NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	16 January 2018
Paper number	H1

Processes and responsibilities for maintenance of the Board Assurance Framework

For approval:	X	For assurance:		To note:	

Accountable Director	Kay Darby, Interim Director of Governance		
Presented by	Kay Darby, Interim Director of Governance	**Author**	Kay Darby, Interim Director of Governance

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

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability	x	Operational Performance		Quality of Care	
Finance and use of resources		Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Executive Directors	email	Comments received
TLG	10 January 2018	For approval

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

Level of assurance and trend

	√	↑ ↓ →
Significant	N/A	
Limited	N/A	
None	N/A	
Not applicable	N/A	

Recommendations	The Board is requested to approve the process and responsibilities for maintenance of the Board Assurance Framework.

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Executive Summary
The Trust BAF and integrated corporate risk register was approved in July 2017 and is reviewed by Board Committees monthly and the Trust Board Bi Monthly. The Audit Committee Handbook (HFMA, 2014) identifies the BAF as: "*the key source of evidence that links strategic objectives to risks and assurances, and the main tool that the Board should use in discharging its overall responsibility for internal control*". The Integrated Governance Handbook (GGI, 2016) sets out the value of a BAF in providing organisations with: "*a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting objectives*".
Background
This paper sets out how the Board Assurance Framework (BAF) process works and the key responsibilities for maintenance of the BAF document.
Issues and options
Roles and Responsibilities **Trust Board** The Board of Directors has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate risks which may threaten the achievement of the Trust's objectives. The Board achieves this primarily through the work of its Committees, through the use of Internal Audit and other sources of independent assurance and by systematic collection and scrutiny of performance data to evidence the achievement of the objectives. The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method for the effective and focussed management of Principal Risks to Trust objectives. The Board determines the Principal Risks and ensures that each is assigned to a Lead Director as well as to a Lead Committee The Board reviews the BAF at each of its Public Board meetings, which are held on a bi-monthly basis. The Trust Board has overall responsibility for ensuring that Principal Risks are adequately mitigated; through monitoring risk mitigation actions and approving changes to the BAF and associated Corporate Risks, as recommended by the Risk Management Group and/or Board Committees. **Audit and Assurance Committee** The Audit and Assurance Committee is responsible for providing assurance to the Board that the BAF continues to be an effective component of the Trust's control and assurance environment. The Audit and Assurance Committee plays a key role in supporting the Trust Board by critically reviewing and reporting on the relevance and robustness of the governance structures and assurance processes on which the Trust Board places reliance. The Audit and Assurance Committee's role is to continually review the relevance and rigour

of the assurance framework and the arrangements under-pinning it. The Audit Committee handbook defines the role of the Committee to review whether:

- The format of the assurance framework is appropriate for the organisation
- The way in which the framework is developed is robust and relevant
- The objectives in the framework reflect the organisations priorities and that both the objectives and priorities are well defined, agreed and recorded
- The key risks are identified and linked to objectives
- The controls in place are sound and complete
- The assurances are reliable and of good quality with all key sources identified
- The underlying data on which assurances are based is reliable, accurate and timely
- There are plans to address gaps in control and/or assurance and that they are implemented in line with agreed timescales

Board Committee Chairs are asked to attend the Audit and Assurance Committee on an annual basis to provide assurance over the BAF processes undertaken at each Board Committee. The Audit and Assurance Committee provides a report to Trust Board on the assurance gained.

Board Assurance Committees

BAF risks are remitted to the relevant Board Committee (as Lead Committee for a given risk) for review at each of its meetings. The role of the Lead Committee is to review the Lead Director's assessment of their Principal Risks, consider the range of assurances received as to the adequacy and effectiveness of primary risk controls, and to require the Lead Director to take appropriate actions to further mitigate risk where needed

The Chair of the Lead Committee will:

- Set an agenda that is driven by gaps in controls and assurances
- Set timeframes for closure of gaps in control
- Review assurances provided by the executive and assess the effectiveness of these
- Seek additional assurance where required
- Escalate Gaps in controls and assurance to the Trust Board

Risk Management Group

The Risk Management Group is an executive group chaired by the CEO formed from the membership of the Trust Leadership Group. It meets quarterly to review the Corporate Risk Register and high level Divisional risks. The group provides confirm and challenge to risk ratings, escalates and de-escalates risks and monitors progress with implementation of mitigating actions. The group identifies corporate risks that are linked to BAF risks.

Executive Directors

The Lead Director is responsible for assessing any Principal Risks assigned to them by the Board and for providing assurance as to the adequacy and effectiveness of primary risk controls to the Lead Committee. Executive directors, as risk owners for BAF risks and the linked Corporate risks, will:

- Review the BAF document and risks on a monthly basis
- Update on progress against gaps in control and assurances and mitigating actions.
- Provide assurances to Board Committees/ Board in relation to progress with mitigating actions, performance data and improvement plans
- Provide an evidenced based rationale for proposed changes to risk ratings

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- Be in attendance at the relevant meeting to be scrutinised in relation to their risk areas

Company Secretary
The Company Secretary will be responsible for the administration of the BAF, in particular:

- Meet with Risk owners monthly to review risks, controls and assurances
- Coordinate the update of the identified performance metrics
- Keep accurate version control
- Update the BAF document for presentation to Board Committees and Trust Board.

Clinical Risk and Governance Lead
Will update the Corporate risks linked to the BAF and identify new risks for inclusion on the BAF document. The update of these risks and associated risk actions will be completed by the risk owners within the identified review dates and reviewed by the Executive lead for the risk and any further changes required. At this Executive review inclusion on the BAF will be considered and if required this will be actioned by the Clinical risk and governance lead who will inform the Company Secretary of any changes.

Recommendations

The Board is requested to approve the process and responsibilities for maintenance of the Board Assurance Framework.

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Board Assurance Framework

For approval:	x	For assurance:		To note:	

Accountable Director	Michelle McKay CEO		
Presented by	Kay Darby Interim Director of Governance	**Author**	Kay Darby Interim Director of Governance

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

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability	√	Operational Performance	√	Quality of Care	√
Finance and use of resources	√	Strategic Change	√	Stakeholders	√

Report previously reviewed by		
Committee/Group	Date	Outcome

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

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Limited		
	None		
	Not applicable		

Recommendations	The Trust Board is asked to review and approve changes to the BAF which have been proposed by the Board sub-committees.

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Date of meeting	16 January 2018
Paper number	H1.2

Executive Summary
The BAF report is provided to update the Trust Board on the management of the Trust's principal risks and underpinning corporate and high level risks.
Background
Relevant risks on the BAF are reviewed by respective Board Committees, Quality Governance, Finance & Performance, People & Culture and Audit & Assurance. The accountable Executive Director reviews the risks in advance of each of these meetings in conjunction with the Clinical risk and governance lead and proposed changes for consideration to the Board sub-committee Since the BAF was last reviewed by the Trust Board in November 2017, the following changes are proposed: R1.1 The Quality Governance Committee supported the reduction in the risk rating from 20 to 16 R3.1 The People &Culture Committee supported the reduction in risk from 16 to 12
Implications
The Trust Board must demonstrate that it is in sufficient control of its activities through monitoring and reviewing Board Assurance Framework reporting, particularly at Board level. In this way the BAF informs the Annual Governance Statement, which is signed by the Chief Executive of the Trust on behalf of the Board.
Recommendations
The Trust Board is asked to review and approve changes to the BAF which have been proposed by the Board sub-committees.
Appendices BAF

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Board Assurance Framework
8th January 2018

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Board Assurance Framework

Summary

The Board Assurance Framework is a dynamic document. It is reviewed prior to Board committee meetings by the Executive lead for each of the Principal risks in conjunction with the Clinical risk and governance lead and the Company Board Secretary.

The relevant sections of the BAF are considered and updated at:

- Quality Governance Committee
- Finance and Performance Committee
- People and Culture Committee
- Audit and Assurance Committee

Following each meeting required amendments to the BAF are shared with the Patient Safety and risk team.

In addition to the review of the principal risks the clinical risk and governance lead also reviews the underpinning risks on the BAF.

This BAF reflects the review undertaken at the Risk management group on 25th October 2017.

