rays & urgent referrals now taking place by Radiologists 1000 images / week outsourced beginning 1/8/16 Standard Operating Process and Procedure - Escalation of Unreported Radiology Reports in place. 8 Radiographer posts recruited into Plain Radiograph Reporting Policy
Sources of Assurance	Management Assurance-Number of unreported films monitored each month at Divisional board meeting. Management Assurance-Weekly review of progress at Executive Group

Performance Monitoring	The total films in this backlog will reduce to below 4,000 by 31st August 2016 and 2,000 by 30th September 2016 and will be cleared completely by 31st October 2016. The Directorate now has a defined action plan, internal standards, esclation policy and monitoring processes in place. This has reduced the risk from likely to possible. The backlog of plain film reporting in 2016 does not now exist, due to increasing capacity both internal and external. The backlog from 2015/2014 circa 5,000 is now being sorted and aim to complete this soon. We await further guidance from RCR peer review in respect of any other backlog prior to 2014.
Gaps in Control	Faliure to atttract good locums at capped rates The 8 radiographers' start dates range between July and September 2016, all will receive 6 week induction training
Gaps in Assurance	Requires regular monthly gap analysis but radiology need to set a reporting standard and define a reasonable hourly reporting rate

Current Risk Level Major Unlikely 8 Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Business case on how to address the issue submitted to Exec team	Santhosh Vijayaraghavan Consultant Radiologist	30/09/2016	Exec team have asked for further amendments to the case in respect of additional training and recruitment.	
Development of internal standards for reporting times.	David Hill Chief Radiographer	30/09/2016	Standards produced and draft sent to directorate for approval. Awiating approval	
Implement 6 monthly audits to ensure adherence. This will	Victoria Riley Superintendant	30/09/2016		

identify which examinations should have been auto reported and have not been tagged appropriately	Radiographer			
Implement further training for radiology staff in autotagging	Victoria Riley Superintendant Radiographer	30/09/2016		
Outsource a further 3000 images with In Health (formerly RIG)	Deena Smith Access and Admin Manager	30/09/2016		
Ensure all staff auto report as per policy especially orthopantomogram (OPG)	Victoria Riley Superintendant Radiographer	18/08/2016	completed	23/08/2016

Target Risk Level	Moderate	Unlikely	6	Very Low

Progress	27.03.2015 The Directorate has agreed and funded from its own resources a Consultant Radiographer post to lead a team of reporting radiographers. The post has been advertised. This initiative will increase the chances of a sustainable solution but there is still a deficit of radiologists and some additional reporting by radiologists is taking place in their own time for additional payment. This will need to continue until a sustainable solution, with adequate staff recruitment is in place. A business case for this is being re-written. This is a high clinical risk (potential for missed serious pathology if no mitigation in place). The risk has been temporarily mitigated with a non-sustainable solution, but some plain films remain unreported and remain at high risk. This risk needs to be resolved requiring the business case to be revised, approved and implemented urgently. As of 15/6/16 there are the following numbers of unreported images Jan 310: Feb 301: Mar 344: April 396 the vast majority are abdominal images. Current backlog of films for just MAY which are unreported is sitting at 944 in month (normal level is around 350) the issue is escalating so I have requested whether we can outsource. Decision was made to outsource some reporting to help with catch up but this is currently now on hold 8/7/2016 15/7/16 agreement to outsource 500/ week. 1500 so far 28/7/16 with 247 awaiting report. 1/8/16 out sourcing 1000/ week 15/09/16 - achieved target of reducing backlog to below 4,000 by 31st August.

Next Review Date 14/10/2016

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 / Urgent Care Oversight Team (UrCOT)
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 and no call buttons 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
Improvement programme for patient flow for ED and the Trust.	Victoria Holmes Interim Operational Manager - Medicine	21/10/2016	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 Urgent Care Programme Board is responsible for the urgent care component of the Patient Care Improvement Plan (PCIP). This is where progress on the actions to improve urgent care and patient flow is tracked. The PCIP work is on-going with a focus on base wards to improve flow. A robust action plan has been developed by WAHT in conjunction with external partners and ECIP and this includes the urgent care concordat. On going work with ECIP team continues including AEC on both site.	
Expansion of ED and improve patient flow	Victoria Holmes Interim Operational Manager - Medicine	30/11/2016	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. 6/5/16 phase 2 of the project will be completed by the end of May. 08/09/16 Phase 2 of the project completed end of August 2016. Phase 3 of the project (internal works) will be completed end of November 2016 therefore completion date changed to reflect this.	
Delivery of Workforce Plan for Medical and Nursing Staff at WRH in preparation for expansion to ED	Victoria Holmes Interim Operational Manager - Medicine	27/01/2017	Business case for nursing establishment has been submitted to the executives and is awaiting approval. 6/5/16 Exec approval has been given for increasing numbers of nurses per shift from 11 to 13 to allow for the ED expansion and also SIAN (Senior Intial Assessment Nurse)nurses. Recriutment has commenced. 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 Up-date 24/6/16 - Nursing Workforce Plan has been reviewed to accommodate increased nursing resource. This will allow for 14, 14, 14 cover as of October 2016 as recruitment is ongoing. Recruitment process for Consultants has commenced with expected completion date of January 2017.	
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	30/06/2015

			track.	
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

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 07/10/2016

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 Minor | Likely | 8 | Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Update clinical record keeping policy and re-launch	Steve Graystone AMD Patient Safety	07/10/2016	HW drafted, SG and SM updated. HW to submit to clinical leads prior to TMC approval. Plan to combine with CRM policy once electronic management elements have been removed. Draft with HRC. Waiting approval end Aug. Due to submit to document approval group w/x 26/9	
Introduce e-forms (direct entry) to eZnotes to address issues such as legibility, time and date.	Steve Graystone AMD Patient Safety	09/01/2017	In IT Workplan, currently at initiation stage. training on how to build eforms has taken place. Awaiting IT developer resources to commence building of the forms. Cannot progress until upgrade of Evolve to version 3.5. Due after data centre move. Upgrade now not due until January.	
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
Review completion of record keeping e-learning	Steve Graystone AMD Patient Safety	06/05/2016	Update of league table requested from Sandra Berry Feb 2016 Information provided as a % only. No league table available. To be presented to HRC	29/04/2016
Agree new process for	Steve Graystone	29/09/2016	Process drafted by HW,professional Dev team and Clinical	26/09/2016

reporting and oversight of improvement plans	AMD Patient Safety	Audit team to present to Dr Graystone. New process to be presented to Lisa Miruszenko. Dr Graystone awaiting update from Jo Logan regarding new Governance process for improvement plans.

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. 14/09/16 - current risk rating reduced (both consequence & likelihood)based on clinical audit results which indicate no concerns regarding quality of records.

Next Review Date 31/03/2017

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 emegrency 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	30/09/2016	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. Update April 2016: New group FoAHSW Implementation Group (FIG) established with role in developing a plan for countywide rota	

			- Due date updated pending feedback from action owner.	
New trust grade surgical posts being developed to increase attractiveness of positions	Val Doyle Surgery	30/01/2015	adverts completed	15/04/2015
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 30/09/2016

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 Group
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) Full Hospital 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-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
Implement SIAN service	Rab McEwan Chief Operating Officer	28/10/2016	Feb 2016 update: Partially implemented SIAN service. Due date extended to April 2016. Up-date 24/6/16 - SIAN nurses have been implemented in the WRH ED department 7 days a week. These nurses are specifically assigned to manage their initial assessment of patients within 15 minutes and ensure prompt handover of patients arriving by ambulance within the same 15 minute timeframe. The next step for the SIAN nursing role is to continue with additional recruitment of nurses into their WRH ED so that service can be fully covered 24/7. Expected completion date October 2016.	
Prepare Winter Plan for 2016/17	Rab McEwan Chief Operating Officer	31/10/2016		
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	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

monitored through Systems Resilience Group.				
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
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	31/03/2016

Target Risk Level	Major	Possible	12	Moderate

Progress	

Next Review Date 07/10/2016

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 Group
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 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
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.	31/03/2016

