Trust Board
There will be a meeting of the Trust Board on Tuesday 8 May 2018 at 09:30 in the **Crompton Rooms A&B, Charles Hastings Education Centre, Worcestershire Royal Hospital**.

This meeting will be followed by a 15 minute public question and answer session.

Mark Yates
Acting Chairman

Agenda		Enclosure
1	**Welcome and apologies for absence**	
2	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*	
3	**Declarations of Interest** *To* receive the update Board's Declaration of Interests and note that *these are available for the public on the Trust website*	**Enc A**
4	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **15 March 2018** as a true and accurate record of discussions.*	**Enc B**
5	**Action Log**	**Enc B1**
6	**Acting** Chairman's **Report**	**Enc C1**
7	Chief Executive's Report	**Enc C2**
8	**Freedom to Speak Up Guardian - presentation** Bryan McGinity	**Enc C3**
9	**Quality of Care**	
9.1	**Integrated Quality & Safety Report *including the Integrated Performance Report*** Chief Nurse/Chief Medical Officer	**Enc D1**
9.2	**Quality Governance Committee Assurance report** Quality Governance Committee Chairman	**Enc D3**

10	**Finance and Use of Resources/Operational Performance**	
10.1	**Financial Performance Report** Chief Finance Officer	**Enc E1**
10.2	**Operational Plan** Director of Planning and Development	**Enc E2**
10.3	**Operational Performance Report *including the Integrated Performance Report*** Interim Chief Operating Officer	**Enc E3**
10.4	**Finance and Performance Committee Assurance Report** Finance and Performance Committee Chairman	**Enc E4**
11	**Leadership and Improvement Capability**	
11.1	**People and Culture report *including the Integrated Performance Report*** Director of People and Culture	**Enc F1**
11.2	**Gender Pay Gap** Director of People and Culture	**Enc F2**
11.3	**Safer Staffing** Chief Nurse	**Enc F3**
11.4	**People and Culture Committee Assurance Report** Acting Chairman	**Enc F4**
12	**Governance**	
12.1	**Board Assurance Framework** Chief Executive	**Enc G1**
12.2	**Cyber security assurance** Chief Finance Officer	**Enc G2**
12.3	**Compliance statements** Chief Executive	**Enc G3**

Any Other Business *as previously notified*

Date of Next Meeting

*The next public Trust Board meeting will be held on 7 June at Worcestershire Cricket Club. The July public board meeting will be held **in the afternoon of** Tuesday 10 July 2018, Education Centre, Kidderminster Hospital and Treatment Centre. This meeting will be followed by the Trust Annual General Meeting.*

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	A

Declarations of Interest

For approval:		For assurance:		To note:	x

Accountable Director	Mark Yates Acting Chairman		
Presented by	Mark Yates Acting 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	
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	x	Operational Performance		Quality of Care	x
Finance and use of resources		Strategic Change		Stakeholders	x

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?*	N	BAF number(s)	All

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is recommended to note the declarations of interest for Board members.

Worcestershire Acute Hospitals NHS Trust

Enclosure A

TRUST BOARD OF DIRECTORS' REGISTER OF INTERESTS 2018/19

Name	Designation	Declared Interest
Mark Yates	Non-Executive Director Acting Chairman *from 1 May 2018*	• Director and Joint Owner of MJY Consulting Ltd.
Michelle McKay	Chief Executive	• None
Richard Haynes	Director of Communications	• Rock House Communications Ltd – Director
Suneil Kapadia	Chief Medical Officer	• Sanofi-Pasteur • Member of the independent drug monitoring committee
Philip Mayhew	Non-Executive Director	• Associate Director – Koru Consulting Limited • Director of Midlands School of Social Entrepreneurs • Director of the Institute for Continuous Improvement in Public Services • Member of Loughborough University's School of Service Operations Management Advisory Board • Chair of Colebridge Trust and Colebridge Enterprises
Vicky Morris	Chief Nursing officer	• None
Richard Oosterom	Associate NED	• MyMed Ltd (company number 09768044), 2.5% shareholding
Tina Ricketts	Director of People and Culture	• None
Jill Robinson	Director of Finance	• None
Inese Robotham	Interim Chief Operating Officer	• None
Kimara Sharpe	Company Secretary	• Secretary – Princess of Wales Hospital League of Friends • Examiner, Advanced Healthcare Governance Module, Institute of Chartered Secretaries and Administrators

Worcestershire Acute Hospitals NHS Trust

Enclosure A

Name	Designation	Declared Interest
Sarah Smith	Director of Planning and Development	• None
Bill Tunnicliffe	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).
Steve Williams	Non-Executive Director	• Governor, Warwickshire College Group; • Director, Unity Ltd

Caragh Merrick	Chairman *until 30 April 2018*	• University of Birmingham
		  ○ Member of Council
		  ○ Honorary Treasurer
		• Royal College of Art
		  ○ Member of Council
		  ○ Deputy Chair of Council
		  ○ Honorary Treasurer

Chris Swan	Non-Executive Director *until 30 April 2018*	• Cobalt Development Ltd

Kimara Sharpe
Company Secretary
May 2018

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON

THURSDAY 15 MARCH 2018 AT 09:30 hours, MDT Meeting Room, Ground Floor, King's Court, WRH

Present:

Chairman:	Caragh Merrick	Chairman
Board members: (voting)	Michelle McKay	Chief Executive
	Suneil Kapadia	Chief Medical Officer
	Inese Robotham	Interim Chief Operating Officer
	Jill Robinson	Director of Finance
	Vicky Morris	Chief Nursing Officer
	Chris Swan	Non-Executive Director
	Bill Tunnicliffe	Non-Executive Director
	Steve Williams	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications
	Richard Oosterom	Associate Non-Executive Director
	Tina Ricketts	Director of People and Culture
	Sarah Smith	Director of Planning and Development
In attendance:	Martin Wood	Deputy Company Secretary
	Cathy Geddes	NHSI Improvement
Public Gallery:	Press	0
	Public	8
Apologies:	Philip Mayhew	Non-Executive Director
	Kimara Sharpe	Company Secretary

137/17 **WELCOME**

Mrs Merrick welcomed members of the public to the meeting and explained that an opportunity for questions would be given at the end of the meeting.

She explained that there was no patient story this month and the Board would be considering the Quality Improvement Strategy with the associated Patient, Carer and Community Plan.

138/17 **ANY OTHER BUSINESS**

There were no items of any other business.

139/17 **DECLARATIONS OF INTERESTS**

The Board noted the additional declaration of interests from Kimara Sharpe:
Examiner, Advanced Healthcare Governance Module, Institute of Chartered Secretaries and Administrators (from March 2018)

There were no additional declarations of interests.

140/17 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 16 JANUARY 2018**

RESOLVED that:-

- The Minutes of the public meeting held on 16 January 2018 be confirmed as a correct record and be signed by the Chair subject to the correction of a typographical error on page 9 which did not affect the accuracy of the minutes.

141/17/1 **MATTERS ARISING/ACTION SCHEDULE**

123/17/1 Mrs Morris said that the metrics for safety walkabouts had been allocated to Divisional Medical Directors and discussions had been held with AHPs about their involvement in these walkabouts. It was not appropriate for Estates to be involved in these walkabouts. They are, however, involved in the PLACE audits. Mrs Morris referenced the Non-Executive director visits and suggested that the Hub should be involved in the outcomes from these visits. This was agreed.

142/17 **Chairman's Report**

Mrs Merrick presented her report. She said that it was important for staff to speak to any Board member and to this end and to enhance the work of the Freedom to Speak Up Guardian she was recommending that Steve Williams be appointed as Freedom to Speak Up NED lead.

Dr Kadapia said that he was the Executive lead for research and development and Medical Education and these roles should be added to the list of Board member responsibilities. A NED lead will also need to be appointed.

ACTION – Mrs Merrick to recommend the appointment of a NED lead for research and development and medical education.

Company Secretary to prove update list of Board responsibilities to the next meeting.

Mrs Merrick also mentioned that Board Development is a dynamic programme and the Session on 10 April 2018 will be an all-day event on strategy and the risks and opportunities for delivering acute services. In May the Board Assurance Framework will be revisited. She invited suggestions for topics for the remainder of the year.

RESOLVED that:-

- The appointment of Steve Williams as NED Lead for Freedom to Speak Up be endorsed.
- The Board level responsibilities be noted.
- The Board development programme be noted.