Risk Heat Map				Current Score (likelihood x impact, arrow indicates any movement since last report) No Movement since last report ↔							
Strategic Objective	**Priorities**	**Risks**	**Outset Scores**	**<=9**	**10**	**12**	**15**	**16**	**20**	**25**	**Target Score**
1. **Deliver safe, high quality compassionate patient care**	P1.1 Embed and assure the revised ward to board governance structures and processes and improve the identification and management of risk	R1.1 If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	4x5=20					**4 x 4 = 16** ↓			**2x4=8**
	P1.2 Develop a more robust improvement, quality and safety culture across the Trust, including learning when things go wrong	R1.2 If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.	5 x 4 = 20						**5 x 4 = 20** ↔		**2x4 = 8**
	P1.3 Ensure the appropriate measures are taken to address all the quality and safety concerns identified by the CQC	R1.3 There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	5X4=20						5 x 4 = 20 ↔		**3 x 3 = 9**
2. Design healthcare around the needs of our patients, with our partners	P2.1 Improve urgent care and patient flow pathways across the whole system to ensure the care is delivered by the right person in the right place first time P2.2 Ensure the Trust meets its agreed trajectories for patient access and operational performance improvement in urgent and elective care	R2 Unless we work with our health and social care partners to understand flow across the system, then we may have inadequate arrangements in place to manage demand (activity)- which may impact on the system resilience and internal efficiencies impacting on delivery of contractual performance (4hr access standard; RTT; Cancer etc)	4x5=20						**4 x 5 = 20** ↔		**3x3=9**
3. Invest and realise the full potential of our staff to provide compassionate and personalised care	P3.1 Develop leadership capacity and capability at all levels within the organisation	R3.1 If we do not have in place a suitably qualified and experienced leadership team (across sub board levels including Divisional and Directorate) then we may fail to deliver the required improvements at pace- with the potential for further deterioration in patient care & experience & escalated regulatory enforcement actions	4 x 4 = 16			**3 x 4 = 12** ↓					**2x2=4**
	P3.2 Develop at all levels an organizational culture and set of behaviours that embody the Trust's values	R3.2 If we do not deliver a cultural change programme we may fail to attract and retain staff with the values and behaviours required to deliver the high quality care we aspire to.	**3 x 5 = 15**				**3 x 5 = 15** ↔				**2 x 2 =4**
4. Ensure the Trust is financially viable and makes the best use of resources for our patients.	P4.1 Systematically improve efficiency and sustain financial performance ensuring that the Trust delivers its financial control total.	R4.1 If we do not have in place effective organisational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern.	3x4=12						**5x4 =20** ↔		**2x3=6**

	P4.2 A compelling vision for the Trust and a workforce strategy that supports the retention of current staff recruitment to vacancies and development of new roles	R4.2 If we do not resource our clinical staff rotas at ward/departmental level then we will not meet patient needs consistently- with the potential for reduced quality & co-ordination of care provision, negative impact on patient flow & access targets: long term impact on staff resilience; poor retention of staff & inability to attract staff.	**5 x 4 = 20**						**5 x 4 = 20** ↔		**3 x 3 = 9**
		R4.3 If we do not have a workforce strategy that addresses organizational development, values and behaviours as well as workforce development and recruitment we will not be able to provide care that meets the needs of our patients; meets the internal workforce demands and fills our vacancies.	**4 x 3 = 12**			**4 x 3 = 12** ↔					**2 x 3 = 6**
5. Develop and sustain our business	Develop a 5 year clinical service strategy that supports the clinical and financial sustainability goals described in the Herefordshire and Worcestershire STP. Strengthen our collaboration and partnership working with other providers in Worcestershire and beyond to ensure local access to a full range of high quality services.	R5 If we are unable to secure the support of our clinical workforce, community and STP stakeholders for the 5 year clinical strategy, we may not be able to make the changes required to ensure long term viability of services.	4x4=16					**4 x 4 = 16**	4 X 4= 16 **4 x 4 =16** ↔		**3x3=9**

Mapped to Single Oversight Framework

1. Leadership and Improvement Capability	2. Operational Performance	3. Quality of Care	4. Finance and use of resources	5. Strategic Change	6. Stakeholders
Invest and realise the full potential of our staff to provide compassionate and personalised care	**Design healthcare around the needs of our patients, with our partners**	**Deliver safe, high quality compassionate patient care**	**Ensure the Trust is financially viable and makes the best use of resources for our patients.**	**Develop and sustain our business**	**Design healthcare around the needs of our patients, with our partners**

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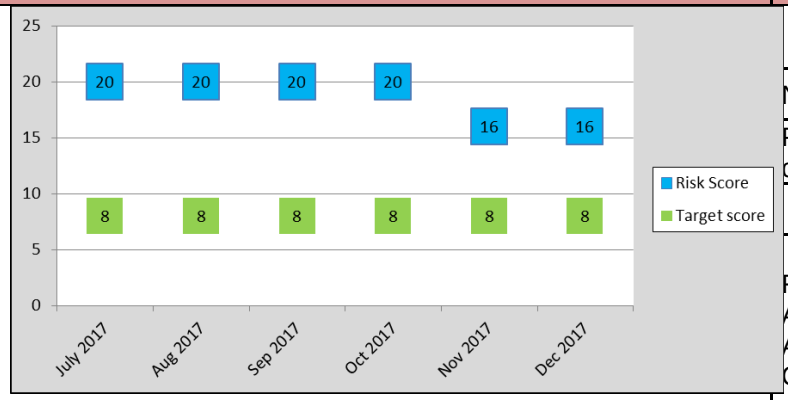
Risk Description	**Principal Risk:** The Trust fails to deliver safe, high quality compassionate patient care to our patients					**Risk ID**	R1.1
Risk Details	If we do not have in place robust clinical governance for the delivery of high quality compassionate care, we may fail to consistently deliver what matters to patients- which may impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.						
Executive lead	**Chief Medical Officer**	**Last Reviewed**	**December 2017**	**Target Date**	**July 2018**	**Review Group**	**QGC**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	**1**	**2.**	3	**4**			5

Risk Rating: Likelihood x Severity	
Initial Risk Score	20
Current Risk Score	16
Target Risk Score	8
Risk Appetite	Low
Direction of travel	↓



Relevant Key Performance Indicators

Metric	Trust compliance November 2017	Target
Complaints responded to within 25 days	52.63%	85%
Number of serious incidents	7	0
Primary Mortality Review completion	54.97% (Oct-17)	>60%
Friends and Family Test A&E Score Acute Score Outpatients Score	91.84% 96.72% 94.96%	>75 >85

Rationale for current score

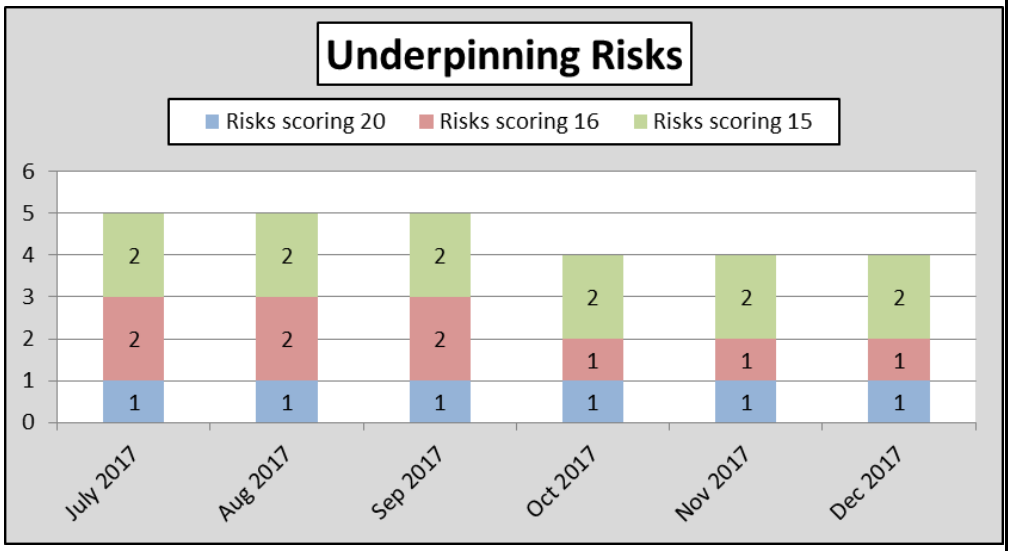
The Trust Clinical Governance systems are not fully embedded from Ward to Board. There is a lack of understanding of risk within the organization. The current process for managing complaints is in need of review. The Trust has been rated as Inadequate by the CQC and is currently in Special Measures.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Quality Improvement Plan reviewed at Quality Improvement Board Quality Governance Committee receives monthly reports from Divisions. National SI reporting system	Review of KPIs at the following :Divisional performance and Accountability meetings Quality Improvement Board Clinical Governance Group

Trust BAF identifying risks to Trust objectives Corporate Risk Register Risk Management Strategy Risk awareness session held with the Board 6/06/17 & BAF discussion held 08/08/17	Quality Governance Committee Quality Improvement Review Group NHSI performance Review meetings Complaints targeted approach with Divisions SI performance monitoring
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Corporate Governance systems and process under review. Additional support required. Review of risk maturity required Exploring support required to strengthen Clinical Governance systems and processes. Engaging support of NHSI to develop a patient experience strategy	Review Divisional Governance meetings to ensure capability exists within the Divisions and provide training as required. Develop agreed proforma with KPI's that all Divisions must report on through their Clinical Governance meetings up to CGG. Support sought from OUH for Risk Maturity review. Seeking additional Governance support for a six month period.