Target Risk Level Catastrophic | Unlikely | 10 | Low

Progress	

Next Review Date 07/10/2016

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 07/10/2016

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 Group
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
New A&E plan to be developed by October 2016 to deliver discharge to assess (DTA)	Rab McEwan Chief Operating Officer	31/10/2016		
Patient Flow Centre to be re-organised	Rab McEwan Chief Operating Officer	31/10/2016	WAHT is hosting PFC to ensure multi-agency teams provide support for wards to support discharge Up-dated 24/6/16 - In reach pilot commenced 16 May 2016. Introduction of electronic discharge notification planned for end of June 2016. 08/09/16 Implementation changed to end of October 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	Rab McEwan Chief Operating Officer	31/10/2015	Commissioned as pathway 3 capacity	01/11/2015

beds as part of winter resilience plan				
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
Obtain health economy sign off of the Worcester wide choice policy	Rab McEwan Chief Operating Officer	20/05/2016	Choice policy agreed	12/04/2016

Target Risk Level	Major	Possible	12	Moderate

Progress	

Next Review Date 07/10/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

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 / Operational Executive Group
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 Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Monitor performance and report to Operational Executive Group	Stephen Jezard Flow Management	30/11/2016		
Risk to be included in Exception report to QGC	Faye Rafferty Quality Governance Manager	08/02/2016		08/02/2016
Improve clinical site coordination at AH and WRH through Hospital at Night and Clinical Site Coordination Team	Rab McEwan Chief Operating Officer	19/08/2016	New team appointed. Agreeing SOPs and performance management process. Action completed	08/09/2016

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. 27.07.2015 Stepdown process being actively managed from September as part of CQUIN. Risk level reduced on basis that overall activity on the ICU has diminished and there have been only two incidences of delayed admission in the past year due to the lack of a critical care bed.

Next Review Date 30/11/2016

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
The Trust to consider working in partnership with HEE regarding the national recruitment programme of nurses from India	Sarah Needham Lead for Workforce and Education	30/11/2016	Currently an interest has been logged with HEE but the Trust is awaiting clarification in terms of the potential cost/benefit to the Trust.	
To develop a nursing workforce strategy paper	Sarah Needham Lead for Workforce and Education	30/11/2016	A nursing workforce strategy is required to support the direction of the Trust in terms of the actions required from a workforce perspective.This strategy will utilise that data and kpis utilised to inform the NWAG report	
To identify learning disability nurses who would like to be support to do further training and enter the Adult Nurse register with NMC	Sarah Needham Lead for Workforce and Education	30/11/2016	Need to identify and set up a recuitment event to encourage LD nurses to commence training to enter the Adult nursing register. It has been identified that approcimately 40 LD nurses were made redundant by the Health and Social Care Trust who could be targetted.	
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
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
Return to Practice event	Sarah Needham Lead for Workforce and Education	26/08/2016	A regional event has been arranged to promote the HEE funding available to encourge nurses in Worcestershire who have lapsed their registration to return to nursing.	13/08/2016
To liaise with local educational providers to recruit staff to the Trust	Sarah Needham Lead for Workforce and Education	31/08/2016	To identify and recruit staff into the organisation via educational providers and this will also take place prior to the last placement for nursing students at Worcester University. Dates are being arraned at the University to recruit student nurses and this will take place in the new semester. This will be in partnership with NHSP/ Presentation has taken place with students promoting the Trust and explaining our new perceptorship programme.	22/08/2016
Trust to consider potential of recruiting abroad	Sarah Needham Lead for Workforce and Education	31/08/2016	European market has now been saturated and English language skills make it a challenge for them to achieve ILETS course level 7. Recruiting from the Phillipines also results in the same challenges. Therefore consideration and funding is required for looking at nurses in India. This work is now being managered and reviewed under the under the nursing workforce strategy review.	22/08/2016
Implemenation of new roles	Lisa Miruszenko Deputy Chief Nursing Officer	30/09/2016	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 Update 17/06/2016: shortlisting for ward administrator and ward housekeeper has taken place and interviews will take place on first week of July 2016. Nursing associate training for fast track program have been shortlisted and commence on 21st June 2016. This consists of 26 members of staff. A further 32 members of staff have been identified for a two year foundation degree and will commence in September 2016. The remainder of applicants have been sent a letter specifying the educational requirements required to be successful in the future and funding has been identified for this. Seven nurses from this cohort have been identified for nurse training and will commence in September 2016.	06/10/2016
To identify funding for the organisation to attend local recruitment fairs	Sarah Needham Lead for Workforce and Education	30/09/2016	Identify the most appropriate recruitment fairs Develop a promotional video highlighting the opportunities to work at the hospital and life living in Worcestershire, links to University, and promotional products.	06/10/2016
To commence a KPI and NWAG report review	Sarah Needham Lead for Workforce and Education	31/10/2016	To commence a Workforce stategy review for the nursing workforce and review the data collected and reported on for the Nursing Workforce Action Group. KPI's and a new report for NWAG has been completed, which supports and informs the scope for the Nursing strategy. This will be completed by the end of November 2017	11/10/2016

Corporate Risk Report

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 30/11/2016

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 Group
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 Management Assurance-The Trust is providing a regular update at Clinical Quality Review meeting with CCGs

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	Possible	9	Low

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Work with the H&C Trust to ensure that commissioners recognise their responsibilty.	Andrew Short Consultant Paediatrician	31/03/2017	Legal advice has been obtained. Following review of advice CMO to write to CCG to establish commissioning intentions.	
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
Ensure roles are covered with suitable medical staff	Andy Phillips Interim Chief Medical Officer	16/05/2016	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. Responsibility for completion sits with CCG	15/09/2016

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. Legal advice has been obtained and the intention is to work with the H&C Trust to ensure that commissioners recognise their responsibilty.

Next Review Date 18/01/2017

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 2774 Failure to provide resilient IT infrastructure resulting in system unavailability which negatively 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 Group
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	30/12/2016	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	Computacenter 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	Computacenter IT Contractors	31/12/2015	Completed but project under review due to slippage. See implementation action entry.	14/09/2015

Corporate Risk Report

Target Risk Level	Major	Unlikely	8	Low

Progress	Data centre project is progressing. It will take month to move infrastructure to the new centre, as part of a schedule plan

Next Review Date 30/12/2016

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

Strategic objective(s)

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,middle grades,registered nurses and health scientists , it will be unable to continue to provide safe patient care at all relevant in-patient sites. Specialising in Emergency Medicine, Acute Medicine, Respiratory, Gastroenterology, Geriatrics, Stroke,Diabeties. and general and specialist nursing staff in the above also , 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,Diabeties and Stroke service.Patients will have to wait longer for cadiac and respiratory specialised investigations. 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,Diabeties , Gastroenterology, Geriatric and Stroke Consultant rotas • ED Middle Grade Medical Staffing rotas • Diabeties Speciality Nursing staff • Adherence to national performance indicators and local guidelines to ensure safe patient care may inturn suffer • Inability to maintain Deanery training status • Maintenance of high quality 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. To ensure robust Divisional Managemet of this risk all Speciality and Directorate risks pertaining to staffing issues have been linked to this risk and will be managed through this risk,which will include any local actions and controls established . Risks- 2714,1719,2861,2307,2785,3017,2692,2696,2723,3141. Risk 3252 is being managed as a seperate risk bespoke to stroke.
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	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 Close monitoring of waiting times for patients requiring specialst respiratory and cardiac investigations. Please see attached performance report
Gaps in Control	Regional competition UK labour market shortages
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Consideration for shared posts	Jo Kenyon General Manager	28/11/2016	At present the Divison is in discussion with the Consultant body to consider the feasability of shared posts-50% Acute Medicine 50% Speciality Medicine.	
Job Planning	Jasper Trevelyan Consultant Cardiologist	30/11/2016	Update provided by HR regarding number of job plans completed.Validity of data queried,terefore HR tasked to revalidate this data and forward to DOP,S and DMD once completed,to enable further planning of job palnning.	
Recruit into vacant Consultant posts	Jo Kenyon General Manager	19/12/2016	Numerous job plans are at present with royal college of physicans for sign off prior to being advertised nationally.The trust has agreed that an in the adVerts will be both on NHS jobs and BMJ.	
To advertise nursing post for specific specialities	Julie Kite Divisional Director of Nursing Medicine	19/12/2016	At present the Division has a rolling advertisement on NHS jobs.For specialist areas to consider the possibility of having bespoke adverts for specialist wards to make job sound more "bespoke".	
To recruit into cardiac and respiratory physiologists consideration is being made to recruit from overseas	Julie Caulfield Cardiology Department Manager	19/12/2016	Currently in the process interviewing and fast tracking 4 existing band 5's into band 6 posts. It is estimated that it'll take 6 months for the band 5's to achieve competencies and move into the band 6 posts. ATR's have been submitted to recruit into the band 5 posts these staff will be moving out of. This is so we can maintain the ambulatory monitoring & ETT's service whilst the existing staff are being fast tracked.It is likely the new band 5's will be recruited from Europe as there are currently very few UK trained Physiologists An ATR will be submitted in November to split a band 6 post to promote 3 long standing band 6's into band 7's when this post becomes vacant, this is to try and retain 3 existing experienced band 6 Physiologists. Finance have confirmed that there will be 30hrs remaining of a band 6 post which can we upgraded with vacant hours in the budget to 37.5hrs to make a full time band 6 to recruit into.	
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
Acute Medicine Consultants – job plans to be written, funding to be secured	Robin Snead Divisional Director of Operations	18/04/2016	Shared jobs are at present being advertised through NHS jobs,await till closing date and short listing has occoured.	28/04/2016
Gastroenterology - Business case completed for additional 4WTEs , services struggling on both sites.	Caroline Lister Directorate Manager	29/08/2016	This has been delayed due to the current financial controls within the trust.Business case has been approved and x1 Gastroenterologist has been appointed.Further posts to be advertised shortly.	06/06/2016
Development of a Nursing Pool	Julie Kite Divisional Director of Nursing Medicine	27/06/2016	Action not viable	30/06/2016
Due to Acute Medical Consultant leaving shortly back up plan to be developed.	Gary Ward Emergency Medicine	30/06/2016	Dr Jenkins will move from Diabeties and provide support to MAU. Plan still being formulated	30/06/2016
Review of medical workforce	Gary Ward Emergency Medicine	26/09/2016	Action has changed will be reviewed next week	29/09/2016
Geriatrics – progressing recruitment of integrated physicians with CCG/WHCT	Jo Kenyon General Manager	31/10/2016	Currently working with external head hunting agencies to target recruitment for specific consultant posts across the division.At present there are x6 vacant posts.Consideration is being made within the Divisison regarding recruitment from overseas. Action not completed therefore closed new actions now in place.	20/10/2016
Recruit Consultant Medical Staff in Stroke services, Respiratory services and Emergency Medicine	Jo Kenyon General Manager	28/11/2016	Currently working with external head hunting agencies to target recruitment for specific consultant posts across the division Action not completed new action commenced	20/10/2016