143/17 **Chief Executive's Report**

Mrs McKay outlined the work being undertaken in respect of the Board's three priorities. In relation to patient flow, she expressed her appreciation for the heroic staff efforts during the recent challenging periods. She will consider how these efforts can be recognised when the challenges subside. The Trust had delivered the month 11 target in the Financial Recovery Plan. On cancer, the Trust has been successful in recruiting a Cancer Services Manager.

Simon Trickett's appointment as Accountable Officer for the Herefordshire and

Worcestershire CCGs will help in progressing integrated care across the STP. There has been learning for the Trust following a recent Coroner's Inquest. The outcome of a recent court case was noted and that the Coroner has timetabled the outstanding inquests. Construction work on the link bridge joining the main Worcester site with Aconbury East is to start in April 2018 and is likely to take six months to complete. She commended the work of Dr Elma Wong who helped save civilians injured in the Yemen civil war. The joint planning guidance will be considered as part of developing the Board's strategy. Dr Simon Eccles has been appointed as the new Chief Clinical Information Officer for Health and Care.

Mr Swan expressed concern over the very limited capital monies for the Trust. Mrs McKay said that this concern was shared by the Finance and Performance Committee. Ms Robinson added that the Trust's application for a capital loan of £16m was not approved. However, an application for £5m was subsequently approved. The capital programme is being reprioritised. This is a significant issue for capital equipment and impacts on the income and expenditure position. Dr Tunnicliffe commented that the development of the Trust's strategy provides an opportunity to consider an Electronic Records System whilst having a cost will provide benefits in the longer term. Mrs McKay said that this was being considered by the Trust's Leadership Group. Mr Oosterom said that this is a significant issue and affects the Trust's ability to move forward particularly with regard to system transformation.

Resolved that:-

- The Board received the report for noting.

144/17 **Integrated Performance Report**

Mrs Merrick introduced the Integrated Performance Report providing an update on the Trust's operational and quality of care performance in January 2018 against the priority metrics that form part of the Single Oversight Framework (SOF). She stated that it is important for the Board to note the comments made particularly the improvements in the last quarter.

Mrs Morris drew attention to the dashboard stating that as of the date of the meeting there are no overdue Serious Incidents. The Quality Governance Committee is focusing on falls performance. VTE performance in January 2018 is 92% with the drive to achieve 95%. The timeliness of complaint responses is not achieving trajectory or the agreed standard of 80%. An action plan has been prepared and complaint management remains a focus for Divisional Governance teams. However, efforts are being made to reduce the number of formal complaints by contacting people sooner to resolve issues of concern.

Resolved that:
The Board

- Received the Summary Integrated Performance Report for Month 10.
- Sought assurance that the risks of under-performance in each area have been suitably mitigated and robust plans are in place to improve performance.

145/17 **QUALITY OF CARE**

145/17/1 **Quality Report**

Mrs Morris presented the Quality Report. She said that it is important for the Board to note that through the Clinical Governance Group, Divisions are recognising collective risks which they have discussed and recorded in their Divisional Risk Registers together with mitigating actions. These include the risks and mitigating actions in relation to the use of surge areas opened over and above the winter plan.

Mr Williams said that it is important that the Trust has strategies in place to address the issues which it is facing particularly around capacity and patient flow rather than reacting to challenges.

Dr Tunnicliffe congratulated Mrs Morris and her team for their hard work and for providing the highest level of safety possible. Nonetheless he said that it is imperative for strategies to be prepared to move away from "fire fighting". Staff have raised serious concerns over the level of care provided and are working under considerable pressure. This situation cannot be allowed to continue. Mr Yates said that adding processes to justify what is already known adds pressure for staff. Mrs McKay confirmed that there are high levels of stress and tiredness amongst staff both within the Trust as well as partners in particular during the last six challenging weeks. She referenced the Carnall Farrar report which identified that the level of stranded patients is below the national average, there is a reduced level of self-referrals, particularly on the Worcester site and relatively strong levels of primary care throughout the County. There have been high levels of unwell patients who are not able to be discharged. The root causes are capacity on the Worcester site which is being addressed in the Acute Service Review. It is essential that there is a move to different models of care with less reliance on a bed base.

Resolved that:-
The Board:-

- Considered the updates provided by the Chief Medical Officer and Chief Nursing Officer on relation to quality and the key actions required to improve the levels of assurance.

145/17/2 **Learning from Deaths**

Dr Kapadia presented the report providing information relating to learning from mortality reviews and the pathways for dissemination of this learning. The Trust is currently reviewing over 75% of deaths for the quality of care delivered. Learning and changes in practice are beginning to emerge from the review process at speciality and corporate level. The Trust has developed a learning pathway to ensure lessons and practice changes are disseminated.

Dr Tunnicliffe offered his congratulations to Dr Kapadia for the process which is beginning to see outcomes. Mr Oosterom also welcomed the good progress being made.

Resolved that:-
The Board:

- Noted the rate of review of care in patients who have died
- Noted the learning and changes in practice
- Noted the proposed learning pathway for dissemination through the Trust

145/17/3 **Quality Governance Committee Report**

Dr Tunnicliffe presented his report. He said that the Committee is working more effectively and the quality of reports has also improved. There remain issues which are subject to the Committee's focus which is producing results. These areas include serious incidents, fractured neck of femur and complaints. There is a mature process for the learning from Never Events. Dr Tunnicliffe is looking at how Divisions can better interact with the Committee.

Dr Kapadia said that there are concerns about providing emergency surgical services

over two sites and from April 2018 there will be new ways of working which will lead to better care and patient flow. Dr Tim Graham has been appointed Honorary Medical Director to work with teams to take this work forward.

ACTION – Dr Kapadia to present a report to the next Trust Board meeting setting out the new surgery model.

Mrs Merrick said that the Trust should consider undertaking a review of the Medicine Division.

Dr Tunnicliffe expressed his appreciation to the work undertaken by Dr Kapadia in making improvements particularly with regard to the Theatre Utilisation Group.

Ms Smith said that Foureyes Insight is working with the Trust as part of the recovery plan. Mr Yates added that all areas of the Trust need to be sighted on the work being undertaken to improve performance.

In response to a question from Mr Swan, Ms Ricketts said that the span of control work will provide clearer leadership.

Post meeting – it was agreed that the surgical model would be presented to the QGC.

RESOLVED that:-
The Board:

- Noted the Committee received the final reports for the two never events, wrong site surgery and misplaced nasogastric tube
- Received the report for assurance.

146/17 **FINANCE AND USE OF RESOURCES/OPERATIONAL PERFORMANCE**

146/17/1 **Financial Performance Report**

Ms Robinson presented the financial performance report for month 10 stating that the Trust delivered the month 10 forecast deficit of £5.5m and recorded £0.5m on non-recurrent delivery against the £2m non recurrent element of the Financial Recovery Plan target. A revised forecast outturn of £57.9m deficit has been agreed with NHS Improvement. The Trust has also achieved the month 11 Financial Recovery Plan trajectory.

Mrs Merrick, on behalf of the Board, expressed her appreciation of all the work undertaken throughout the organisation to achieve this financial position. There is still the requirement to deliver the month 12 Financial Recovery Plan target. She stressed that the work on the Financial Recovery Plan is not being undertaken at the expense of other work.

Mrs Merrick asked Dr Kapadia and Mrs Morris if patient safety had been compromised during the recent financial challenges. In response, Dr Kapadia said patient safety issues have been kept to a minimum and there is no evidence that the financial position has impacted on patient safety. Mrs Morris said that the quality impact assessments will be a focus in 2018/19 to ensure a robust process is in place. Dr Tunnicliffe commended Dr Kapadia and Mrs Morris for the level of safety and patient experience provided.

Mr Swan asked about the impact on the Trust's financial position of the work being undertaken by Rob Cooper. In response, Ms Robinson said that Mr Cooper is critical to the Trust's financial recovery and his services are to be retained for the first quarter of

2018/19 to provide rigour in the confirm and challenge meetings so that momentum is not lost as was the case in the previous financial year.

Mr Swan asked as a result of the revised income and expenditure forecast to £57.9m, whether the Trust needs to increase its planned interim revenue support to maintain payments to suppliers and whether there are any supplier invoices outstanding. Ms Robinson said in response that there are no significant invoices outstanding this financial year. Cash resources are tight and decisions are not taken lightly regarding payments to suppliers. Interim revenue support has been approved by both NHS Improvement and the Department of Health and Social Care.