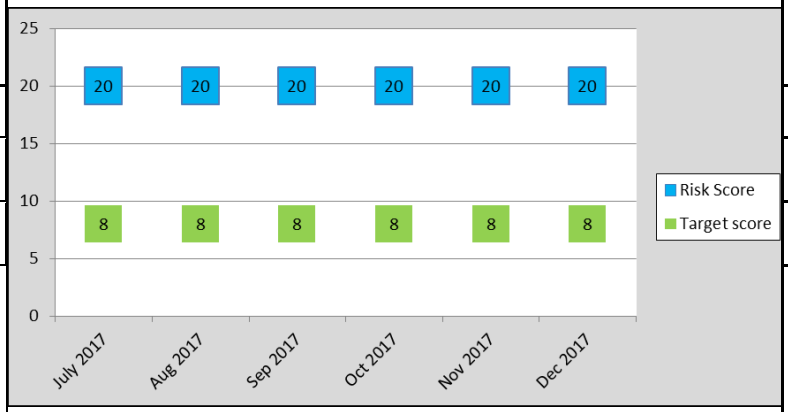
Related High Risks (>14 and DATIX ID)

2591	**Medicine Risk Register:** EDS not completed in a timely manner	20
3428	**Corporate Risk Register:** There is a risk that patients may suffer avoidable harm if deterioration is not recognised and escalated via NEWS	15
3325	**Corporate Risk Register:** There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.	16
3340	**Corporate Nursing, Governance and Risk:** Risk of non-compliance to MRSA policy leading to bacteraemia or wound infection resulting in patient harm.	15



Risk Description	**Principal Risk:** The Trust fails to deliver safe, high quality compassionate patient care to our patients					Risk ID	R1.2
Risk Details	If we do not have a clear improvement journey vision that engages staff and builds improvement capability, we may fail to deliver sustained change and improvements required.						
Executive lead	Chief Nurse	Last Reviewed	December 2017	Target Date	July 2018	Review Group	QGC/TLG
CQC Domain(s)	Safe	Caring	Responsive	Effective	Well Led		
Corporate Objective(s)	1	2	3	4	5		

Risk Rating: Likelihood x Severity	
Initial Risk Score	20
Current Risk Score	20
Target Risk Score	8
Risk Appetite	Moderate
Direction of travel	⟺



Relevant Key Performance Indicators		
Metric	**Trust compliance November 2017**	**Target**
F&F Test (Q2 17/18) Re care & treatment Re place to work	Likely/extremely likely 60% 43%	70%
Discharges before 10:00	8%	15%
Number of staff training in improvement methodology	0	TBA
CQC Well Led Domain	Inadequate	Requires improvement
Number of improvement projects started per month	Commence November	TBA
Number of improvement projects that are off trajectory	Commence November	TBA

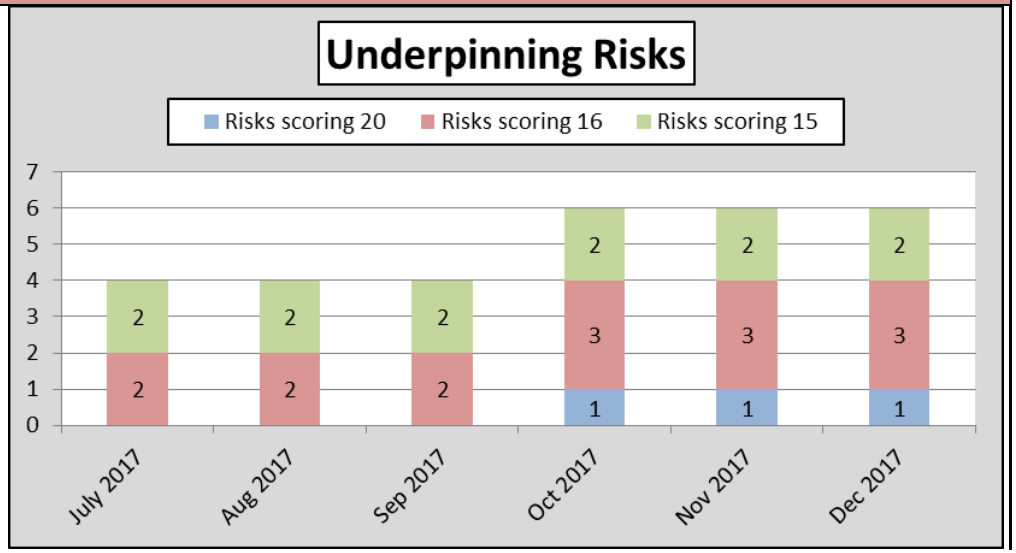
Rationale for current score
The Trust does not currently have a Quality Improvement Strategy and agreed QI methodology. There is limited QI capability within the organization.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Some QI methodology being applied to specific projects such as Red to Green. Quality Improvement framework based on Model for Improvement (PDSA) underdevelopment to be cross referenced with 4ward Process Flow approach Trust invite to wave 3 of Quality Service Improvement and Redesign (QSIR) issued	KPI's for Red to Green programme KPI's for PMO projects KPIs for QIP projects Annual staff survey report.

Human Factors monthly training programme ongoing. Human Factors 2018 approach ongoing, plans to train another cohort of 6 HF trainers to further develop HF capacity and capability. Review of LfE online training modules has been undertaken, these will be promoted across the trust Close links established with West Midlands AHSN, training opportunities to be promoted to trust staff as available. Project Management support in process of being set up to enable delivery of improvements, initial focus on CIP's ensuring link to quality. Quality Improvement Plan written and Quality Improvement Board in place to monitor progress.	Monthly QIP exception reports Frailty Improvement 4ward programme Mandated professional standards Wards pulling patients Ward round/board round Training booked for November
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of QI methodology Lack of QI capability, Board development started 6/7th June with session from AQuA. Further session planned on Mortality in September 2017.	Strengthen links with West Midlands Academic Health Science Network to agree programme of training and development for staff linked to patient safety. Identify individuals who have QI capability..

Related High Risks (>14 and DATIX ID)

3428	**Corporate Risk Register:** There is a risk that patients may suffer avoidable harm if deterioration is not recognised and escalated via NEWS	15
3419	**Corporate Risk Register:** There is a risk of avoidable harm if improvements are not made following mortality review	16
3340	**Corporate Nursing, Governance and Risk:** Risk of non-compliance to MRSA policy leading to bacteraemia or wound infection resulting in patient harm.	15
2976	**SCSD Risk Register:** Failure to achieve JAG Accreditation	16
3482	**Corporate risk register**: There is a risk that patient safety, effectiveness and management may be compromised in ED	20
2957	**Corporate risk register**: Risk of HCAI due to inadequate or ineffective performance and quality of cleaning in clinical areas	16



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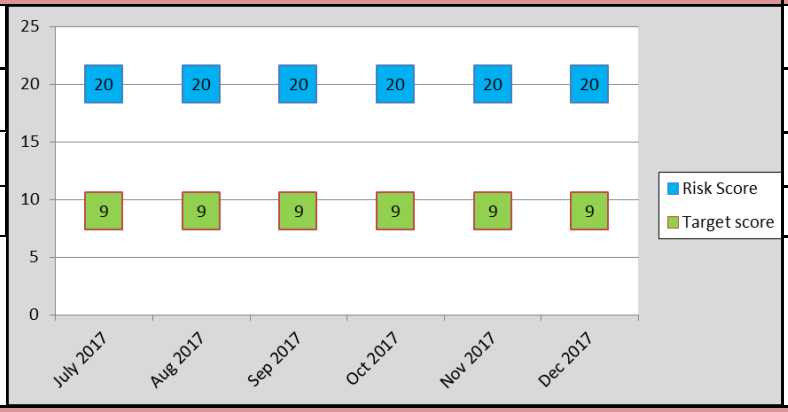
Risk Description	**Principal Risk:** There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes					**Risk ID**	R1.3	
Risk Details	There is a risk that patient safety and performance against objectives may be adversely affected. This is caused by weaknesses in Trust systems and processes that are unknown or undetected prior to an incident occurring. The effect has potential for delays in communication, diagnosis, treatment and follow up within and without of the organisation. The impact is an increased patient safety risk, increased reputational risk, failure to meet objectives and likelihood of complaint/claim.							
Executive lead	**Chief Medical Officer**	**Last Reviewed**	**December 2017**	**Target Date**		**Dec 2018**	**Review Group**	**TLG**
CQC Domain(s)	**Safe**	Caring		Responsive		**Effective**		Well Led
Corporate Objective(s)	**1**	2		3		4		5

Risk Rating: Likelihood x Severity	
Initial Risk Score	16
Current Risk Score	20
Target Risk Score	9
Risk Appetite	Low
Direction of travel	⟺



Relevant Key Performance Indicators

Metric	Trust compliance November 2017	Target
% of eligible staff trained to use electronic systems	Unable to establish baseline	90% of relevant staff
Valid NHS Number on patient records	99%	100%
Valid GP on patient records	100%	100%