Target Risk Level	Moderate	Possible	9	Low

Date Generated: 24/10/2016

Progress	Currently out to recruitment 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-ordination the recruitment of all the vacant posts. Further posts are currently out to advert for specialty and acute medicine hybrid job plans. Active recruitment to stroke consultant physicians posts is also ongoing. 30/06/16 Discussed at DMB risk 2690 has been closed and this is now the main risk within Medicine regarding staffing/safe patient care.AMU WRH now has Dr Jenkins and long term locum Dr El Nasir to support area. 28/09/16 Risks within the Division are in the process of being reviewed and consolidated within this risk to be robustly managed within the Division and give Specialities and Directorates assurance that staffing issues are being taken seriously. Risk has been reviewed by the Division and has been updated with numerous risks linked and in turn closed to enable the Division to robustly manage this staffing risk. 20/10/16

Next Review Date 14/11/2016

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 Major Possible 12 Moderate

Director/Committee	Chief Executive /
Description/Impact	Capital Programme Resource having to be used to repay loans leading to potential 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 use of emergency basck supplies from specialist sub contractors e.g. boilers, chillers and generators
Sources of Assurance	Management Assurance-Regular reporting through risk management group

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 Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Distressed Capital Funding being sought from NHSI	Ray Cochrane Directorate support manager	31/10/2016	Bid submitted - awaiting confirmation.	
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
Salix Funding sourced for major equipment replacement	Ray Cochrane Directorate support manager	04/07/2016	Ongoing, due date updated to April 2016. Meetings held with Cynergin and Essentia to take forward business cases for Salix funding.	25/07/2016
Funding being sought through CPG	Ray Cochrane Directorate support manager	01/09/2016	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.	09/09/2016

Target Risk Level Catastrophic Unlikely 10 Low

Progress	Paper presented to Risk Executive Group 7th December 2015 Have a contractor on board who is looking at obtaining Salix funding for major equipment for all three sites

Next Review Date 20/01/2017

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

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 and water safety group Governance via monthly Water Safety Group meetings Authorising Engineer (Water) appointed Flushing process developed and implemented - Augmented care areas flushed daily and audited by infection control. AHR and KTC have flushing process, flushing folders have been distributed to wards, training sessions ongoing at all sites. WRH Flushing folders have been isssued to WRH 17th and 18th March 2016. latest audit of KTC and AHR gave a compliance score of approximately 90% - trialling compass IT based flushing records in AHR & KTC WRH flushing Audit 20% compliance Water Policy Finalised and Water Safety Plan developed final version being reviewed by SN / MA 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, Trust Contractor being managed by RP / WST will report monthly on PPM KPIs to WSG 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 Looking at a water treatment plant for new breast building 220 Newtown
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 in place. Water supply testing results monitored by Water Safety Group Positive patient test results in augmented care areas investigated to determine whether hospital attributable WSG reports to TIPCC
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 sub optimal response from hard services provider re actions to mitigate risks e.g. installation of PAL filters (Avon 4 and Silver)
Gaps in Assurance	

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
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
Daily / weekly flushing of all outlets in augmented care / ward areas	Simon Noon Principal Engineer & Statutory Standards Manager	07/09/2015	Flushing in each unit requested in accordance with HTM 04-01. Kidderminster, Alexandra Hospitals and WRH implemented, Flushing log books issued will be improved with rollout of compass.	16/09/2015
Point of use filters fitted to outlets	Simon Noon Principal Engineer & Statutory	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	16/09/2015

	Standards Manager		filters based on HTM04-01 addendum has been agreed based on agreed clear results.	
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
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
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
Complete Water Safety Plan with ratification at TIPCC	Simon Noon Principal Engineer & Statutory Standards Manager	03/10/2016	Water Safety Plan in progress, but requires further modification. HTM04-01 has bee revised content of which needs to be assessed and incorporated into WSP for board ratification.	25/07/2016
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. 14/10/2016 New testing schedule is in place for AHR and Kidderminster and a UKAS acredited lab has been appointed to take the samples new sampling programme started in August	14/10/2016

Target Risk Level	Major	Unlikely	8	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 with microbiology to achieve sign off based on availability of resource. A meeting to disucuss furhter is planned to resolve.

Next Review Date 28/01/2017

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

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	30/11/2016	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. TV Lead to discuss with interim CoN re SKIN Bundle and revision of care and comfort charts to remove PU element and have a separate SKIN bundle. Due to unexpected sickness of the Senior members of the TV team - this has been delayed. 25/07/2016 Unable to progress due to capacity issues within the team. 9/8/16 Same as above - due date put forward. Same as above - due date put forward.	
Discuss opportunities to ensure staff are prompted to turn patients	Elaine Bethell Tissue Viability	30/11/2016	Exploring possibility of using electronic whiteboard to prompt staff and to explore ideas using Datix as an automatic prompt with the Trust Risk Officer. 25/07/2016 Extended due date by one month as work commenced and awaiting response from Business Analyst. 9/8/16 As above - still waiting despite chasing. Due date put forward. 11/10/16 - Still no progress - date put forward.	
Implement 'react to red skin' pathway with 2 hourly	Elaine Bethell Tissue Viability	30/11/2016	24/12/12 - To be trailled alongside care and comfort documentation by end January 2016. This has now been	

repositions			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. TV Lead to discuss with Interim CoN re strategy for React to Red and tools that need funding. 25/07/2016 Due Date extended by one month as awaiting final confirmation regarding implementation. 9/8/16 Launch date 12/10/16 To be piloted on several wards on 12/10/16 then rolled out in other areas.
Replace chairs not fit for purpose	Elaine Bethell Tissue Viability	30/11/2016	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. Divisions to replace chairs within their own Divisions. Unsure of progress to date. 25/07/2016 Contacted Divisional Directors of Nursing to suggest change of action owner and determine progress. 9/8/16 - Chasing up why orders from DDoN have not been processed via Procurement or Finance in the last few months. Medical Division are placing an order for chairs today. 11/10/16 - Divisions are purchasing chairs - not all that need replacing purchased to date.

Target Risk Level	Minor	Unlikely	4	Very Low

Progress	June 2016 update: Accountability meetings held by Deputy CNO have been implemented for grade 3 and 4 pressure ulcers.