ACTION – Ms Robinson to ensure that the Finance and Performance Committee looks at the working capital facility to ensure equity to suppliers.

Mr Oosterom was pleased about the change of process to deliver outcomes taking into account risks and opportunities.

RESOLVED that:-
The Board:

- Noted the YTD financial position at the end of Month 10
- Noted the YTD Month 10 delivery to the revised forecast
- Noted the discussion of the detailed key risks to delivering the revised full year forecast of £57.9m at the Finance and Performance Committee and was assured that sufficient mitigation exists to deliver this financial position
- Noted that further cash support has been approved by both NHSI and DH through uncommitted term loans in line with the revised forecast outturn deficit of £57.9m
- Approved submission of documentation to draw down the £5m emergency capital loan (Q4 - £2.4m)

146/17/2 **Patient Flow**

Ms Robotham presented the report stating that the Winter Plan was implemented and has been delivering expected outcomes. There has been an unprecedented increase in emergency demand compared to last winter resulting in increased attendances, ambulance conveyances and emergency admissions. There has been some reduction in the number of patients spending time on the Emergency Departments corridor on the Worcester site up to February 2018. Both Emergency Departments remain severely overcrowded and both sites continue to operate at bed occupancy close to or above 100%. The Trust has been allocated additional improvement support by Carnall Farrar. Carnal Farrar have identified that additional acute capacity is required.

Ms Robotham said that there are particular challenges with the use of Endoscopy as a surge area. The Trust's Leadership Group earlier this month approved a proposal for the temporary relocation of one room of endoscopy activity to Theatre 7 at the Alex, for a period of two months. There are three patients waiting greater than 52 weeks. With regard to patient flow, some pathways were not fully utilised and the Assessment Units have not been able to move patients due to the need to find surge capacity areas. The Trust continues to work with partner organisations. It is important to maintain staff motivation, engagement and retention due to the challenges which they are experiencing.

Dr Tunnicliffe thanked Ms Robotham for the work which had demonstrated an improved performance compared to last year.

Mr Yates asked how staff were held to account for not delivering the Internal

Professional Standards (IPS). He also said that the pressures experienced at the front door are not felt elsewhere in the organisation. In response, Dr Kapadia said that it is not possible to identify with certainty the extent to which IPS are being adhered to. Clinicians attend bed meetings and audits have been undertaken of the wards to assess adherence. There are sick patients on wards and it is not appropriate for them to be discharged.

Mr Oosterom said that the Carnall Farrar report had made recommendations to address the root causes of patient flow. Mrs McKay explained that Carnall Farrar have been commissioned by NHS England and they will determine the next steps from their report. Recommendations have been made in ten areas and the Trust has agreed to focus initially on four, namely, ambulance handovers, speciality assessment, assessment unit utilisation and demand and capacity. Mrs Merrick said that lessons need to be learnt from the report and to help preparation of strategic and operational plans for next winter. Mrs McKay added that winter plans for next winter are required by the end of April 2018. Workforce issues are a particular challenge to having an alternative plan.

RESOLVED that:-

- The Board received for assurance the update on patient flow and the report from external support provided by Carnall Farrar to the Trust.

147/17/3 **Cancer Report**

Ms Robotham presented the update report on Cancer Waiting Times. She drew attention to the two week wait breast symptomatic standard which was achieved for three consecutive months (September – November 2017). There was a significant deterioration in January 2018 due to the failure of mammography equipment at the Alexandra Hospital. Performance was recovered in February 2018 at 89.2% (unvalidated). Performance for the two week wait for all remaining cancers had contracted overall. Performance against the 62 day standard remains challenging and it is clear that the standard will not be achieved until the current backlog of patients over 62 days is reduced further to below 50. The current backlog is 73 patients. The backlog in colorectal has reduced from 105 to 5 largely as a result if the personal intervention of the clinical lead. The backlog of urology patients has reduced. There are issues with lung cancer due to workforce and imaging issues.

Mr Swan asked for information when the cancer 62 day standard will be achieved. In response, Ms Robotham said that the NHS I Intensive Support team will be working with the Trust for six weeks from this month to focus on further improvement including operational management of the 62 day pathway. The number of patients is relatively small so improvements will be on a step change basis. The backlog will be further reduced in quarter 2. She stressed that all avenues have been explored for private organisations to help with reducing the backlog but they are not in a position to undertake all the work. The removal of endoscopy as an escalation area will help improve cancer performance.

Dr Tunnicliffe said that it is good that the Trust has been able to recruit an experienced Cancer Manager.

Mrs Morris added that the harm review process is an integral part of understanding cancer performance.

RESOLVED that:-
The Board:

- Received the update for assurance regarding current cancer performance, initiatives to improve performance and the external support provided to the Trust.

147/17/4 **Finance and Performance Committee Assurance Report**

Mr Williams, in the absence of the Chair, presented the report stating that all areas had already been considered in the meeting with the exception of the Medium Term Financial Plan which was being considered later.

RESOLVED that:-

The Board confirmed that it was assured that:

- The Trust continues to put actions in place to optimise operational performance
- The additional measures put in place to grip and maintain financial control are effective.
- A robust financial recovery plan is in place for 2017/18 and is being closely monitored by the Executive Team.
- The Trust is managing the Capital Programme to ensure the Capital Resource Limit is met.
- The Finance Team continues to actively pursue an outcome on the bids for capital loans.

The Board is also

- Approved the revised Terms of Reference
- Approved the recommendation that R4.2 of the BAF is re-assigned to the People & Culture Committee
- Approved the March Revenue Loan (Interim cash support)

148/17 **LEADERSHIP AND IMPROVEMENT CAPABILITY**

148/17/1 **People and Culture Report**

Ms Ricketts presented the report providing an overview of the effectiveness of the People and Culture Strategy. An implementation plan has been developed to support delivery of the Strategy and the People and Culture Committee have identified three priorities for improvement and requested that plans be developed by 31 March 2018 to ensure progress is made in leadership development, staff communication and engagement (with an initial focus on medical engagement) and apprenticeship levy plan for 2018/19. Other actions within the implementation plan have been intentionally weighted for the first nine months of 2018 to ensure good progress is made against the strategy. A span of control review will commence on quarter 1 of 2018/19 which will see a reduction in the number of management layers and where practicable the introduction of generic job titles and job descriptions to ensure consistency of roles and responsibilities.

Ms Ricketts said that the results of the second 4ward checkpoint showed a response rate of just below 45% compared to 26% for the first checkpoint.

Mr Oosterom referred to the span of control review stating that it is not good practice for the Trust to evaluate its own structures, benchmarking and direct and non direct patient activity as this may not address the root causes. Ms Ricketts said that the Model Hospital is being used as the benchmark for the review and she will present a report to the People and Culture Committee setting out the review methodology.

ACTION – Mrs Ricketts to report to the People and Culture Committee on the Model Hospital benchmark.

Mrs Merrick commented on the enormity of the workforce agenda. She invited Mr

Swan to arrange for the People and Culture Committee to consider whether support should be provided to the Director of People and Culture in this task.

ACTION – Mr Swan to take forward with the People and Culture Committee whether support is required for the Director of People and Culture.

Mrs Merrick suggested that the June Board Development session should consider a deep dive into People and Culture.

ACTION – Mrs Merrick to consider a deep dive into People and Culture as part of the Board Development Programme.

RESOLVED that:-

- The Board noted the report which is provided for assurance.

149/17/2 **Staff Survey 2017 - Results**

Mrs Ricketts presented the report setting out the results of the 2017 Staff Survey. The Trust remains in the bottom quartile for the staff survey results when compared to its peer group, but nonetheless, the findings confirm that the Trust has improved its results in two thirds of the questions. The Trust is in the top 20% of acute Trusts for staff reporting errors, near misses or incidents in the last month. Further work remains to improve performance particularly to improve personal development review (PDR) compliance and to ensure that colleagues have the confidence to raise concerns.

RESOLVED that:-

- The Board noted the results of the Staff Survey and that the People and Culture Committee will be discussing the results on detail on 19 March 2018.