Rationale for current score

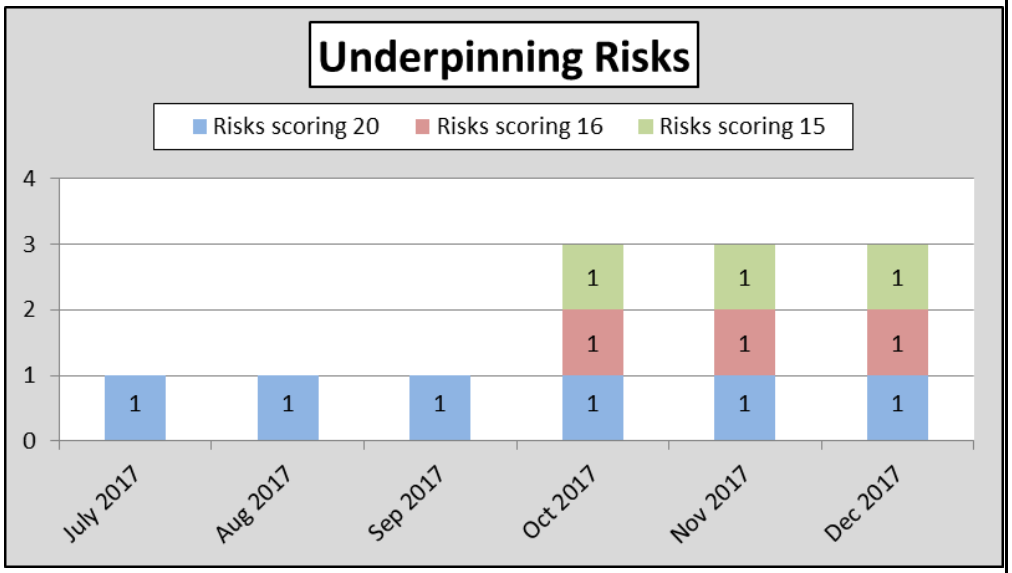
Recent serious incident has highlighted significant weaknesses in a communication system with external stakeholders. At present, it is unclear whether this has resulted in patient harm.
The Trust needs to be assured that adequate controls are in place to prevent serious incidents within Trust systems and processes. It is unknown when a similar incident could occur.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

Audit of electronic system for clinic letter generation and circulation with an associated action plan Harm review where communication with patients and or GPs has failed	Monthly backlog reports from Bluespier. Harm reviews of all letters underway - weekly reports on progress. Review scheduled by Internal audit
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
The Trust is unclear whether other systems may fail No audit of electronic reporting systems Staff training position unclear	Staff training is required to reduce the existing problem Identification of current systems and audits already undertaken to formulate gap analysis. There is a need to secure an external review of all patient data systems to ensure there are no other gaps in controls across the Trust.

Related High Risks (>14 and DATIX ID)

3522	**Corporate risk register**: There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	20
3395	Risk of interruption to clinical services as the trust network switches are End of Life and cannot be supported by the supplier The Trust has a number of switches that are End of Life. These switches are no longer supported by the manufacturer or by Computacenter and cannot be fixed in the event of failure. A failure of switches will stop the delivery of ICT services to any clinical or corporate area or for a business critical application.	16
3524	Trust remote access solution is end of life and not supported by vendor. The current remote access solution is now End of Life and is not supported by the vendor Microsoft. With application and system updates (Java update, system patches) and technological advances, the UAG solution will not be able to service staff who require remote access once these updates have been applied to desktop and laptop devices in the next three months.	15



Worcestershire NHS
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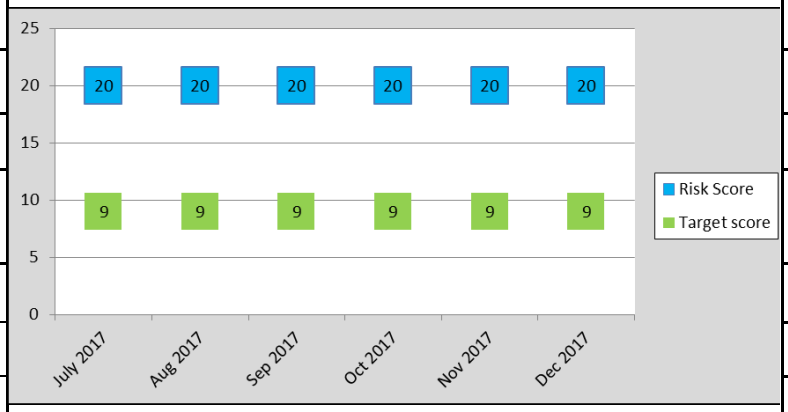
Risk Description	**Principal Risk :** The Trust is unable to design healthcare around the needs of our patients, with our partners					**Risk ID**	R2.1
Risk Details	Unless we work with our health and social care partners to understand flow across the system, then we will have inadequate arrangements in place to manage demand (activity) which will impact on the system resilience and internal efficiencies impacting on delivery of contractual performance (4hr access standard; RTT; Cancer etc.)						
Executive lead	**Chief Operating officer**	**Last Reviewed**	**December 2017**	**Target Date**	**Sept 2018**	**Review Group**	**QGC/TLG**
CQC Domain(s)	**Safe**	Caring		**Responsive**	**Effective**		Well Led
Corporate Objective(s)	1	**2**		3	4		5

Risk Rating: Likelihood x Severity	
Initial Risk Score	20
Current Risk Score	20
Target Risk Score	9
Risk Appetite	High
Direction of travel	⟺



Relevant Key Performance Indicators

Metric	**Trust compliance November 2017**	**Target**
Emergency Access Standard	80.33%	95%
Non-elective stranded patients	41.11%	15%
12 hour breaches	17	0
Number of DTOC patients	31	As good as or better than the national average
Referral to Treatment	85.49%	92%
Cancer 62 day	72.76%	85%
Diagnostics	1.29%	<1%

Rationale for current score

The Trust is not currently meeting any of the national performance standards and has significant problems with flow of urgent care patients.

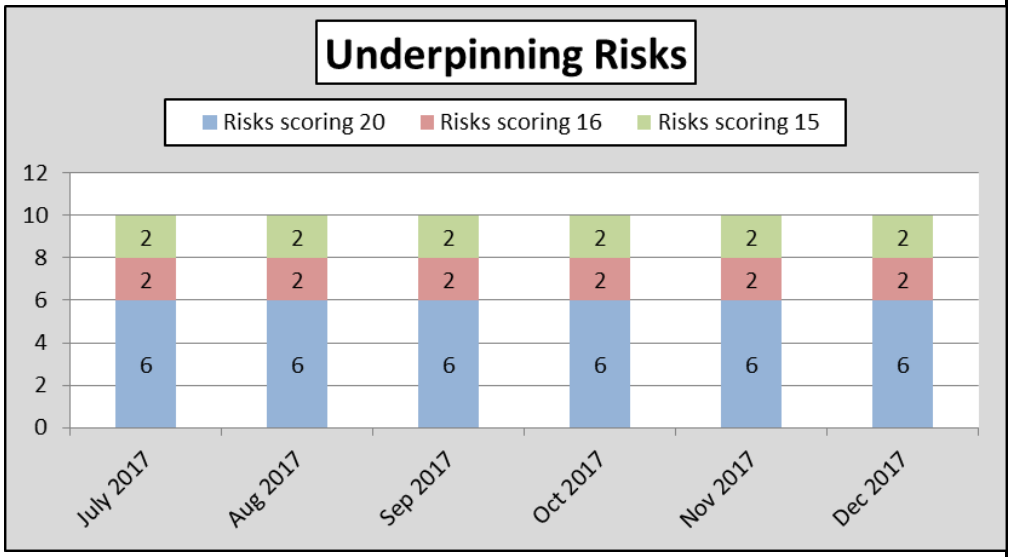
Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**

A comprehensive Patient Flow work stream has been created. It has five key projects underpinned by Internal Professional Standards: 1. **Front** - covering A&E, MAU and Short stay 2. **Middle** - covering Ward Processes 3. **Back** - covering Stranded Patients 4. **Bed Management** - covering our SOPs and Operational processes 5. **Frailty** - countywide frailty pathway at the Alexandra Hospital	**Front:** Compliance with the 4 hour ED standard - mandated nationally 90% by September, 95% by March 2018 All patients triaged in 15 minutes All patients seen by an ED doctor within an hour All patients seen by a Specialist Doctor within 1 hour of referral % of patients spending less than 24 hours in MAU % of Patients spending less than 72 hours in Short Stay **Middle:** Number of beds given to the Assessment Units by 10am Daily Senior Reviews completed by noon % of beds allocated within one hour of DTA EDS completed within one hour of decision to discharge 33% of discharges by noon Number of patients through the Discharge Lounge daily Empty beds in Assessment Units by noon **Back:** No patient waiting more than 24 hours for an assessment Discharge Planned on admission using EDDs (within 14 hours of Admission) 'Ticket Home' (drawn up by the Ward on the day of Admission to the Ward) Less than 20 patients waiting for external POCs, Community or Nursing/Residential Care beds **Bed Management** All SOPs and Bed Management policies reviewed and implemented by 9/17 Site Management and On Call system revisited and changes implemented by 8/17 Medical Bed numbers on the Worcester site reviewed and Demand clearly articulated by 8/17 **Frailty** Frailty pathway commenced on 16/10/2017

6. **System level Winter plan and escalation**	A&E delivery Board and A&E escalation meetings monitor progress against plans Local Health Economy wide Winter Control room to be in place from 01/11/2017
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Failure to adhere to internal professional standards, escalate and follow escalation policy Limited impact of whole system working Lack of out of hospital pathways	Ensure all internal processes are followed in line with internal policies. Continue to push system partners to develop strategies to ensure patients receive care in the right place at the right time. Ensure implementation of Winter plan initiatives within the set timescales.