Next Review Date 30/11/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

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 Group
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 Clinical Audit-Trustwide audit completed April 2016 & reported August 2016

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
Divisions to develop action plans in response to audit findings	Rab McEwan Chief Operating Officer	31/10/2016		
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
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.	31/03/2016

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 04/11/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**2908 Use and release of information which is inaccurate, false or misleading resulting in patient harm, reputation and legal damage**
Date opened	28/05/2015
Strategic goal	Ensure the Trust is sustainable and financially viable and makes the best use of resource
Strategic objective(s)	Deliver effective care
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Medical Officer / 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 Data Quality Lead Clinician Data Quality Review Group Revised System of data collection for VTE
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 Data Quality Lead clinician post vacant
Gaps in Assurance	Internal Audit forward plan may not include all FOMI datasets

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Check and assure rules to create VTE data	Mark Crowther Consultant Haematologist	31/10/2016	Group established with ToR and meeting regularly.	
Establish A&E dataset reporting	Nicola O'Brien Deputy Head of Information	09/11/2016	With KeDo	
Address audit recommendations around training for VTE data entry	Jan Stevens Interim Chief Nursing Officer	30/11/2016	Work underway via Divisional Directors of Nursing to ensure accurate data entry. Oct 2016 update: VTE improvement is part of the Caring Safely Work Programme. A short life working group is being established with multidisciplinary representation and project support. The programme team will be invited to undertake improvement training which is being provided by AQuA (Advancing Quality Alliance). Review date extended to end of November.	
Complete assurance process for all key data items	Rebecca Brown Head of Information	30/06/2017		
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	Rebecca Brown	30/06/2015	Initial review completed. Further detailed work required for	26/06/2015

ensure compliance with minimum standards	Head of Information		all key systems to establish risks and caveats. Outline for required FOMI assurance work written. Bring forward into a further more detailed action.	
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
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
New clinical lead required for DQSG	Rebecca Brown Head of Information	04/03/2016	This role is currently held by Alex Blackwell, O&G Consultant.	20/05/2016
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) Schedule established for quality indicators. Process and governance established for all indicators. New action - to complete assurance for all key data items.	31/05/2016
A&E dataset roll out	Rebecca Brown Head of Information	11/03/2016	Information specialist to ensure roll out by end of contract. Dataset available. Being managed by Business Intelligence Project Board.	23/06/2016

Target Risk Level	Major	Unlikely	8	Low

Progress	Further gaps and actions may be identified following the review of relevant datasets. Update June 2016: Trust recieved a qualified audit opinion for Completion of VTE prophylaxis proforma. New action added regarding this.

Next Review Date 30/12/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

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 investiagation reports in STEIS QA tool for investigation reports
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
Review SI meeting terms of reference	Chris Rawlings Head of Clinical Governance & Risk Management	31/10/2016	Previous ToRs completed and approved. However, the meeting has changed and further revision has been required. Terms of reference revised and these will be agreed as part of the overarching review of the governance committees proposed to the QGC in August and for which Board approval will be sought.	
Introduce a liat of trained investigators that Divisions select from when assigning an investigation lead for SIs.	Chris Rawlings Head of Clinical Governance & Risk Management	04/11/2016		
Introduce closer control of the SI report production process by the Patient Safety Team with a 45 working day target for producing a draft.	Chris Rawlings Head of Clinical Governance & Risk Management	04/11/2016	Policy includes this target.	
Provide workshops for trained investigators to establish investigation practice based on training and provide peer support.	Chris Rawlings Head of Clinical Governance & Risk Management	04/11/2016		
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	Chris Rawlings Head of Clinical	31/10/2015	Discussed and supported at the Datix User Group. Divisions requested to use the Datix Action module for all serious	30/10/2015

Datix action module for the recording and management of SIs and then all incidents / complaints	Governance & Risk Management		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.	
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
Job planning to allow senior clinical staff to lead on investigations to be completed	Andy Phillips Interim Chief Medical Officer	30/04/2016	Job planning is in progress. This action is also recorded in the Internal Audit report on the SI system received in December 2015 March 2016 - confirming progress with CMO 26/07/16 - confirmed that job plans already include SPA time which should allow for incident investigation. Back on track with SI reports, therefore action complete.	26/07/2016
Develop and agree phase 2 training for investigations & workshops for trained staff	Chris Rawlings Head of Clinical Governance & Risk Management	30/09/2016	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. Veritas booked for training in July and September 2016 for more than 60 staff, with a review following that. Due date moved to end September 2016. July training completed.	14/09/2016
Revise incident reporting and investigation policies to match the revised process & disseminate the changes effectively	Chris Rawlings Head of Clinical Governance & Risk Management	20/09/2016	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 new weekly Governance Operational Meeting on 15th January needs to be included. SI policies remain under review. New expected completion date end July 2016. A revised flowchart describing the new process was agreed in July at the Operational Governane Meeting. This is being included in the revised policy. Policies revised and out for consultation before approval planned for 12th September.	15/09/2016

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. Improved performance in overdue SIs has been seen and reported via Trust dashboards. Regular meetings have been scheduled with the CCG to support good communication and reduce delays in approval on STEIS.

Next Review Date 04/11/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

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 - now the SitRep 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 Management Assurance-Divisional Quality Dashboards inclusion of metrics for patient safety incident management Management Assurance-Divisional reports provided to the Quality Governance 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 Inclusion of the metric in Divisional Quality Dashboards.
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
Gaps in Assurance	

Current Risk Level Major Possible 12 Moderate

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Monitor performance of Divisions against trajectories for patient safety incident management	Chris Rawlings Head of Clinical Governance & Risk Management	02/12/2016	Metric included in Divisional Quality Dashboards and monitored. Currently above 40% but as this is part of the new quality monitoring process it will be continue to be monitored through that route. Closure date extended to allow time for this to become effective.	
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 March 2016 - data now available on dashboards and on-line via the intranet. 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
Determine further controls to maintain / sustain the improvement in response and management while ensuring that each incident report is	Chris Rawlings Head of Clinical Governance & Risk Management	30/06/2016	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	26/07/2016

appropriately reviewed	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. March 2016 - Discuss at OGM on 1st April - targetted support for departments/wards with high numbers of open incidents (from Divisions and/or corporate team) and review incidents reported to determine whether a) they are incidents, b) the high reporting areas need to report them c) whether the individual investigations need to be reported d) whether the ward/department structure and systems allow for incident review and timely closure. Expected closure date moved on to June 30th to allow time for these measures to take effect. Performance improved to 19% of incidents open >20 working days on 26th July. Significant improvement and in line wiht trajectories for improvement. Target therefore achieved via new controls and monitoring. Action therefore closed at this time but performance will be reviewed through the Trust and Divisional quality dashboards with exception reports required if performance breaches the target.

Target Risk Level	Major	Unlikely	8	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 performance 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. March 2016 - Discuss at OGM on 1st April - targetted support for departments/wards with high numbers of open incidents (from Divisions and/or corporate team) and review incidents reported to determine whether a) they are incidents, b) the high reporting areas need to report them c) whether the individual investigations need to be reported d) whether the ward/department structure and systems allow for incident review and timely closure The improved performance on the number of incidents open >20 working days suggests improved management of patient safety incidents. The risk has therefore been reduced to 'amber / moderate' Aug 16: Datix bug affected the metrics adversely but improvement in performance still seen so risk rating remains Amber. Review extended to include incidents not allocated to the Clinical Divisions. Weekly Sitrep has replaced the weekly incident report to include risks , complaints and CAS alerts. Snapshot of timeliness of incident reporting shows that circa 85% are reported within 24hrs of occurring.

Next Review Date 02/11/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

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 / Operational Executive Group
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
Review contract with Worcestershire Health & Care Trust	Jo Kenyon General Manager	28/11/2016	Chris Tidman has contacted and held a discussion with Simon Haresnape requesting the HCT to confirm their their commissioning intentions for WFGPU by 31st March 2016. Commissioning intentions have been reviewed and GP unit is scheduled for closure 1st September 2016.Further meetings with WH+CT have been held and plan is for possibly 16 beds at KTC. At present transfer is on hold due to some building issues	
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
Ensure interim safety	Robin Snead	21/03/2016		28/04/2016

measures are effective	Divisional Director of Operations			

Target Risk Level	Catastrophic	Unlikely	10	Low

Progress	Wyre Forest Clinical Commissioning Group currently deciding on the future community ward based services required. Due to the delays, Robin Snead to discuss interim solutions with Pharmacy and Wyre Forest CCG to provide further risk mitigation. Update-Scheduled closure for GP unit is 1st September 2016 29/09/16 Transfer at present is on hold due to building issues.