149/17/3 **People and Culture Committee Assurance Report**

Mr Swan presented this report highlighting that staff engagement and empowerment remained a concern. The Committee is now to meet bi-monthly with membership amended to include the Chief Nursing Officer and Chief Medical Officer. Revised terms of reference were presented for approval.

RESOLVED that:-
The Board

- Approved the revised terms of reference
- Received the report for assurance

150/17 **GOVERNANCE**

150/17/1 **Integrated Performance Report - Review**

Mrs Merrick said that from the discussions the messages in the Integrated Performance Report are interlinked with the central theme of patient flow. She invited the Board to endorse the Report.

RESOLVED that the Board endorsed the Integrated Performance Report.

150/17/2 **Board Assurance Framework and Corporate Risk Register**

Mrs Merrick presented the Board Assurance Framework (BAF) report providing an update on the management of the principal risks and underpinning corporate and high level operational risks. The Assurance Committees have made recommendations for changes. A review has been undertaken of corporate and high level risks linked to the BAF risks and some changes were recommended. Directors have updated controls, assurance, gaps in controls and assurances and mitigating actions. The Risk

Management Group has approved changes to the Corporate Risk Register

Mrs Merrick said that the BAF is to be reviewed in the April/May Board Development Session to align more closely with the strategic objectives.

RESOLVED that:-

- The Board approved the BAF and Corporate and High Level Risk Register

150/17/3 **Standing Financial Instructions**

Ms Robinson presented the report seeking approval to the Standing Financial Instructions and the Scheme of Delegation. The documents had been circulated to a group of stakeholders for comment, including the Chair of the Audit and Assurance Committee.

Ms Ricketts identified that in Section 27 - *Delegated Matter – Personnel, Pay and expenses - Sick Leave - Return to work part-time on full pay to assist recovery; and Extension of sick leave on full pay* had contractual implications and as such the delegation should rest with the Director of People and Culture and not the Departmental Manager/Line Manager.

RESOLVED that:-

The Board:-

- Approved the Standing Financial Instructions and Scheme of Delegation, subject to the above amendment for implementation effective 1st April 2018.

150/17/4 **Audit and Assurance Committee Report**

Mr Williams presented the report stating that the items in the report had already been considered by the Board with the exception of the report on the risk assessment of clinical information systems: This risk assessment was initiated following the GP letters incident. The review focussed on seven main clinical systems. The Head of Internal Audit expressed concerned about the lack of viewing and action of abnormal test results and the IT performance of certain systems. It was noted that while there were some IT issues, a large component of the weaknesses raised was the lack of consistent use of the systems by Trust staff with some notable pockets of resistance.

Action: Mrs Merrick asked that Mr Williams arrange for the Audit and Assurance Committee to track progress with the recommendations in the risk assessment of clinical information systems.

RESOLVED that:-

- The Board noted the report for assurance.

151/17 **STRATEGIC CHANGE**

151/17/1 **Acute Services Strategy**

Ms Smith presented the report providing an update on current internal and external strategy work which has the potential to impact on acute services development in the County in the short to medium term. Acute services delivered by the Trust are subject to four existing or developing strategies. Firstly, the majority of service changes set out in the Future of Acute Hospital Services in Worcestershire Programme (FoAHSW) have been implemented. The remaining changes relating to surgery have been included in the Trust's new Clinical Services Strategy which is being developed The Clinical Services Strategy will be subject to wider engagement in March 2018. The further centralisation of services at the Worcestershire Royal site as part of the Future of Acute Hospital Services means that the Trust cannot delay the ASR capital project

with the most critical issue being access to additional inpatient bed capacity. Work on the link bridge is to start in April 2018 following a loan approval of £3m. The 2017/18 capital loan application will enable the reprioritisation of our internal capital programme to unlock funds for the ASR project within the project timelines. Carnall Farrar are supporting work to complete the Aconbury East refurbishment at the same time to provide additional capacity of four wards for next winter. This challenge is to access capital finding of £8m in advance of approval to the full business case. This Board considered this essential and all efforts would be undertaken to make representations for this to happen. Ms Smith was invited to prepare briefing slides for the NEDs.

ACTION – Ms Smith to prepare background slides for NEDs.

In April 2018 the Herefordshire and Worcestershire STP began an Acute Clinical Sustainability Strategy for Herefordshire and Worcestershire. A briefing document setting out the scope and approach to the work will be presented to a future Board meeting.

RESOLVED that:-
The Board

- Received the report for assurance.
- Authorised the Chief Executive to accept the loan of £3m.

151/17/2 **Quality Improvement Strategy and Associated Plans**

Mrs Morris presented the high level Quality Improvement Strategy (QIS) and more detailed associated plans which have been prepared with our patients, staff, public, stakeholder's and community.

ACTION – Mr Haynes to circulate to the Trust Board the video link to the QIS, to consider the benefit of promoting the QIS through video.

Dr Kapadia added that the QIS contains stretch targets and it linked to the Trust's signature behaviours.

Mrs Geddes asked about the extent if staff capability to deliver the strategy. In response, Mrs Morris said that there will be detailed capacity and capability plans to support the Strategy.

ACTION – Progress on how the Trust is delivering the Strategy to be included as a standing agenda item for each Board meeting. Mrs Morris to provide report.

(Dr Kapadia left the meeting)

On presenting the supporting plans, Mrs Morris said that the Patient, Carer and Community plan required an additional reference to antimicrobial stewardship as recommended by the Infection Control Committee.

RESOLVED that:-
The Board

- Approved the Quality Improvement Strategy and associated plans and delegated approval of the final objective trajectories to the Quality Governance Committee.

151/17/3 **Medium Term Financial Strategy**

Ms Robinson presented the report setting out the basis on which the first draft operating plan was submitted to NHS Improvement on 8 March 2018. There is an

operational risk of between £10m and £15m whilst the detailed operational plans are prepared. The four main areas of activity are patient flow, productivity/efficiency, span of control and estates utilisation.

Mrs Merrick said that it is important for the Trust to have a credible recovery plan with the capacity to deliver.

RESOLVED that:-
The Board:

- Noted progress developing detailed financial plans and budgets for 2018/19 and the submission on 8 March 2018 of the first draft operating plan in line with the direction agreed at the Board development day on 8 February 2018.
- Noted the current status of the Recovery Programme and the timetable for completion of the PIDs / QIAs
- Noted the 2 stage budget sign off process (pre and post CIP)

152/17 **STAKEHOLDERS**

152/17/1 **Statement of Commitment**

Mrs McKay presented the report.

The Five Year Forward View document outlined a vision of a more integrated health and social care system which provides holistic care to local people.

This statement outlines broad commitment to the principles and benefits of working together in a more integrated way. It does not intend to define or commit individual organisations to a future state as the detail of this is still unclear but offers the assurance from all organisations that they are committed to work in partnership moving forward. The Board considered an earlier version of this document at the Board Development Session in December 2017. The document has been updated to reflect the change of language to integrated care systems and amendments made by partner organisations over the last two months.

RESOLVED that:-
The Board:-

- Approved and endorsed the attached Statement of Commitment and that the Chief Executive be authorised to sign the statement.

152/17/2 **Communications and Engagement Update**

Mr Haynes presented his report which was the first of its kind to be shared with the current Trust Board with the purpose to summarise recent achievements and issues in the Trust's efforts to engage effectively with key internal and external stakeholders. In furtherance of our signature behaviour "Work Together, Celebrate Together" it highlighted a selection of positive stories from across the Trust. As part of our commitment to "Listen, Learn and Lead" it also provided illustrations of some of the challenges faced by our Trust in engaging effectively with our priority audiences and some of the actions that are being taken to address those challenges.

He invited feedback from Board members on the style of report.

RESOLVED that:-
The Board

- Noted content of the report.

153/17/3 **ANY OTHER BUSINESS**

There were no further items of business

DATE OF NEXT MEETING
The next Public Trust Board meeting will be held on Tuesday 8 May 2018 at 09:30 in the Crompton Room A and B, Charles Hastings Education Centre, Worcestershire Royal Hospital.

The meeting closed at 12.54 hours.