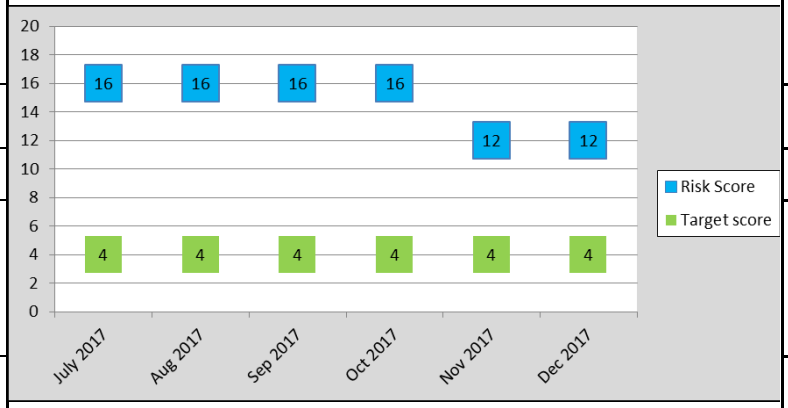
Related High Risks (>14 and DATIX ID)

2148	**Corporate Risk Register:** Patients may be harmed following a delay in diagnosis due to lack of appointment capacity within Endoscopy	20
2709	**Corporate Risk Register**: Risk of delayed admission to critical care from full unit	16
2790	As a result of high occupancy levels, patient care may be compromised (previous BAF risk incorporated into R2)	20
2981	**Medicine Risk Register:** Capacity	20
3289	**Corporate Risk Register:** Risk that patient safety may be compromised as Trust will be unable to meet contracted activity (RTT) within Gynaecology service	20
3331	**Surgical Risk Register:** There are high levels of patients that are not in the right specialty bed. Leading to delay in specialty review.	15
3482	**Corporate Risk Register:** There is a risk that patient safety, effectiveness and management may be compromised in ED.	20
2299	**Corporate Risk Register:** Patients not receiving follow-ups within clinically stipulated timescale, may result in loss of vision	15
3361	**Medicine Risk Register:** SIAN area -ED WRH	20
3483	**Corporate Risk Register:** Patients may be harmed due to delays in treatment/waiting times	16



Risk Description	**Principal Risk:** Failure to invest and realise the full potential of our staff to provide compassionate and personalised care					**Risk ID**	R3.1
Risk Details	If we do not have in place a suitably qualified and experienced leadership team (across sub board levels including Divisional and Directorate) then we may fail to deliver the required improvements at pace with the potential for further deterioration in patient care & experience & escalated regulatory enforcement actions						
Executive lead	**Chief Executive Officer**	**Last Reviewed**	**December 2017**	**Target Date**	**April 2018**	**Review Group**	**P&C/TLG**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	1	2	**3**	4			5

Risk Rating: Likelihood x Severity		
Initial Risk Score	16	
Current Risk Score	12	
Target Risk Score	4	
Risk Appetite	High	
Direction of travel	↓	



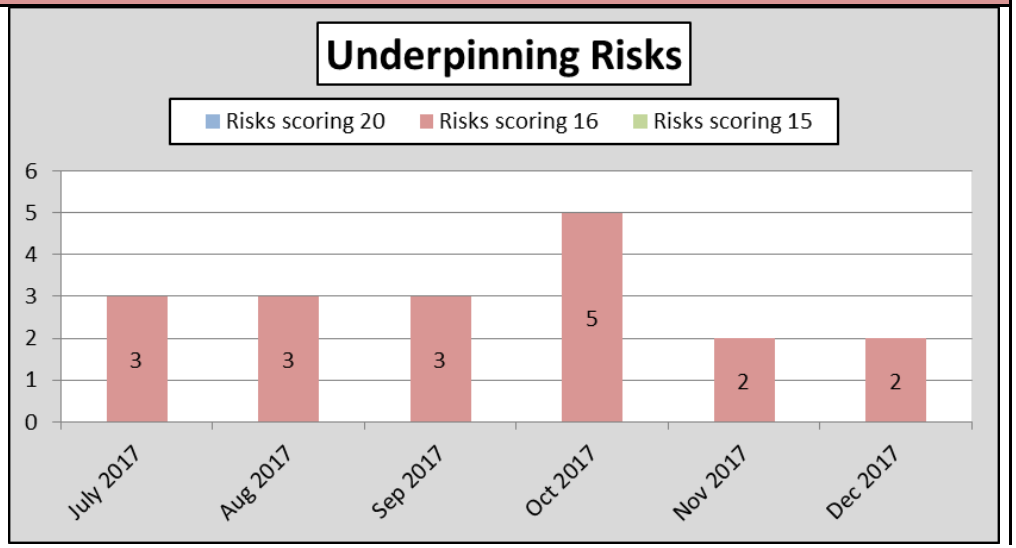
Relevant Key Performance Indicators		
Metric	**Trust compliance November 2017**	**Target**
CQC well led domain rating	Inadequate	Requires Improvement
Fit and Proper Persons Test is completed for all of the leadership team	100%	100%
Vacancies	7.83%	Vacancy rate of 8% or lower
Mandatory Training	88.90%	>90%
Pulse	Baseline N/A	Net Leadership score of 50% for EP2 Net Culture score of 45% for CP1
% of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	89.97%	85%

Rationale for current score
The Trust has only recently appointed substantively to the majority of its Executive Director positions and a number of the NEDs are new in post. In addition there are significant gaps in capability within the current divisional leadership teams.

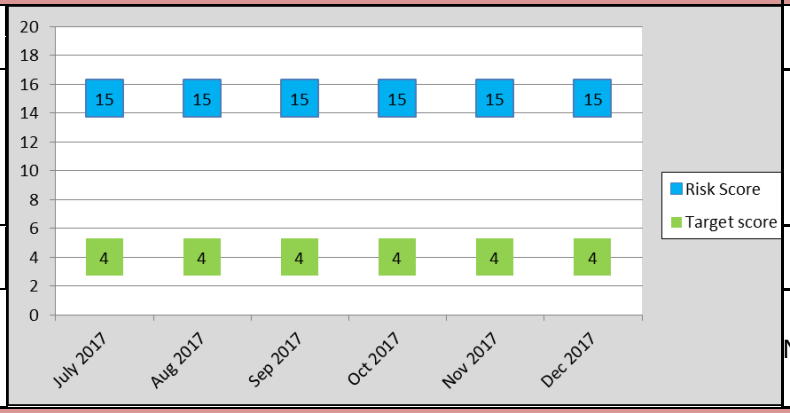
Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Executive Team appointed NEDs appointed. Board development Programme Culture Change programme (Pulse) including one-on-one coaching for TLG and Board Trust Leadership Group	Accountability Framework in development Staff survey results FFT CQC rating on Well Led domain Appraisal and mandatory training KPI's Net Leadership score Net culture score Board workforce sub-committee
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Recruitment plan not fully embedded. Lack of overarching workforce strategy Lack of Trust wide Training needs analysis	Develop workforce strategy that addresses recruitment issues and has a clear OD element within it to address leadership gaps. Ensure Pulse culture change programme is fully supported.

Related High Risks (>14 and DATIX ID)

3485	**Corporate risk register**: There is a risk that the Trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
2711	Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	16



Risk Description	**Principal Risk:** Failure to invest and realise the full potential of our staff to provide compassionate and personalised care					**Risk ID**	R3.2
Risk Details	If we do not deliver a cultural change programme we may fail to attract and retain staff with the values and behaviours required to deliver the high quality care we aspire to.						
Executive lead	**Chief Executive Officer**	**Last Reviewed**	**December 2017**	**Target Date**	**Sept 2018**	**Review Group**	**P&C/TLG**
CQC Domain(s)	**Safe**	**Caring**	Responsive	**Effective**			**Well Led**
Corporate Objective(s)	1	2	**3**	4			5

Risk Rating: Likelihood x Severity		
Initial Risk Score	15	
Current Risk Score	15	
Target Risk Score	4	
Risk Appetite	Significant	
Direction of travel		

Relevant Key Performance Indicators		
Metric	**Trust compliance November 2017**	**Target**
Mandatory training compliance	88.90%	90%
Pulse Net leadership and culture scores	**No baseline available**	Net leaderships core for EP2- 50% Net culture score for CP1- 45%
Board leadership score		
National Staff Survey 2017		

Rationale for current score

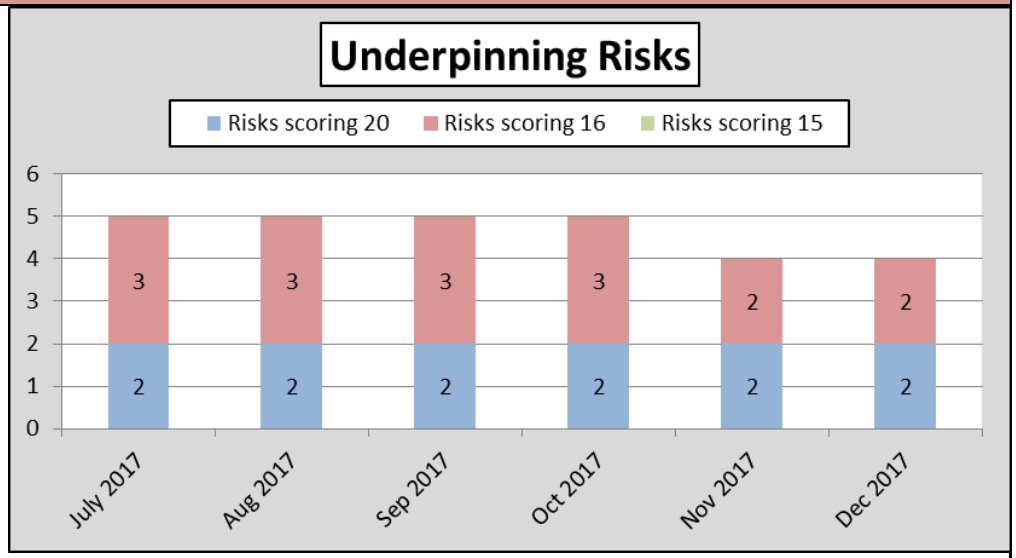
There are significant cultural and behavioural issues within the Trust that require action. The Trust has engaged external support to deliver a cultural change programme over the next three years.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Pulse Australasia appointed to deliver cultural change programme Culture Committee in place. Board development Programme Trust Leadership Group and Board one-on-one coaching	Accountability Framework in development Staff survey results Staff FFT CQC rating on Well Led domain

4ward programme	Appraisal and mandatory training KPI's Net Leadership scores Patient feedback, themes from complaints
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of overarching workforce strategy Pulse programme not fully rolled out	Develop workforce strategy that addresses recruitment issues and has a clear OD element within it to address leadership gaps. Deliver cultural change programme.