Next Review Date 21/11/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

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 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 Countywide multidisciplinary Stroke Strategy Group established
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
Work through stroke stratergy	Trevor Hubbard Deputy Divisional Director of Operations Medicine (Interim)	12/12/2016	At present there is a stroke improvement strategy with four strands capacity being one this is being progressed with the CCg's regarding potential consideration of co-horting all community beds specifically for stroke patients in one area however discussions are continuing.	
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
Highlight to CCG'S the issues with availibility of stepdown beds	Jo Kenyon General Manager	26/09/2016	This is action is still in progress Up-date 24/6/16 - Integrated MDT established with Health and Care Trust to improve discharge process from community beds. Locum consultant appointed to provide medical cover in community. COO to Chair a monthly health economy wide/strategy meetings to address stroke capacity constraints.	04/10/2016

Expected completion date August 2016
Further controls now in place

Target Risk Level	Moderate	Unlikely	6	Very Low

Progress

Next Review Date 19/12/2016

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 sustainable and financially viable and makes the best use of resource
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 Task & Finish Group - Locum and Agency Costs Work Force Assurance Group established
Sources of Assurance	Management Assurance-WAG Medical Workforce Report

Performance Monitoring	medical vacancy rate expenditure on medical agency staff
Gaps in Control	
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Review recruitment strategy to encourage more applications to WAHT	Sandra Berry Training Manager WRH	04/11/2016	Recruitment Strategy reviewed and a report due to Trust Board 02/11/16	
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
Develop strategy to increase substantial consultant body	Andy Phillips Interim Chief Medical Officer	13/06/2016	Update March 2016: Workforce Development Plan in progress, to be completed May 2016. April 2016 update: Regular WAG medical staff report to Trust Board commenced in April 2016 which includes actions taken by divisions. June 2016 update: WAG medical staff report continues. Action closed.	13/06/2016
Ensure divisions provide clear strategy to increase substantive workforce and reduce costs	Andrew Short Consultant Paediatrician	19/08/2016	Divisional recruitment plans are now provided as part of performance review.	19/09/2016
Create a centralised locum co-ordinator team.	Sandra Berry Training Manager WRH	30/09/2016	Team created	30/09/2016

Target Risk Level Moderate Possible 9 Low

Progress	14/09/16 Workforce assurance group established Bank and Agency task and finish group established Agency expenditure is reducing

Next Review Date 16/12/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 3252 Reduced Cons & middle grade stroke drs in post; reduced emerg & routine stroke work will occur impacting on care delivery

Date opened 06/07/2016

Strategic goal

Strategic objective(s)

Initial Risk Level Catastrophic | Almost certain | 25 | High

Director/Committee	Chief Operating Officer /
Description/Impact	Current position - 2 substantive Consultants in post alongside x2 locums out of a compliment of 5 required to run a five day service. Recruitment to vacant slots across all grades are reliant on locums which have been difficult to fill. 1. Stroke patient in ED & MAU will not be seen by the stroke team unless for Thrombolysis. 3. For the last few months and anticipated the next few, all follow up clinics have been cancelled 4. No stroke outliers are being seen by the stroke medical team
Key Controls	CNS triaging TIA referrals with the aim to run a clinic supported by the consultant Stroke Therapists are continuing to see stroke patients in ED MAU and outlying wards Stroke pathway has adapted to provide interim guidance to all medical staff Revised Stroke pathway in use in ED and MAU (attached in docs section) Telephone triage is being performed by stroke Consultant to ensure appropriate patients are reviewed Waiting list is at present being validated by sroke Consultant
Sources of Assurance	External Audit-SSNAP data analysis Internal Audit-Monitoring of high and low risk TIA waiting lists

Performance Monitoring	
Gaps in Control	
Gaps in Assurance	

Current Risk Level Major | Almost certain | 20 | High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Recruitment of 2 substantive Consultants to be completed	Jo Kenyon General Manager	12/12/2016	6/7/16 ATR's secured Two JD,S are currently with the Royal College of Physician's for review and approval.	
Scope the possibility of the trust employing a stroke consultant nurse.	Trevor Hubbard Deputy Divisional Director of Operations Medicine (Interim)	12/12/2016		
Locum Registrar to commence high risk TIA service	Caroline Lister Directorate Manager	20/07/2016	6/7 Awaiting a start date for locum Registrar Locum Registrar now in post	27/07/2016
Liase and formulate plans to deliver service with H&C Trust and CCG's (Stroke Strategy Forum)	Caroline Lister Directorate Manager	31/08/2016	6/7/16 Initial meeting 5/7, attended by Trust, H&C Trust and CCG (AND PATIENT REP) 1. Futher strategic meeting early week beginning 11/7 2. Caroline Lister and Marsha Jones to set up twice weekly MDT's on ASU with H&C Trust in reaching with the aim to increase discharges and therefore reduce outliers 3. Strategically the Acute Trust, CCG, and H&C Trust to look at joint model across the economy for bothe workforce and patient pathway Harm reviews underway 27/7/16	04/10/2016

Target Risk Level Catastrophic | Blank | 20 | High

Progress	At presens work in progress with the deveolpement of 4 workstreams within stroke . These will be exploring-Assesment of patients,capacity,workforce and outcomes.

Next Review Date 21/11/2016

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk 3289 If there is insufficient medical,nursing and physical capacity within gynae we will be unable to meet contracted activity.

Date opened 16/08/2016

Strategic goal

Strategic objective(s)

Initial Risk Level Major | Almost certain | 20 | High

Director/Committee	Chief Operating Officer / Trust Board
Description/Impact	Insufficient bed capacity due to the emergency maternity reconfiguration which has lead to the loss of the gynae ward. *Gynae inpatient ward converted into antenatal ward post reconfiguration, this has led to a lack of gynae inpatient capacity. *A lack of inpatient capacity leads to breach of RTT. *Loss of the EGAU previously located on lavender gynaecology ward has led to services being transferred to an area previously used solely for outpatients. * Transfer of EGAU to Clover suite has impacted on patient experience within the collocated services of EGAU, EPAU,coloposcopy and outpatients. * The clover suite is a non inpatient area which now accommodates EGAU patients overnight when there is a lack of bed capacity on the acute side. *Gynae outliers are frequently cared for by non gynaecology trained nursing staff this has led to a number of patient safety incidents. * Lack of inpatient capacity has had a detrimental affect on patients experience leading to an increase in complaints, especially regarding late cancellation of elective surgery. * Staff moral, recruitment and retention has been negatively affected by the loss of a dedicated gynaecology ward. * Lack of inpatient gynaecology beds prevent the full utilisation of surgical lists resulting in loss of capacity, impacting negatively on the financial status of the woman's directorate. * Late cancellation and lack of capacity negatively impacts on the financial performance of the directorate. * The requirement to staff separate consultant level obstetric and gynaecology on call rotas on the Worcester site post reconfiguration, has negatively impacted on the Alexandra out of hours cover.
Key Controls	4 bedded bay created within the maternity template for inpatient gynae beds. Monday - Friday with strict adherance to inclusion and exclusion criteria Utilisation of inpatient facilities and inpatient lists with junior doctor cover out of hours provided by hospital at night team on the AH site. Senior cover provided by gynaecological consultants in addition to regular O&G on call at WRH. Implementation of pathways such as rapid hydration to reduce admission of gynae emergency admissions Engagement in Lisenting in Action in order to improve Clover environment for utilisation as EGAU EPAU Coloposcopy and outpatients. Separate Obs & Gynae consultant on call and development of hot week, has improved availbility and consistency of senior Gynae advice and review. Weekly review of waiting lists to reschedule patients with the aim to meet RTT standards and avoid breaches. Review of job plans within the womens directorate to optimise cross site working and theatre utilisation. Ongoing recruitement for specialist gynaecology nurses. Utilisation of inpatient facilities and inpatient lists with junior doctor cover out of hours provided by hospital at night team on the AH site. Senior cover provided by gynaecological consultants in addition to regular O&G on call at WRH. Trust long term plans include development of a womens surgical unit on the WRH site. Capturing data relating to incidents and complaints in association with lack of inpatient capacity. LiA - Gynaecology is one of the first 10 actions.
Sources of Assurance	Management Assurance-Measuring RTT Management Assurance-Monitoring incidents Internal reports to the Board-Highlighted to risk to executive team Management Assurance-Measuring RTT Management Assurance-Monitoring incidents Internal reports to the Board-Highlighted to risk to executive team