Signed _____ **Date** _____

Mark Yates, Acting Chairman

Enc B

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – MAY 2018

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
15-3-18	QGC Committee	145/17/3	Present a report to the next Trust Board meeting setting out the new surgery model	SK	May 2018		To be discussed at the QGC in June. Action closed.	
15-3-18	People and Culture Report	148/17/1	Consider a deep dive into People and Culture as part of the Board Development Programme	CM	June 2018		On board development list of topics. Action closed	
15-3-18	Acute Services Strategy	151/17/1	Prepare background slides for NEDs	SS	April 2018		Acton closed.	
15-3-18	Quality Improvement Strategy and Associated Plans	151/17/2	Progress on how the Trust is delivering the Strategy be included as a standing agenda item for each Board meeting.	VM	May 2018		Within the Quality Report	
09-11-17	Patient Story	91/17	Source a patient pathway story for presentation in May 2018	VM	May 2018		Will be picked up within the inpatient survey item on agenda. Action closed.	
15-3-18	Financial Performance Report	146/17/1	Ensure that the Finance and Performance Committee looks at the working capital facility to ensure equity to suppliers	JR			Transferred to F&P	

15-3-18	People and Culture Report	148/17/1	Report to the People and Culture Committee on the Model Hospital benchmark.	TR			Transferred to P&C	
15-3-18	People and Culture Report	148/17/1	Take forward with the People and Culture Committee whether support is required for the Director of People and Culture	CS			Being taken forward by the CEO. Action closed.	
15-3-18	Audit and Assurance Committee Report	150/17/4	Arrange for the Audit and Assurance Committee to track progress with the recommendations in the risk assessment of clinical information systems.	SW			Transferred to A&A	
15-3-18	Quality Improvement Strategy and Associated Plans	151/17/2	Circulate to the Trust Board the video link to the QIS, to consider the benefit of promoting the QIS through video	RH			Action Completed.	

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	C1

Acting Chairman's Report

For approval:	x	For assurance:		To note:	x

Accountable Director	Mark Yates Acting Chairman		
Presented by	Mark Yates Acting 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		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		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?*	N	BAF number(s)	

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Level of assurance and trend

Recommendations	The Board is requested to • Approve the board level responsibilities • Note the report

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	C1

Executive Summary

Since the last Board meeting, Caragh Merrick and Chris Swan have tendered their resignations to NHS Improvement. I should like to express the Board's thanks to both Caragh and Chris for their service on this Board. The whole Board would like to wish them the very best for their futures. I can assure you that NHS Improvement are currently working to replace both positions on the Board.

Board Committee – membership

I have revised the Committee membership and I recommend to the Board the approval of the following interim arrangements:

Audit and Assurance Committee
Chair – Steve Williams
Members – Phil Mayhew

People and Culture Committee
Chair – Mark Yates
Members – Richard Oosterom

Remuneration Committee
Chair – Mark Yates
Member – Steve Williams

Quality Governance Committee, Finance and Performance Committee – no changes

Board meetings –June/July 2018

I have arranged for the following meetings in June and July:

7 June – there will be a meeting of the Board in public which will be followed by the Board Away Day. The venue for the whole day is the Worcestershire County Cricket Club, Worcester.

10 July – the format of the day will be private board followed by public board and then the AGM. The venue is Kidderminster Education Centre.

The following table gives an up to date list of Board level responsibilities following on from the last board meeting held in March.

	Position	Exec lead	NED
1	Caldicott Guardian	Associate Medical Director Patient Safety, Steve Graystone. Graham James, Deputy CMO, will become the Guardian once he has attended the training.	N/A
2	Senior Information Risk Owner	Chief Finance Officer, Jill Robinson	N/A
3	Health & Safety	Director of People and Culture, Tina Ricketts	N/A
4	FOI Qualified	Chief Executive, Michelle McKay	N/A

	person		
5	Quality	Chief Nursing Officer, Vicky Morris	N/A
6	Director of Infection Prevention & Control	Chief Nursing Officer, Vicky Morris	N/A
7	Decontamination	Chief Finance Officer	N/A
8	Sustainability	Chief Finance Officer	N/A
9	Anti Fraud & Security	Chief Finance Officer, Jill Robinson	N/A
10	CQC Registered Manager	Chief Nursing Officer, Vicky Morris	N/A
11	Data Protection Officer	Company Secretary, Kimara Sharpe	N/A
12	Accountable Officer for Controlled Drugs	Chief Pharmacist, Rachel Montgomery	N/A
13	Responsible Officer	Chief Medical Officer, Suneil Kapadia	N/A
14	Medical Validation	Chief Medical Officer, Suneil Kapadia	N/A
15	Organ donation	Chief Medical Officer, Suneil Kapadia	N/A
16	Emergency Planning	Chief Operating Officer, Inese Robotham	Mark Yates
17	Freedom To Speak Up Guardian	Bryan McGinity	Steve Williams
18	Equality & Diversity lead	Tina Ricketts	Mark Yates
19	Learning from Deaths	Chief Medical Officer, Suneil Kapadia	Bill Tunnicliffe
20	Model Hospital	Chief Finance Officer, Jill Robinson	Phil Mayhew
21	R&D lead	Chief Medical Officer, Suneil Kapadia	Bill Tunnicliffe
22	Medical Education	Chief Medical Officer, Suneil Kapadia	Bill Tunnicliffe
23	Senior Independent NED	N/A	Mark Yates
24	End of Life NED lead	N/A	Steve Williams
25	Local Maternity Service NED lead	N/A	Mark Yates

Recommendations

The Board is requested to

- Approve the board level responsibilities
- Note the report

NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	8 May 2018
Paper number	C2

Chief Executive's report

For approval:		For assurance:		To note:	x

Accountable Director	Michelle McKay Chief Executive		
Presented by	Michelle McKay Chief Executive	**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	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	x	Quality of Care	x
Finance and use of resources	x	Strategic Change	x	Stakeholders	x

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?*	N	BAF number(s)	

Level of assurance and trend							
Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is requested to note this report.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	C2

Executive Summary

Resignation of Mrs Caragh Merrick, Chairman

Since the last meeting of the Board, Mrs Merrick has resigned her position as Chairman effective from 30 April 2018. On behalf of the board and staff across our hospitals, I would like to thank Caragh for her inspiring leadership and her passion and commitment to local hospital services and the wider community of Worcestershire. I would also like to thank her personally for the support she has given me since I joined the Trust and wish her all the very best for the future.

NHS Improvement are progressing the recruitment process for the Chairman and a Non-Executive Director following the resignation of Chris Swan.

Three key priorities: The Board has identified three key areas of focus. These are patient flow, finance and cancer, as measured by the 62 day treatment indicator. My report has a short summary of our progress in these three areas.

Patient flow: In relation to the emergency access standard, overall performance for 2017/18 was 78.91%; this is a decrease from 81.50% for 2016/17. 5,086 more patients waiting longer than 4 hours. Despite the increase in 12 hour breaches in March, the total number for the year was 140; 258 fewer than 2016/17. There were a total of 48,052 ambulance conveyances in 2017/18 up from 46,247 the previous year; a 3.9% increase across the two main sites. Reviewing the split by site, ambulance conveyances to the Worcester site saw a 5.92% increase and to the Alexandra Hospital a 0.17% increase comparing 2016/17 to 2017/18. It is extremely disappointing that we have not seen improved performance in this key area. I can assure the Board that a very strong focus on improving performance continues, both within the Trust and also within the health economy.

Finance: The Trust has recorded a pre audited deficit of £57.9m pre Sustainability and Transformational Funding for months 1 to 12 of 2017/18 financial year which is £15.2m worse than the original operating plan submitted to NHSI. This out turn position is consistent with the revised forecast outturn agreed with NHSI in December 2017, in the Trust's financial recovery plan. As a result of the revised I&E forecast to £57.9m deficit, the Trust required additional interim revenue support in 2017/18. This requirement for revenue support in line with the planned deficit continues into 2018/19. Requests are being made for access to support on a month by month basis.

On the three key financial duties, the Trust has: not achieved its Breakeven Duty, achieved the External Financing Limit and met its Capital Resource Limit.

Cancer 62 days: The Trust has not achieved the operational standard in month 12. However, the March trajectory of 80% was achieved, with 82.07% of patients treated within 62 days. This is the best performance by the Trust since February 2016, which we are looking to sustain and improve.

There will be further discussion of these three key priorities throughout the meeting and further detail is also contained within the integrated performance report.

Date of meeting	8 May 2018
Paper number	C2

CQC
We received an unannounced visit from the CQC in March. This was in addition to the visits in January and February. The report from all three visits is expected over the next few weeks.