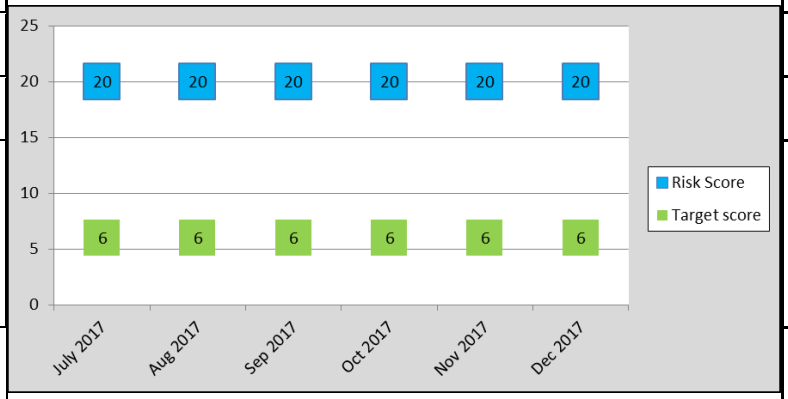
Related High Risks (>14 and DATIX ID)

2711	**Corporate Nursing Governance and Risk:** Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	16
2873	**Corporate Nursing Governance and Risk:** Staff do not complete appropriate Safeguarding Training, opportunities to identify patients at risk of harm will be missed	20
3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
2791	**Medicine Risk Register:** Inappropriate staffing levels	20



Risk Description	**Principal Risk:** .The Trust is unable to ensure financial viability and make the best use of resources for our patients.					**Risk ID**	R4.1
Risk Details	If we do not have in place effective organizational financial management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan leading to failure to deliver the control total, impact on cash flow and long term sustainability as a going concern.						
Executive lead	**Chief Finance Officer**	**Last Reviewed**	**December 2017**	**Target Date**	**March 2018 +1/4ly gateway checks**	**Review Group**	**FPC**
CQC Domain(s)	**Safe**	**Caring**		Responsive	**Effective**		**Well Led**
Corporate Objective(s)	1	2		3	**4**		**5**

Risk Rating: Likelihood x Severity	
Initial Risk Score	12
Current Risk Score	20
Target Risk Score	6
Risk Appetite	Moderate
Direction of travel	⟺



Relevant Key Performance Indicators

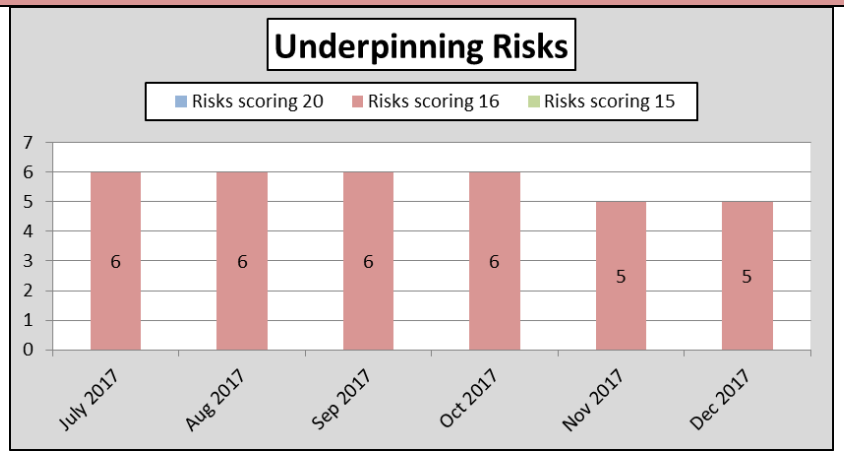
Metric	**Trust compliance September 2017**	**Target**
Compliance with monthly control total	Q1 Target achieved Q2 target missed	Per the financial plan
CIP delivery in Line with Plan	Not compliant at End of September	Per the financial plan
Operational Metrics linked to STF	Partially compliant at End of September	Per the agreed trajectories
Compliance with Capital Resource Limit (Forecast)	N/A	Per the financial plan
Carter productivity data through model hospital	Model Hospital key opportunity areas identified and being developed into action plans aligned to medium term financial plan	TBA
Better Payment practice Code	Performance deteriorated over Q2; further deterioration expected throughout remainder of 2017/18. Not compliant	95%

Rationale for current score
The Trust has robust monitoring of financial management in place reported through the monthly Performance meetings up to Finance and Performance Committee. There are risks to the control total due to the scale of improvement required within the Trust and the continued high use of temporary staff.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Finance and Performance Committee ensuring that risks are being acted on Financial Recovery Plans requested from each Budget Holder (Division & Corporate) to focus on: • Cost Control actions – Medical Staff, Job Planning, Additional Sessions & Agency control, Nurse roster management, Agency Cap, automated procurement system • Detailed budget analysis at directorate level (monthly) • Activity Data Quality, recording and coding Finance Training refreshed with all budget managers to ensure compliance with Trust procedures CIP programme integrated with Model Hospital and focus on key projects Monitoring performance against capital programme Daily Cashflow forecasting	Monitoring of development and performance against CIP targets Monthly finance reports with detailed analysis of performance v control total and actions identified in Financial Recovery plans Numbers of breaches of agency cap Weekly review of RTT remediation plans External review through NHSI, internal audit and benchmarking Better Payment Practice Code performance Capital spend variance to CRL
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
QIA process for CIPs not embedded Further use of resources of model hospital	Ensure QIA meetings in diary and process agreed. Ensure all CIP projects have completed QIAs

Related High Risks (>14 and DATIX ID)

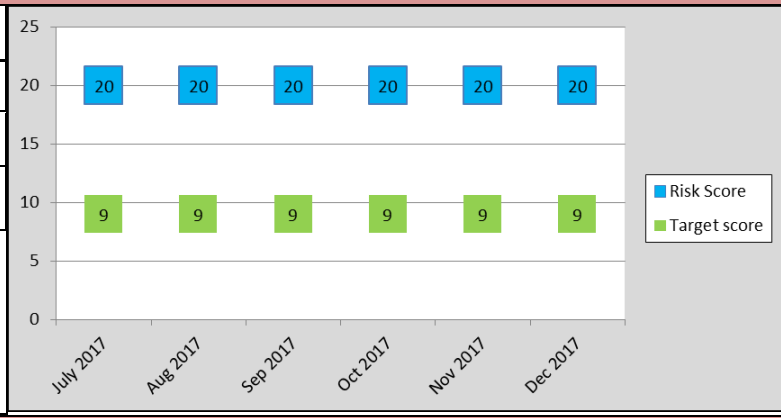
3481	**Corporate Risk Register:** Lack of capital resources prevents the Trust from transforming operations	16
3486	**Corporate Risk Register:** If the Trust does not achieve patient A&E Targets, there will be significant impact on finances	16
3487	**Corporate Risk Register:** There is a risk that there will be insufficient funding available to open 2 extra wards this winter 2017/18	16
2744	**Corporate Risk Register:** There is a risk that the CR units could fail. This could be catastrophic for plain film service delivery to the Alexandra site	16
2856	**Corporate Risk Register:** Lack of Investment Leading to Failure of Essential Plant and Machinery Causing interruptions in Patient Care or Personal Injury	16



Worcestershire NHS
Acute Hospitals NHS Trust

Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.					**Risk ID**	R4.2
Risk Details	If we do not resource our clinical staff rotas at ward/departmental level then we will not meet patient needs consistently with the potential for reduced quality & co-ordination of care provision, negative impact on patient flow & access targets: long term impact on substantive staff resilience; appropriate deployment of staff and poor retention of staff & inability to attract staff.						
Executive lead	**Chief Executive Officer**	**Last Reviewed**	**December 2017**	**Target Date**	**April 2018**	**Review Group**	**F&P**
CQC Domain(s)	Safe	**Caring**		**Responsive**		**Effective**	**Well Led**
Corporate Objective(s)	1	2		3		**4**	5