Performance Monitoring	* Financial performance * Performance against RTT * Complaints * Incidents * Recruitment & retention * Patient experience
Gaps in Control	Gynaecology patients being cared for by non specialist nurses. Bed capacity on WRH not adequate for activity within the Trust. Specialist gynaecology nurses not utilising skills within a dedicated environment. Previously agreed to ring fence 6 female surgical beds on Chestnut ward, this is not robust. Theatre utilisation on the WRH site is affected by capacity contraints.
Gaps in Assurance	RTT / financial performance. RTT Health Education West Midlands (HEWM) report

Current Risk Level Major | Almost certain | 20 | High

Corporate Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Explored the possibility of utilisation of vacant space at AH for outpatient procedures.	Tracy Baldwin Sister- Day Surgery Unit	14/10/2016	Additional capacity to relieve pressure on WRH site 8/8/16 Awaiting costings from estates at the Alex for work required to move EJU. 20th September 2016 - Walkaround by Matron, Rob Game, C Garlick & Liz Court. Reviewed outstanding work required. R Game to take forward with estates.	
Matron and DDNM ongoing discussion relating to recruitment.	Tracy Baldwin Sister- Day Surgery Unit	14/10/2016	DDNM to discuss plans with matron and escalated to executives the impending issues 3/6/16 Agreement reached to appoint 5 WTE trained nurses ATR in progress 18/7/16 Interviews to appoint 4 trained nurses will take place 5/8/16. 16.08.16 interviews took place, one nurse recruited. No others attended for interview. 22/9/16 - further interviews to recruit staff will take place on 30/9/16.	
DMT to escalate to Board regarding lack of ring fenced female surgical beds.	Cathy Garlick Director of Operations - Women & Children	31/10/2016	Need agreement with G.James & M Markell for joint escalation between W&M & Surgery.	
Obtain update from LiA regarding Clover suite redevelopment.	Angus Thomson Clinical Director - Obstetrics and Gynae	30/12/2016	Set of plans that are awaiting costing by estates dept. New action to review and reduce costing. Update 23.9.16 - A further LiA meeting has taken place 7.9.16 to review plans to try to reduce costing, now awaiting estates to update directorate. Additional meeting planned for 30 Sept 2016. Meeting held 30.9.16 - Final plans to be submitted to contractors for quote back within three weeks. Additional concerns expressed by other users of Clover suite - meeting set up for 12.10.16 Meeting held with multi-department and multidisciplinary involvement on 12.10.16. A number of major concerns raised about whole plan, colocation of Respiratory and Gynaecology clinics, colocation of outpatient and assessment services, relocation of colorectal specialist nurses and relocation of out-patient sisters. No concensus agreed. Subsequent escalation to CEO has suggested that some forward movement is essential accepting concerns raised and trying to find solutions wherever possible. Robin Snead to negotiate how to achieve progress - email to be attached as evidence.	
Pilot for use of 4 antenatal beds for Gynae inpatients.	Tracy Baldwin Sister- Day Surgery Unit	27/06/2016	Pilot carried out for 1 week, this proved successful	11/07/2016
Escalate risk to Trust Board for inclusion on corporate risk register	Cathy Garlick Director of Operations - Women & Children	26/08/2016	New risk added to divisional and directorate level. Amalgamation of the following risks ID 3130, 3156. 3068, 3060, 3064, 3070, 3206.	23/08/2016
LiA meeting with CEO plans to scope a reconfigared environment for EGAU and EPAU	Angus Thomson Clinical Director - Obstetrics and Gynae	30/09/2016	Estates reviewing potential reconfiguration of Clover to allow gynaecology expansion. 18/7/16 Meetings ongoing further meeting on 12/7/16 to review plans. Estates to re design and recost changes. Liked to other action - Closed	23/08/2016
Include new overarching risk in Trust Board report (QGC)	Fay Baillie Interim Director of Nursing & Midwifery	21/09/2016	Risk ID3289 approved by C Garlick, This will be included in DDNM QGC report Sept 2016.	14/09/2016
Ring fance beds for 6 female surgical beds on Chestnut Ward	Janice Kerr Directorate Manger Women & Children	28/09/2016	To be discussed at Divisional Management Board meeting on 28th September 2016. It had been identified as an action by the deanery.	28/09/2016

Target Risk Level	Minor	Unlikely	4	Very Low

Progress	Linking all risks pertaining to the overarching risk of the " Lack of gynaecology inpatient capacity" Escalated to executive team for inclusion on corporate risk register. Project director to support moves to vacant space at AH. 2nd week September 2016

Next Review Date 31/10/2016

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2 November 2016 **Enc H2**

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 recommended to:
	• Approve the terms of reference for the Auditor Panel
	• Note the lack of assurance in relation to
	  • Discharge policy
	  • RTT and training
	  • VTE recording
	• Note the report
	
	There are a high number of items that have necessitated a referral to an executive director. This is unacceptable and as Committee Chair, I would like to request that staff members when requested to attend the Committee do attend to ensure that assurance is given.

Previously considered by	N/A

Priorities (√)

Investing in staff	
Delivering better performance and flow	
Improving safety	
Stabilising our finances	√

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 15 September 2016.

Title of report	Audit and Assurance Committee
Name of director	Bryan McGinity

Date of meeting: 2 November 2016 **Enc H2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 2 NOVEMBER 2016

1. Situation

The Audit and Assurance Committee met on 15 September 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 Auditor Panel

The Committee approved the terms of reference for the Auditor Panel and these are presented for ratification by the Trust board.

3.2 Finance Statement and Action Plan

The Committee were assured on the process in place for the management of the final accounts process for 2016/17.

3.3 Discharge Policy/RTT (training) follow up

The Committee were disappointed that further assurance had not been given in relation to these two audits. Relevant staff have now been invited to the next meeting in November.

3.4 External Audit

The Annual Audit letter was presented. The External Auditor would present the Letter to the AGM on 29 September.

3.5 Internal Audit

The Committee requested actions to be taken in respect of the outstanding actions relating to internal audit reports over recent years. This is being managed through the executive team.

The Committee received the following audits:

- Medical revalidation (moderate): Assurance was sought about the appointment of the associate medical director which has been vacant for sometime and it was understood that the portfolio was being redesigned.
- Serious incidents (moderate): As Chair, I have written to the Interim CNO to gain assurance on this area.

3.6 Annual Security report

The Committee approved this for presentation to the Trust board.

Title of report	Audit and Assurance Committee
Name of director	Bryan McGinity

3.7 **Quality Account – VTE performance**

The Committee were not assured in relation to progress being made in the recording of VTE. A qualified audit was given in relation to this in th equality account for 2015/16. Unfortunately no-one was able to attend the meeting to discuss this item. We referred the issue to the QGC for urgent consideration.

3.10 Items received

The Committee received the following items:

- BAF
- Losses and compensations
- NHS LA risk assessment
- Annual satisfaction survey – internal audit
- Anti-fraud update

The Committee have reinvigorated its monitoring of other Committees and have a programme in place.

4 Recommendation

The Board is recommended to:

- Approve the terms of reference for the Auditor Panel
- Note the lack of assurance in relation to
    - Discharge policy
    - RTT and training
    - VTE recording
- Note the report

There are a high number of items that have necessitated a referral to an executive director. This is unacceptable and as Committee Chair, I would like to request that staff members when requested to attend the Committee do attend to ensure that assurance is given.

Bryan McGinity
Chair – Audit and Assurance

Worcestershire NHS
Acute Hospitals NHS Trust

Terms of Reference

AUDITOR PANEL

Version: 1.1

Terms of Reference approved by: Audit and Assurance Committee

Date approved: July 2016

Author: Company Secretary

Responsible directorate: Finance

Review date: March 2017

Reference: HFMA briefing paper, December 2015
https://www.hfma.org.uk/docs/default-source/publications/responses/ap-terms-of-reference-14-dec-2015.pdf?sfvrsn=0

Date of meeting: 2 November 2016 **Enc H2**

AUDITOR PANEL

TERMS OF REFERENCE

1 Authority

The auditor panel is authorised by the board to carry out the functions specified below and can seek any information it requires from any employees/ relevant third parties. All employees are directed to cooperate with any request made by the auditor panel.