General Data Protection Regulation (GDPR): The Trust will not be compliant with the new the GDPR by the time of the 'go live' date of 25 May. There is an action plan in place with all the actions needed to be undertaken identified. It is anticipated that full compliance will be achieved by 31 December. The main areas of non-compliance relate to data mapping (i.e. a comprehensive list of all personal identifiable information (PII) held and what happens to it) and contracts i.e. ensuring that all our suppliers that we transfer PII to are compliant. To this end, we are appointing a data mapping officer on a short term contract and Procurement have a dedicated junior to chase up responses to a letter sent to all our suppliers (which is in the 1000s). The data protection officer is undertaking awareness raising sessions with all staff. We will be compliant in respect of reporting data breaches and subject access requests. We have been assured that as long as we recognise where we need to take action and that action is indeed being taken on those areas, if the Information Commissioner has cause to audit us on our compliance then she will look favourably on us. The Board will be receiving a detailed update after this meeting.

Provider Sustainability Fund – Assurance Statement: The Trust has signed the assurance statement which allows access to the Provider Sustainability Fund**, a**s set out in the NHS planning guidance – *Refreshing NHS Plans for 2018/19*. 30% of the Provider Sustainability Fund will be linked to delivery of the A&E 4 hour target based on the criteria set out in the Provider Sustainability Fund guidance.

Providers who accept their control total and so have access to the Provider Sustainability Fund for 2018/19 will continue to be exempt from the application of an agreed range of contractual performance sanctions, as set out in Schedule 4A (Operational Standards) and Schedule 4B (National Quality Requirements) of the NHS Standard Contract.

Health and Care Trust – new medical director: John Devapriam has joined the Health and Care Trust as their new medical director. John is the National Professional Advisor for Learning Disability for the CQC, and chairs the Quality Network for Learning Disabilities for the Royal College of Psychiatrists. John became a Fellow of the Royal College of Psychiatrists in 2015. His previous position was at Leicestershire Partnerships NHS Trust where he has been Consultant Psychiatrist in Learning Disabilities and Clinical Director for the Adult Mental Health and LD directorate.

Changes to the CCG Governing Body Membership: Each of the three Worcestershire CCG Governing Bodies have agreed to restructure their membership and introduce shared Lay Members as part of plans to allow for Governing Body Meetings 'in common' from May 2018. The following changes will come into force.

Governing Body GP Members:

NHS Redditch and Bromsgrove CCG *(with effect from 1st April 2018)*

- Dr Richard Davies - CCG Clinical Chair
- Dr Jonathan Leach - CCG Governing Body GP

NHS South Worcestershire CCG *(with effect from 1st April 2018)*

Date of meeting	8 May 2018
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- Dr Anthony Kelly – CCG Clinical Chair
- Dr George Henry – CCG Governing Body GP
- Dr David Farmer – CCG Governing Body GP

NHS Wyre Forest CCG *(with effect from 1st June 2018)*

- Dr Clare Marley – CCG Clinical Chair
- Dr Louise Bramble – CCG Governing Body GP
- Dr Tristan Brodie – CCG Governing Body GP

Governing Body Lay Members Following an external recruitment process the following individuals have now been confirmed in post (subject to formal approval at the next CCG Governing Body Meetings) and will serve on all three Governing Bodies from the 1st of April 2018:

- Fred Mumford - Lay Member for Audit and Governance and Conflicts of Interest Guardian
- Sarah Harvey Speck - Lay Member for Patient and Public Involvement (PPI) and Quality
- Rob Parker - Lay Member for Finance
- Trish Haines - Lay Member for Primary Care

Merger approved: University Hospitals Birmingham NHS Foundation Trust (UHB) was given permission to acquire Heart of England NHS Foundation Trust. The new Trust (UHB) commenced on 1 April 2018. All existing hospitals will retain their current established name.

Three Counties Medical School: Whilst the recent announcement of new national medical schools did not include the proposal for the Three Counties, plans are being drawn up to ensure that when the next round of bids is requested (likely to be in 18 months' time), the proposal for a local medical school will be well advanced and therefore be in a better position to be successful.

Principles for social care: The Rt Hon Jeremy Hunt has set out the seven key principles that will guide the Government's thinking ahead of the social care green paper, to be published later in 2018. The seven principles are:

- Quality
- Whole-person integrated care
- Control
- Workforce,
- Supported families and carers
- a sustainable funding model for social care supported by the diverse, vibrant and stable market and
- Security for all.

New GP Contract: new national GP contract went live on 1 April. There is a 3.4% increase in the value of the contract. All GPs will use digital tools to help patients get quicker and easier access to family doctors and specialists as a result of the changes.

Background

This report is to brief the board on various local and national issues.

Date of meeting	8 May 2018
Paper number	C2

Recommendations
The board is requested to receive this report for noting.

NHS
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Date of meeting	8 May 2018
Paper number	C3

Freedom to Speak up (FTSU) first bi-annual report to the Board

For approval:		For assurance:	x	To note:	

Accountable Director	Tina Ricketts Director of People and Culture		
Presented by	Bryan McGinity FTSU Guardian	**Author**	Bryan McGinity FTSU Guardian

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		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		Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	**Date**	**Outcome**
People and Culture Committee	19 March 2018	Received for assurance

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

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is recommended to: • Support the on-going communication of the FTSU programme to all staff. • Discuss whether there could be any improvement on the FTSU programme. • Note the analysis of learning from both the Southport and Ormskirk Trust and North Lincolnshire and Goole

	Trust case reviews which will be incorporated into the FTSU Working Group. • Receive the plan to develop an effective learning process from concerns raised for assurance.

NHS
Worcestershire
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Date of meeting	8 May 2018
Paper number	C3

Executive Summary

The role of a Freedom to speak up Guardian is mandatory within all NHS Trusts following the Francis Report.

It is also incumbent that each Trust gives adequate support in order to enable their FTSU Guardian to do their job effectively. Based upon discussions at regional and national level, including meetings with the CQC, the Worcestershire Acute Trust is in the *good* category for support given to the FTSU Guardian in terms of the hours for the role and appropriate administrative support.

The role has been well communicated within the Trust and the result is in the number of cases received to date (42).

I welcome the opportunity to present to the Board at the meeting on 8 May.

Background

Role of Guardian

Every Trust has to have a nominated Guardian and the Trust appointed Bryan McGinity as a substantive appointment as of January 1st 2018. The Trust has also appointed Steve Williams as the NED Guardian, and Bryan and Steve met on 24th April to review the FTSU programme

.

Role of Champions

We have appointed 30 Champions spread across all three sites and departments who can be the first point of contact for staff who wish to either discuss or raise a potential concern. So the role of the champion is to support any member of staff who wishes to raise a concern, take their full details and forward to the Guardian for action. We have also created a network meeting of champions to meet initially on a quarterly basis to review progress, and propose improvements. The first such meetings were held in March 2018 with the next meetings due in late June (We hold them in each of the three sites in order to support attendance.) This inaugural Champions' Network meeting was very useful in raising a number of points which are now in process of being followed up so we can report on progress at the next meeting.

Issues and options

Policy and Process

The Speaking Up/Raising Concerns Policy was approved on 25th April 2018. The Policy ensures that the Guardian sets up a process to deal/respond with every concern raised and is responsible for updating both the staff member and Champion on a regular basis so the person does not feel left unsupported. The case is only closed once the staff member agrees that this is correct. The reporting form is due to be reviewed in April by the Guardian and a number of champions in order to ensure that it is effective and totally user friendly. It will be the responsibility of the FTSU Committee to annually review and update the FTSU Policy. The Process ensures that each and every concern reported by a staff member is always treated seriously and the appropriate procedure is implemented in order to seek to resolve the issue.

Cases

From August 2017 (when the acting role was announced by the CEO) to September 2017 we received 8 cases, in the quarter ending December 2017 we received 17 cases and in this

latest quarter to end of March 2018 we have received also 17 cases.

It is noticeable, with the data from National Office, that there is a very wide spread of cases received by each Guardian across England with many reporting in single figures (which would not appear to tie in with the National NHS Data of 24% of staff noting cases of bullying and harassment) ranging to some Trusts in the range of 50 plus per quarter. I think we are in the middle of the ladder with our 17 cases per quarter.