Risk Rating: Likelihood x Severity	
Initial Risk Score	20
Current Risk Score	20
Target Risk Score	9
Risk Appetite	Moderate
Direction of travel	⟺



Relevant Key Performance Indicators

Metric	**Trust compliance November 2017**	**Target**
Vacancies	7.83%	8% or less
Turnover rate	11.16%	10<>12%
NHSP - Agency Fill Rate	26.72%	n/a
Safer staffing	96.2% (day) 103% (night)	95%
Agency Staff - Medics (WTE) Indicative	118	<=85

Rationale for current score

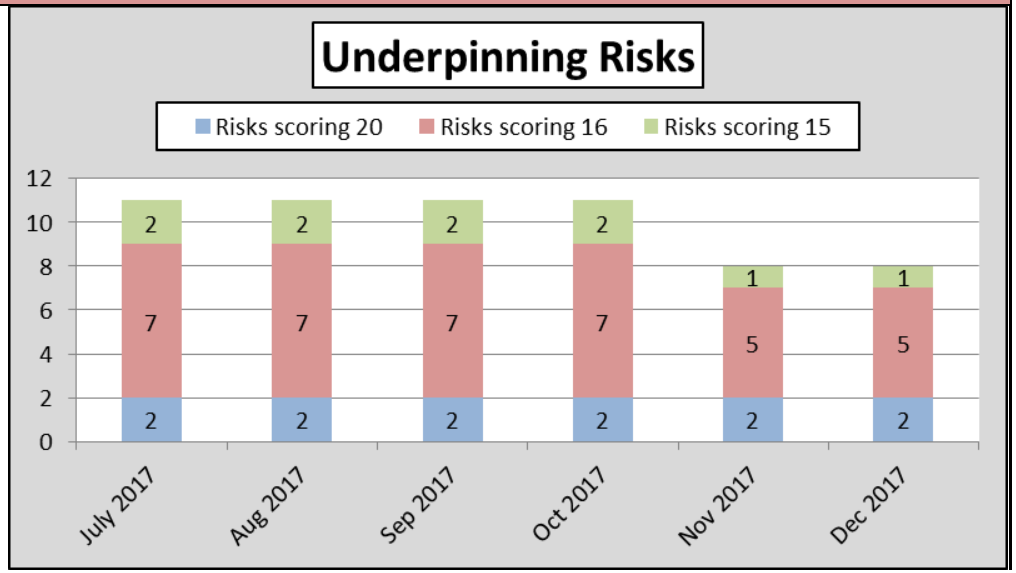
The Trust lacks a comprehensive workforce strategy and does not have robust recruitment plans embedded for the levels of vacancies that currently exist. The Trust is in Special Measures so will struggle to attract and retain staff.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Prospective staff rotas Recruitment plan developed but not yet embedded. Use of temporary staff to cover vacancies where possible. Vacancy rates monitored through Performance and Accountability meetings	HR workforce reports Agency use/ shift fill rate. Performance against recruitment trajectory Staff survey

Business cases agreed for new Consultant posts being recruited to.	FFT Recruitment KPIs Turnover rate Board workforce sub-committee
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of workforce strategy and robust recruitment and retention plan.	Develop a workforce strategy

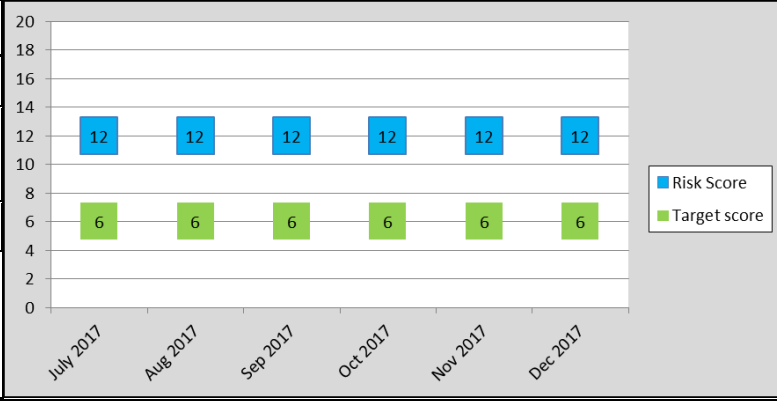
Related High Risks (>14 and DATIX ID)

2711	**Corporate Nursing, Governance and Risk:** Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	16
2791	**Medicine Risk Register:** Inappropriate staffing levels	20
3170	**Medicine Risk Register:** Lack of seven day Consultant review in respiratory high care	15
3292	**Corporate Nursing, Governance and Risk:** Poor fill rate from our temporary staffing provider NHSP resulting in reduced staffing levels below the required and safe level.	16
3296	**Medicine Risk Register:** Gastroenterology cover at the Alexandra Hospital	16
3484	**Corporate Risk Register:** Potential sub optimal care in overflow wards due to staffing	16
3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
3505	**Human Resources Risk:** Inability to recruit Clinical Staff	20



Risk Description	**Principal Risk:** The Trust is unable to ensure financial viability and make the best use of resources for our patients.					**Risk ID**	R4.3
Risk Details	R4.3 If we do not have a workforce strategy that addresses organizational development, values and behaviours as well as workforce development and recruitment we will not be able to provide care that meets the needs of our patients; meets the internal workforce demands and fills our vacancies.						
Executive lead	**Chief Executive Officer**	**Last Reviewed**	**December 2017**	**Target Date**	**April 2018**	**Review Group**	**P&C**
CQC Domain(s)	Safe	**Caring**		**Responsive**	**Effective**		**Well Led**
Corporate Objective(s)	1	2		3	**4**		5

Risk Rating: Likelihood x Severity		
Initial Risk Score	12	
Current Risk Score	12	
Target Risk Score	6	
Risk Appetite	High	
Direction of travel	⟺	



Relevant Key Performance Indicators		
Metric	**Trust compliance November 2017**	**Target**
Vacancies	7.83%	8% or less
Turnover rate	11.16%	10<>12%
F&F Test (Q2 17/18) Re care & treatment Re place to work	Likely/extremely likely 60% 43%	70%
Pulse Net culture score	No baseline available	45% @CP1

Rationale for current score

The Trust lacks a comprehensive workforce strategy and does not have robust recruitment plans embedded for the levels of vacancies that currently exist. It also lacks a workforce development strategy that identifies new roles and plans to develop these. In addition the relationship with HEE, the West Midlands Academic Health Science Network and local Universities needs strengthening.

Controls: what are we currently doing about the risk?	**Assurances: how do we know if the things we are doing are having an impact?**
Prospective staff rotas Some recruitment plans in place. Use of temporary staff to cover vacancies where possible.	HR workforce reports Agency use/ shift fill rate. Performance against recruitment trajectory

Vacancy rates monitored through Performance and Accountability meetings Business cases agreed for new Consultant posts with recruitment underway. The Trust does have a small number of Physicians Assistants in place and a clinical lead identified to progress this work.	Staff survey FFT Recruitment KPIs Turnover rate Board workforce sub-committee
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of workforce strategy and embedded recruitment and retention plan. Weak relationships with HEE and local Universities	Develop a workforce strategy Strengthen links with HEE and local Universities. Set trajectories for developing new roles

Related High Risks (>14 and DATIX ID)

2711	**Corporate Nursing, Governance and Risk:** Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.	16
2791	**Medicine Risk Register:** Inappropriate staffing levels	20
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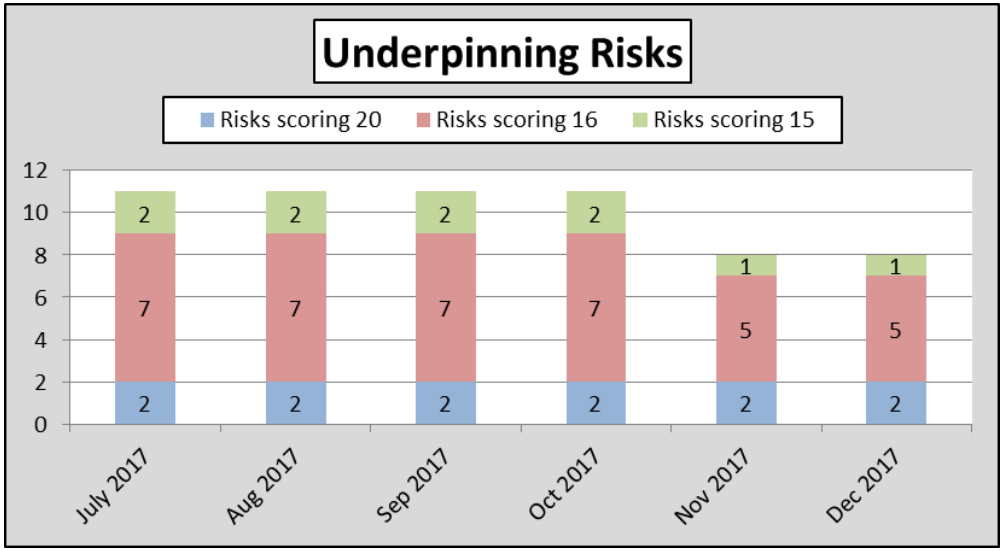
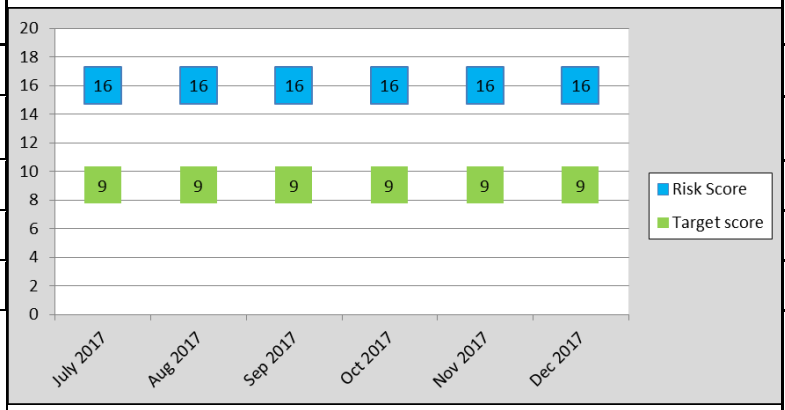