The auditor panel is authorised by the board to obtain outside legal or other independent professional advice (for example, from procurement specialists) and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such 'outside advice' must be obtained in line with the Trust's existing rules.

2 Conflicts of interest

Conflicts of interests must be declared and recorded at the start of each meeting of the auditor panel. If a conflict of interest arises, the chairperson may require the affected auditor panel member to withdraw at the relevant discussion or voting point.

3 Terms of Reference

The auditor panel's functions are to:

- Advise the Trust board on the selection and appointment of the external auditor. This includes:
  - agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules
  - making a recommendation to the board as to who should be appointed
  - ensuring that any conflicts of interest are dealt with effectively
- Advise the Trust board on the maintenance of an independent relationship with the appointed external auditor
- Advise (if asked) the Trust board on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor
- Advise the Trust board on any decision about the removal or resignation of the external auditor.

4 Membership

The auditor panel shall comprise three non-executive directors, one of which shall be appointed chair by the Trust board.

This satisfies the requirement that an auditor panel must have at least three members with a majority who are independent and non-executive members of the board.

In line with the requirements of the *Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015* (regulation 6) each member's independence must be reviewed against the criteria laid down in the regulations.

The following shall be in attendance at each meeting:

- The Director of Resources
- Deputy Director of Finance
- Company Secretary

4.1 Chairperson

The audit and assurance committee chairperson will be the chair the auditor panel

4.2 Attendance at meetings

The auditor panel's chairperson may invite executive directors and others to attend depending on the requirements of each meeting's agenda. These invitees are not members of the auditor panel.

5 Quorum

Two members present.

6 Frequency of meetings

The auditor panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the audit and assurance committee.

Auditor panel business shall be identified clearly and separately on the agenda and audit and assurance committee members shall deal with these matters as auditor panel members NOT as audit and assurance committee members.

The auditor panel's chairperson shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the audit and assurance committee.

7 Reporting

The chairperson of the auditor panel will report to the board on how the auditor panel discharges its responsibilities.

The minutes of the panel's meetings will be formally recorded and a summary submitted to the board by the panel's chairperson. The chairperson of the auditor panel must draw to the attention of the board any issues that require disclosure to the full board, or require executive action.

8 Record of Business

The Company Secretary is responsible for the administration of the committee.

9 Review Period

Terms of reference will be reviewed annually by 31st March.

KS/audit panel final

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2 November **Enc I1**

Report to Trust Board (in public)

Title	**Annual Security Report 2016**
Sponsoring Director	**Gareth Robinson, Interim Chief Operating Officer**
Author	**Paul Graham, Health & Safety Manager and LSMS**
Action Required	The Board is requested to accept the contents of this report as assurance that the Trust is continuing to manage security across all three hospital sites and acknowledge the outstanding actions as listed.
Previously considered by	*Audit and Assurance Committee*

Priorities (√)

Investing in staff	√
Delivering better performance and flow	
Improving safety	√
Stabilising our finances	

Related Board Assurance Framework Entries	*N/A*
Legal Implications or Regulatory requirements	To meet the requirements of the NHS Standard Contract
Glossary	Nil

Key Messages

- The number of physical assaults on members of staff has increased since 2015.
- Where appropriate the Trust continues to work with the Police to ensure that perpetrators of violence and aggression receive the appropriate level of sanctions.
- The Trust's LSMS will be staging a Security Awareness Week during October to remind all staff of the tools available to them that can help to manage violence and aggression.
- The Trust currently has an overall Green rating for complying with the NHS Security Management Standards.

Date of meeting: 2 November **Enc I1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD- NOVEMBER 2016

1. Situation

This report Is to inform the Trust Board of the security management activities that have been carried out during the past 12 months in line with meeting the security objectives outlined in the NHS Standard Contract. It summarises the activities that have been captured under the various key areas of security management and identifies a number of areas of action to mitigate the risks to the Trust.

2. Background

In line with the NHS Standard Contract and the Standards for Providers 2015/16 – Security Management guidance issued by NHS Protect the Trust has a responsibility to ensure compliance with the following objectives:

- Strategic Governance
- Inform & involve
- Prevent & deter
- Hold to Account

The Trust's Health & Safety Committee, chaired by the Chief Operating Officer, reviews all security issues and where appropriate escalates any significant issues the Trust Audit Committee. During the last 12 months the following topics have been discussed:

- Violence & aggression – use of administrative sanctions
- National violence against NHS staff statistics
- Security staff at the Kidderminster Treatment Centre

3. Assessment

Strategic Governance

The Chief Operating Officer is the appointed Security Management Director (SMD).

The Trust continues to use the risk assessment process to help identify where there is a need to allocate resources for security purposes.
The Trust has a Security Strategy in place which sets out the following objectives:

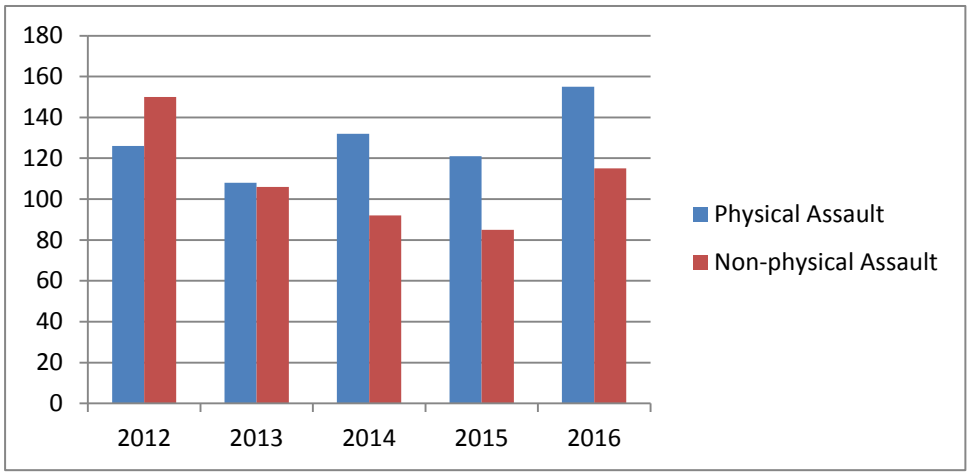
- To effectively manage any security risks
- To meet the security requirements of our Commissioners as set out in the NHS Standard Contract
- To provide Conflict Resolution training to all front line staff
- To provide lone workers with personal protective equipment

Inform & Involve:

The Trust continues to monitor compliance with Policy for the Management of Violence & Aggression and where appropriate follows up cases of non-compliance with the Police to ensure that the relevant criminal sanctions are applied to any offenders. The Trust also has issued a number of administrative sanctions to patients who have displayed abusive and violent behaviour towards its staff. During October 2016 the Trust's LSMS will be staging a Security Awareness Week. He will be visiting each of the hospital sites to inform staff of the administrative sanctions that are available and some of on-going security work carried out by NHS Protect.

Incidents of violence and aggression are recorded on the Trust DATIX Incident Reporting System and summary reports are submitted to the H&S Committee on a quarterly basis. The number of physical and non-physical assaults have increased during 2015/16 compared to the previous years (see Graph 1 below). The vast majority of physical assaults continue to be committed by patients who lack the capacity to understand what they are doing. All these incidents are investigated by the responsible managers involving where necessary the LSMS and the Police.

Graph 1: Comparison of physical and non-physical assaults 2012-2016



Victims of violence & aggression are kept informed as to any follow actions taken by the Trust or Police. Details are also recorded on the Datix system. In April 2015 the Risk Officer carried out a Risk Survey the results of which indicated that 27% of staff identified that verbal abuse was one of their top 5 risks. Many staff also felt that there was a lack of willingness to address verbal aggression and threats against members of staff. The LSMS has begun to closely monitor the issuing of administrative and legal sanctions against members of the public who

commit assaults against staff. This information will be shared with staff to help demonstrate that the Trust does take violence & aggression seriously and will where necessary provide staff with the appropriate level of support.

During 2015/16 the Trust responded to an NHS Protect request to provide information on door access swipe card systems. It also received and disseminated new Best Practice Guidelines on Emergency Department Patients in Police Custody.