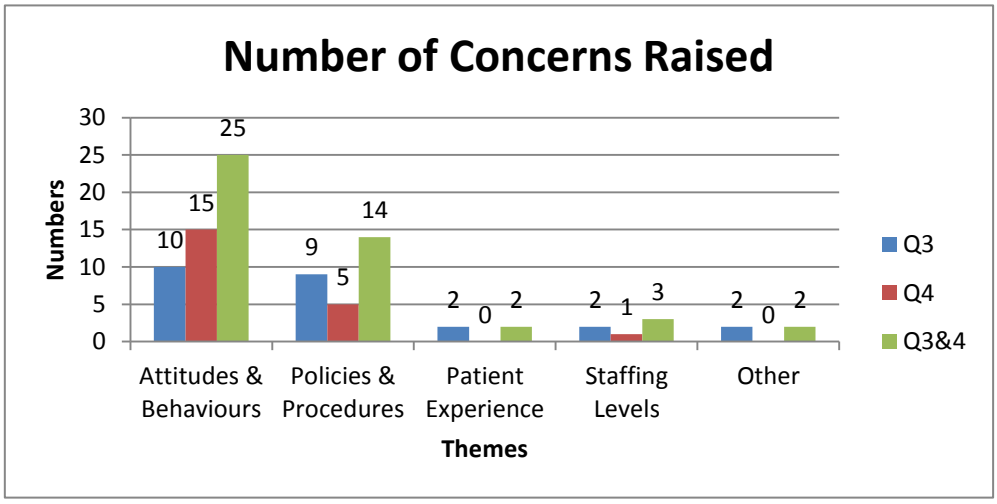
The majority of cases raised within our Trust cover the theme of inappropriate behaviour, generally from within in a working group or department/ward. Inappropriate behaviour is the term we use to cover a range of poor behaviours including bullying, poor conduct with patients or staff etc. We have a few cases from different staff which cover one issue /area and these have been followed up with the senior Director concerned.

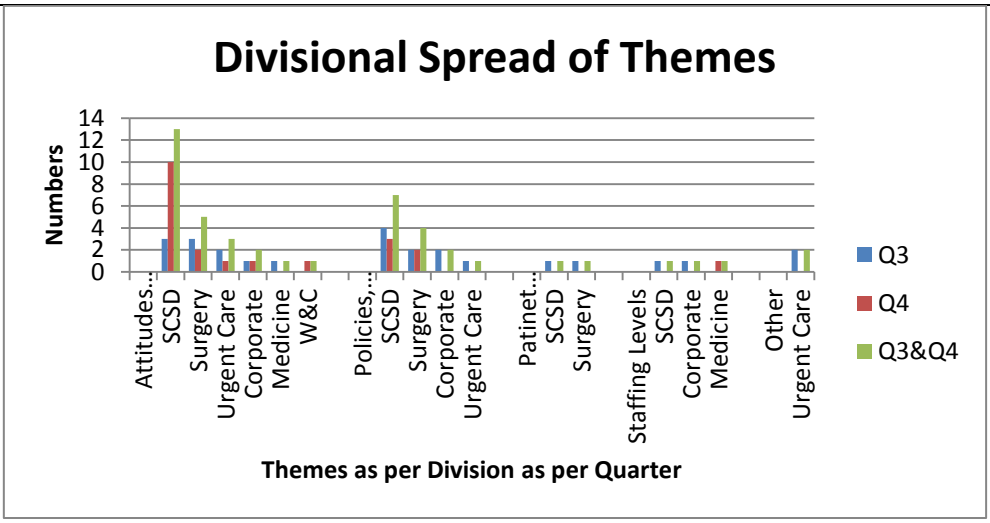
In each of the cases of patient experience the details were promptly shared with the Chief Nurse or the relevant Divisional Director of Nursing.

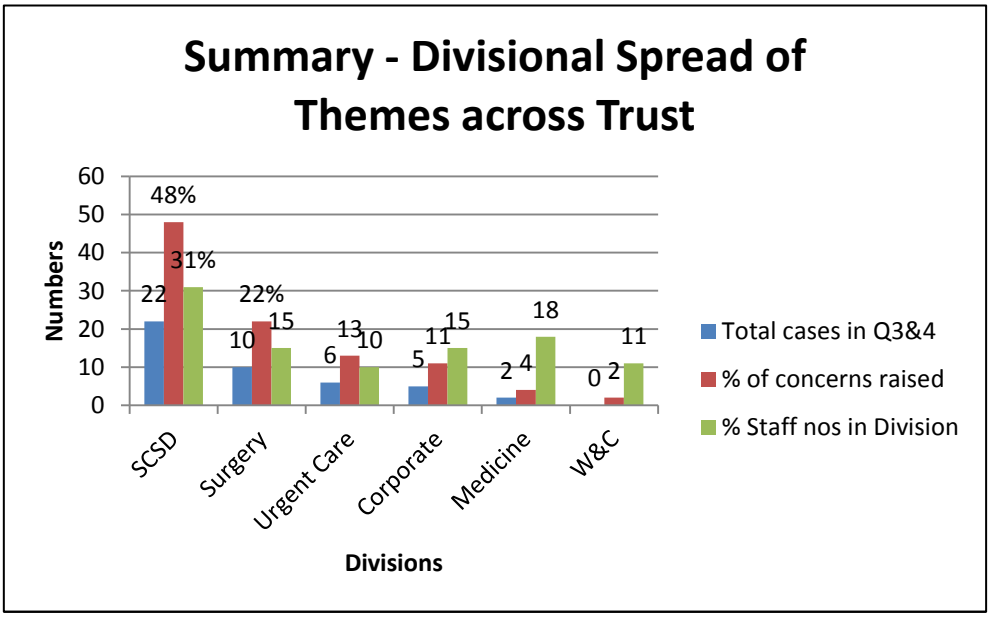
Staffing levels have been raised with relevant Divisional Boards.

Under other, there are two allegations of fraud, which are with the internal auditors.

The total of themes raised exceeds the 42 cases, as in a number of cases there are sometimes two or more main themes. Of the 42 cases raised to date 28 have been closed. The 14 open cases all have an agreed action plan in place.







It is to be expected with the marketing and promotion to date to raise awareness of the programme that we should have received an increase in the number of concerns. Also at this stage it may be too early to make comment on the Divisional spread, however this will be considered by Champions and then by the FTSU Committee within its review in mid-year.

Marketing

We have spent considerable time trying to make the organisation aware of the FTSU programme across the Trust.

This has included

- Presentations to every Directorate Board
- Staff presentations to a range of departments at all three sites
- Presentations to all FY1s, FY2s and student nurses and the Senior Nurse events

- Payslip insert
- Articles in the Worcestershire Way and on the front page of the intranet.
- Screensavers and ward whiteboards in week commencing 29th April.

With the level of NHS staff turnover it is essential that these communication events are held both on a regular basis and using innovative ideas. We also have a 15 minute introduction to FTSU at every induction event and all mandatory training events.

Governance
The progress on and a review of the FTSU programme is reported to:

- The FTSU Working Group (chaired by Deputy Director of HR) bi-monthly – revised Terms of Reference were submitted to the March 2018 People and Culture Committee for approval
- The People and Culture Committee in March and September each year
- The Board in May and November each year
- The Audit and Assurance committee annually in September
- The Chief Executive on a quarterly basis from 30th January 2018.

In addition we submit a quarterly report to the FTSU National Office, and the Guardian attends the Regional FTSU meetings quarterly in the West Midlands and the National FTSU Meetings bi-annually in London.

Training
The Trust Guardian has been on a two day course in March 2018 run by the National FTSU Office in order to support them in training other Trust Guardians. An apparent issue within our own Trust is that it appears in a number of cases that a number of managers and directors have not been trained in dealing with both difficult issues and with concerns raised by staff. We have drafted a process which we would seek to include in all management training programmes. This will be submitted to the Trust Training and Development team for consideration within their management training programmes. I think a by-product of this issue is the perceived lack of clear support that we give to new managerial appointments on the management and leadership aspects of their role.

Learning and Development
It is critical that we do not just run the FTSU programme on an on-going day to day basis but that we actively learn from the themes and issues, and build that learning into the Trust. It is our intention that the next report will cover this crucial element. We have as well as our own learning, the results and learning opportunities of the National FTSU office cases reviews on the progress in South Lincolnshire and Goole NHS Trust and also the Southport and Ormskirk NHS Trust. I would intend, with the support of FTSU Committee to develop an on-going action plan on the issues raised by the end of June 2018.