Risk Description	**Principal Risk:** The Trust is unable to develop and deliver a long term sustainable clinical services strategy					**Risk ID**	R5
Risk Details	If we are unable to secure the support of our community and STP stakeholders for the clinical services strategy, we may not be able to make the changes required to ensure long term viability of services						
Executive lead	**Director of Strategy and Planning**	**Last Reviewed**	**December 2017**	**Target Date**	**3 years**	**Review Group**	**TLG**
CQC Domain(s)	Safe	**Caring**		**Responsive**		**Effective**	**Well Led**
Corporate Objective(s)	1	2		3	4		**5**

Risk Rating: Likelihood x Severity	
Initial Risk Score	16
Current Risk Score	16
Target Risk Score	9
Risk Appetite	High
Direction of travel	⟺



Relevant Key Performance Indicators		
Metric	**Trust compliance June 2017**	**Target**
Medical vacancy rate	TBC	TBC
Clinical staff turnover	11.23%	TBC
Board Approved Clinical Strategy	TBC	Approved Strategy
Trust financial breakeven	TBC	TBC
Safer staffing fill rate	TBC	TBC
Agency spend	TBC	TBC

Rationale for current score

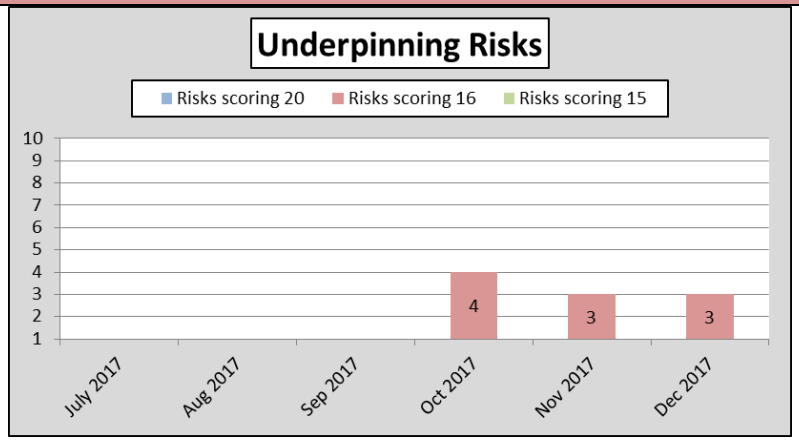
The Trust has recently completed the FoAHSW programme but the impact on the clinical and financial viability of services has been confined to a small number of Trust specialties. As a three site Trust with a significant underlying financial deficit and ongoing recruitment challenges there is the need for a more far reaching, more radical strategy for Trust sites and services. Currently the STP plans are underdeveloped and those which have greater traction are acute services focused with robust Trust leadership and are plans that support greater financial and clinical sustainability of acute services through new countywide service models, repatriation of out of county activity and stronger clinical networks. There is a risk that as NHSE resources are aligned with STPs the pace of change will increase and the Trust needs to have a clear

clinical services strategy for inclusion in the STP that it can use STP mechanisms and processes to support and drive. There is a risk from competing priorities for clinical leadership capacity to develop the strategy.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
• The Trust is engaged in the STP at Partnership Board level and at Delivery Board level and is leading three of the key STP work streams. • The Trust has convened a Clinical Council reporting to the Strategy Group for the purpose of 1. Overseeing full implementation of the FoAHSW model 2. Sponsoring and overseeing the development of the Trust clinical service strategy and 3. Overseeing the sustainability of clinical services at the Trust reporting into the quarterly system – wide Quality and Sustainability Group • The Council will review the recommendations from the Herefordshire and Worcestershire STP Clinical Reference Group and ensure alignment with the Trust's strategic clinical service priorities.	Improvement in the clinical and financial sustainability of Trust services and the financial sustainability of the Trust overall. 4ward programme
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
The Trust needs to elicit greater confidence in its ability to improve performance and delivery in terms of operational and quality improvement. The Trust needs a greater level of engagement with/from clinical leaders at all levels.	Develop robust quality, operational and financial improvement plans and increase our level of ambition in terms of clinical service redesign. Use the Pulse programme as a vehicle for improving clinical engagement in Trust plans and strategies.

Related High Risks (>14 and DATIX ID)

3485	**Corporate Risk Register:** There is a risk that the trust is unable to deliver safe and effective care due to medical and nursing vacancies	16
3481	**Corporate Risk Register:** Lack of capital resources prevents the Trust from transforming operations	16
3483	**Corporate Risk Register:** Patients may be harmed due to delays in treatment/waiting times	16



NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	16 January 2018
Paper number	H2

Audit and Assurance Committee report

For approval:		For assurance:	x	To note:	

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

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

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance		Quality of Care	
Finance and use of resources	x	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Not applicable		

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

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Limited	√	
	None		
	Not applicable		

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	16 January 2018
Paper number	H2

Executive Summary

I should first like to thank Bryan McGinity for chairing the Committee until his term of office ended last month.

The Committee at its meeting on the 30 November, discussed the following items:

- **Review of Finance and Performance Committee**: The Committee Chair presented his annual review of the F&P Committee. It was agreed that the Committee was functioning well with no problems in relation to attendance. Concern was raised by the length of reports being presented. It was explained that a process was being developed for shortened reports.
- **External audit progress report**: The financial statements audit is about to commence. It was agreed to send to all Board members the update on national documents.
- **Internal audit progress report**: Progress is slightly behind plan due to the late agreement of the plan.
  - Members were disappointed at the lack of attendance by senior officers to present internal audit reports. This will be rectified at the meeting in January but it meant that we were unable to ascertain progress against the data quality referral to treatment audit and the delayed discharged report. The data quality report received moderate assurance and the delayed discharges limited assurance.
  - Temporary staffing follow up: Moderate assurance was given. This audit was undertaken in February 2017.
- A revised process was outlined for the receipt of audit reports within the Trust. All reports will be presented to the TLG and this will ensure that recommendations are embedded within the Trust.
- I will be discussing with the Head of Internal Audit the development of the audit plan for 2017/18 and will be able to report back on this in my next report.
- **Board Assurance Framework**: A revised process for managing the BAF was discussed with the Interim Director of Governance. This item is on the Board agenda.
- **Tender waivers**: The regular six monthly report was given by the Head of Procurement. A review of the process will be undertaken in 2018.
- **Annual Governance Statement**: The significant issues were approved as a midyear statement.
- Other items presented:
  - Debt write off
  - Anti fraud update
  - Work plan

Background

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

Issues and options

There was considerable discussion about the BAF at the Committee and this is an agenda item on the Trust Board agenda.

Recommendations

The Trust Board is requested to note the report for assurance

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	16 January 2018
Paper number	H3

Remuneration Committee - Workplan

For approval:		For assurance:		To note:	x

Accountable Director	Caragh Merrick, Chairman		
Presented by	Caragh Merrick, Chairman	**Author**	Kimara Sharpe Company Secretary

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

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability	x	Operational Performance		Quality of Care	
Finance and use of resources	x	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Remuneration Committee	December 2017 (email)	Approved

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

Level of assurance and trend				
		√	↑ ↓ →	
	Significant			
	Limited			
	None			
	Not applicable	√		

Recommendations	The Board is requested to note the workplan.

NHS
Worcestershire
Acute Hospitals
NHS Trust

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Remuneration Committee
Work plan
2018

Chairman: Caragh Merrick
Members: Steve Williams
Mark Yates
Michelle McKay (except when considering her own remuneration)

In attendance Tina Ricketts (Director of People and Culture)
Kimara Sharpe, Company Secretary

The Remuneration Committee meets formally twice a year. There maybe other occasions when a meeting is required and this will either be electronic or face to face.

April/May 2018
The agenda for this meeting will include the following:

- Directors' performance against objectives and assessment in respect of any bonus payment
- CEO performance against objectives and assessment in respect of any bonus payment
- Consideration of any pay rise for posts outside Agenda for Change terms and conditions (this item is dependent on the AfC pay rise being notified to the Trust)
- Succession plan
    - Board directors
    - Senior leaders
- Talent management plan

August/September
The agenda for this meeting will include the following:

- Consultant excellence awards

Kimara Sharpe
Company Secretary