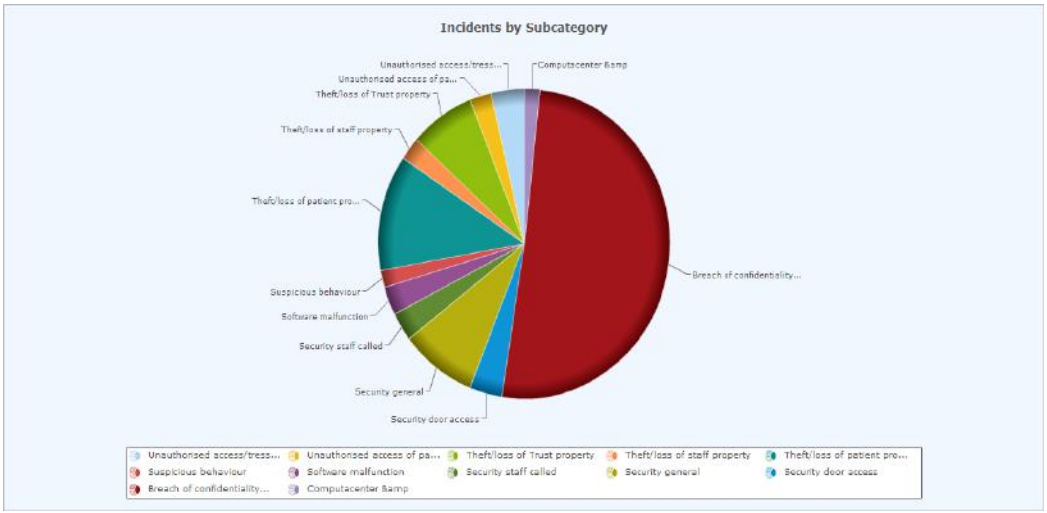
Security has recently been reviewed at the Kidderminster Treatment Centre following a number of concerns raised about the level of security response to any security incident. Work has begun to increase the security presence on site particularly around the Minor Injuries Unit and especially outside of normal working hours.

Prevent & Deter

The Trust continues to provide Conflict Resolution training and training in the use of Therapeutic Holding techniques for appropriate staff. The current attendance rate for all violence & aggression training sits at 81%.

The Chart below shows the types of security incidents reported that were associated with Trust/Patient assets. All data protection incidents were followed up by the Head of Information Governance and action taken accordingly. A report on Information Security was presented to the H&S Committee in June 2015.

Summary of Asset Protection Incidents 2015/16



In June 2015 the Trust also reviewed its Security Lockdown Plan. This is now available on the Trust's intranet site.

Title of report	Annual Security Report 2016
Name of director	Gareth Robinson

Cyber-Security

The Trust has measures in place to reduce the risk of exploitation through cybercrime. We have protection from N3, which is the secure network that all NHS organisations use. N3 also provide a web filtering service to reduce the risk of emails from unknown senders and sources. This service also monitors internet behaviour and blocks access to websites that are flagged by NHS Digital as known risks. NHS Digital also provides weekly bulletins regarding known threats through its CareCERT service. These alert Trusts to potential cyber threats from newly or known malware or ransom-ware attacks.

To compliment these measures, the Trust also has internet browsing policies that stop all access to sites that are not classified as safe or are uncategorised. The Trust has Anti-Virus software that stop viruses and known ransom-ware attacks that have been identified by IT malware/anti-virus companies. The updates for this software are continual and computers, laptops and any servers that have access to the internet have anti-virus clients installed as standard.

The Trust is working with Computacenter, as part of our managed IT service provision, to develop a cyber-security roadmap to highlight risks and identify solutions for those risks. The roadmap is currently under development and will be available in the next month.

Hold to Account

The LSMS continues to work closely with the local Police to establish stronger links so that the Trust can receive timely feedback in terms of pending court cases and the application of criminal sanctions.

During 2015/16 the Police were involved in 22 security incidents 2 of which resulted in criminal sanctions being applied. The one defendant pleaded guilty to her offences and was sentenced to 8 weeks imprisonment which was suspended for 12 months. She was also required to comply with a supervision period of 18 months (Rehabilitation Activity Requirement).

Areas of Action

In November 2016, The Trust will submit its up to date Self Review Tool (SRT) which will include a security management work plan. This work plan will list the following actions that need to be closed before the Trust can indicate that they are fully compliant with the Security Management Standards.

1. *Complete the link up with Datix to report all security incident via SIRS (Security Incident Reporting System) – First trial report due*

to be submitted in October 2016

2. *Ensure that staff and patients have access to safe and secure facilities for the storage of their personal property – Review currently on-going*
3. *Upgrade the Baby Abduction System at the WRH – Currently being installed*

4 Recommendation

The Board is requested to accept the contents of this report as assurance that the Trust is continuing to manage security across all three hospital sites and acknowledge the outstanding actions as listed.

Gareth Robinson
Interim Chief Operating Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2 November 2016 **Enc J1**

Report to Trust Board (in public)

Title	**Charitable Funds Committee report**
Sponsoring Director	**Andrew Sleigh** **Chairman, Charitable Funds Committee**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	The Board is asked to review the report and note the following: • The meeting was not quorate • Members are keen that fund managers spend the money received and have expressed concern at the slow pace of spend for some funds. Managers' attention should be drawn to opportunities where funds can enhance patient experience • The Investment report from CCLA which indicated that the Trust's return on its investment was slightly ahead of market comparators. • The decision to transfer £200k from £500K cash from the Trust's Charitable Funds account to the Trust's investor (CCLA) to gain a better return, whist anticipating increased future rate of commitment.
Previously considered by	*N/A*

Priorities (√) not applicable

Investing in staff	
Delivering better performance and flow	
Improving safety	
Stabilising our finances	

Related Board Assurance Framework Entries	Not applicable
Legal Implications or Regulatory requirements	The Charitable Funds are regulated through the Charity Commission
Glossary	

Key Messages

When considering this report, members are requested to note that they are doing so as Trustees of the Charitable Fund, not as Trust Board members, thus have duty to ensure that the money is used as requested by the donor for the benefit of the Trust's patients or staff or wide community.

Title of report	Charitable Funds report
Name of director	Andrew Sleigh

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 2 November 2016 **Enc J1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – NOVEMBER 2016

1. Situation

This is the routine report to the trust board from the Charitable Funds Committee.

2. Background

All Trust board members are trustees of the Charitable Funds monies and so have a duty to ensure the best use of the money. The Trust has approximately £1.67m invested with CCLA and a further cash sum with the Trust's bank.

Funds are utilised where possible for capital projects. There are significant criteria that need to be met prior to the funds being utilised.

3. Items discussed

3.1 CCLA investment

The Investment manager attended the meeting to discuss the portfolio held with CCLA. The £1.67m is split into three funds, investment, property and bonds. This has generated an income yield of 4.02%. The gross return from the investment fund to 30 June was 6.9%, the fixed interest fund was 10.9% (benefiting from low bond yields), and for the property fund 5.6%. The first two funds have performed slightly better than a comparator group. The property fund (23% of portfolio) is affected by the Brexit vote and currently suffers liquidity restrictions, like many other property funds. Note that the investment fund abides by specific ethical criteria.

Members agreed to transfer £200k to the CCLA from the cash account leaving £350k, which was considered adequate for the planed increased commitment rate.

3.2 Other items discussed

3.2.1 **Draft Annual Report and Annual Accounts**: These will be examined by the external auditor and presented to the next meeting of the Committee. The committee noted the need to avoid holding large balances in funds and has agreed to tighten reporting and scrutiny of uncommitted funds. Donations decreased in 2015/16, but the committee received indications that donations have recovered strongly in the current year through a number of changes in our promotional activity that were agreed previously.

3.2.2 **Risk register**: The risks identified were examined in detail and the register amended accordingly. There are no 'high risks' that the Committee is managing

3.2.3 **Balance sheet**

3.2.4 **Statement of Financial Activities**

3.2.5 **General Fund balances**

3.2.6 **Expenditure plans:** The expenditure in relation to AV equipment (a partnership with Health Education England, CHEC charitable funds and the

Trust Charitable Funds) as well as equipment for patients with Dementia were noted.

4 The meeting was not quorate. It would be helpful to have a clinician present at each meeting.

5 Recommendation

The Board is asked to review the report and note the following:

- The meeting was not quorate
- Members are keen that fund managers spend the money received and have expressed concern at the slow pace of spend for some funds. Managers' attention should be drawn to opportunities where funds can enhance patient experience
- The Investment report from CCLA which indicated that the Trust's return on its investment was slightly ahead of market comparators.
- The decision to transfer £200k from £500K cash from the Trust's Charitable Funds account to the Trust's investor (CCLA) to gain a better return, whist anticipating increased future rate of commitment.

Andrew Sleigh
Non-Executive Director