Staff Survey
A number of Trusts conduct staff FTSU surveys of all staff, plus an additional survey of staff who have raised a concern. With the number of other surveys and information requests of staff within our Trust it is proposed that we do not at this stage have a general staff survey, but launch a FTSU participants survey following the next quarterly FTSU Champions network meetings in June.

Worcestershire Acute Hospitals NHS Trust

Date of meeting	8 May 2018
Paper number	C3

Recommendations
The Board is recommended to: • Support the on-going communication of the FTSU programme to all staff. • Discuss whether there could be any improvement on the FTSU programme. • Note the analysis of learning from both the Southport and Ormskirk Trust and North Lincolnshire and Goole Trust case reviews which will be incorporated into the FTSU Working Group. • Receive the plan to develop an effective learning process from concerns raised for assurance.
Appendices None

NHS
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Date of meeting	8 May 2018
Paper number	D1

Integrated Quality & Safety Report

For approval:		For assurance:	x	To note:	

Accountable Director	Vicky Morris, Chief Nursing Officer Suneil Kapadia, Chief Medical Officer		
Presented by	Vicky Morris, Chief Nursing Officer Suneil Kapadia, Chief Medical Officer	**Author**	Vicky Morris, Chief Nursing Officer Suneil Kapadia, Chief Medical Officer

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		Develop and sustain our business			

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Quality Governance Committee	19th April 2018	Received

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

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☒	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Trust Board are asked to • note the commentary provided which supports the

	improving performance across the Integrated performance report (Quality section) • note the CQUIN programme.

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Date of meeting	8 May 2018
Paper number	D1

Executive Summary
This paper is provided to ensure the Board are sighted on areas of the Quality Improvement and any information regarding the Quality Improvement Strategy.
Background
The Trust Board have agreed an Integrated performance Report which is provided to the Board. This report has been developed in order that the Chief Nursing Officer and Chief Medical Officer can comment on any Quality variances within the Integrated performance report and also any key issues which they feel the Trust Board need to be briefed on.
Issues and options

1.0 Integrated Performance Report- Quality Indicators

The Clinical Governance Group (CGG) reviews all aspects of quality performance with the Divisions in detail and uses real time data from informatics, the quality audits undertaken and the papers presented to CGG to triangulate the information. Upward reporting is to the Quality Governance Committee (QGC) and which consider a level of assurance against the quality and safety aspects of the Board Assurance Framework.

1.1 Complaints Management and Performance Report

Significant improvements have been made by the Divisions in both reducing their overdue complaints and improving the timeliness of the current complaints process, increasing the % of complaint responses from 31.15% in August ’17 to 78.57% at the end of March. The national standard has been 80%, however the contractual target is 75%.

Close monitoring will need to continue in order for this improved performance to continue and then be sustained.

1.2 Overdue serious incidents

The performance and timeliness of managing serious incidents had significantly improved by the end of March 2018, with only 1 complex Serious incident being overdue.

1.3 VTE assessments

The Trust reported a VTE assessment compliance of 92.25% for Q4 2017/18 [NB in the IPR the month 12 figure is shown, not Q4. Both are correct.]. This is below the expected 95%. Work is being undertaken to ensure the capture of data from clinical notes to Oasis as well as ensuring assessments are being undertaken.

1.4 Mortality

HSMR and SHMI values continue to fall and are within expected variation i.e. the Trust is not an outlier for these metrics. Primary mortality reviews completed within 30days for February 2018 is 52.59%, down from 56.28% in January 2018. The uncompleted backlog awaiting review is more or less unchanged (decrease 0.4%) at 22.65%.

Of the serious incidents closed during February 2018 none related to the death of a patient. There were therefore no avoidable deaths identified during February 2018.

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2 Quality Improvement Strategy (QIS) - Underpinning Strategic Quality Improvement Plans

The Trust Board in March approved the QIS and gave full delegated authority to the Quality Governance Committee to review and approve the final profile of trajectories and key performance indicators for the three underpinning Quality Improvement Plans. These plans were approved by QGC after some minor adjustments.

The draft Divisional Quality Plans, to underpin the implementation of the QIS were also reviewed by QGC and need some further refinement before being finalised and approved in the Clinical Governance Group.

3 CQUIN Programme Review and Forward Look

Whilst the performance of CQUINs will be reported in the Quality Account (being presented to the June Trust Board) it is worthy of note that improvements in Quality and innovation are taking place within and across the Trust with all CQUIN objectives either partially or fully achieved.

The programme of CQUINs for 18/19 (determined nationally) have been reviewed and discussed with Commissioners with the Trust contracted to complete 13 CQUINs in 2018/19, the majority of which are enhancements to existing objectives outlined in the 2017/19 CQUINs Programme.

- The NHS e-Referrals CQUIN and Supporting Proactive and Safe discharge CQUIN will conclude and will not become part of the 2018/19 CQUIN programme

- Reducing Ill Health as a Result of Risky Behaviours (Alcohol and Tobacco) CQUIN has been commissioned for the 2018/19 programme**.** The CQUIN seeks to identify and offer advice to patients who smoke or whose alcohol consumption is above recommended levels. Under the 'cap and collar' arrangements, the Trust would not lose payment if the CQUIN objectives were not met. The Commissioners are aware that the Trust is not in a position to meet the CQUIN requirements as smoking and alcohol services are not effectively commissioned in Worcestershire. Commissioners have, therefore, agreed for the Trust to scope a proposal to utilise the existing alcohol liaison service.

4 Quality Impact Assessment (QIA) – Emergency Surgical Pathway

The QIA for the centralisation of emergency surgery at WRH from 9 April 2018 was approved by TLG (vs CMO & CNO only) on 4th April 2018. The original proposal for this service change had been included and approved in the Future of Acute Hospital Services in Worcestershire (FoASH) consultation. KPIs have been developed to ascertain the effect of the pathway and its impact on other services. Further work is required to determine more precisely the financial implications of the proposal in relation to income and the tariff changes.

Recommendations

The Trust Board are asked to

- note the commentary provided which supports the improving performance across the Integrated performance report (Quality section)
- note the CQUIN programme.

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Appendices: None

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Date of meeting	8 May 2018
Paper number	D3

Quality Governance Committee Assurance Report

For approval:		For assurance:	x	To note:	

Accountable Director	Bill Tunnicliffe Non-Executive Director		
Presented by	Bill Tunnicliffe Non-Executive Director	**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	x	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	x
Finance and use of resources		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)	P1.1 P1.2 P1.3

Please see the individual summaries in the report

Level of assurance and trend							
Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The board is requested • Note the substantial improvement on complaints performance • Note that the Committee will receive another update on the never events action plans at its June meeting • Note that the Committee reviewed the metrics associated with the divisional quality improvement plans and that the monitoring of these plans will be through the Clinical Governance Group (CGG)

Date of meeting	8 May 2018
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	• Note that the Committee received the quality impact assessment for the acute surgical pathway changes which were implemented on 9 April • To receive this report for assurance.

Date of meeting	8 May 2018
Paper number	D3

Executive Summary

Never events: the Committee received an update in relation to the action plans associated with the never events. Clearly actions have been undertaken to have a more robust approach to the management of dental surgery and the positioning of nasogastric tubes. I have requested that the audit of the new dental surgery process is presented to the Committee. We expressed concern that some of the actions have not yet been completed and I have requested a review of the action plan at our June meeting.

Delayed correspondence: The Chief Nurse stated that the monitoring of the sending out of letters to GPs will be undertaken through the Clinical Governance Group. I am concerned that the Trust is not meeting the 10 day standard of sending out letters. I was assured there is an awareness of the requirement but I asked for clearer accountability for the clinicians. This item will be reported routinely via the CGG report to the QGC and we will be able to review the progress through the SQUID tool.

Serious incident reviews: We were pleased with the progress with the closure of serious incidents. The CCG commented that the quality of the reports have improved.

Primary mortality reviews: The numbers have plateaued. There will be a focus on this at our next meeting.

Quality Improvement Strategy: We approved the priorities for the QIS. We agreed that there were some improvements that need to be undertaken to the divisional plans. They will provide the underpinning plans to deliver the QIS for the Trust. We went through the plans in detail to challenge the metrics and whether they are ambitious enough or whether they are over ambitious. Monitoring will take place at the Committee. We were particularly impressed with the Women and Children plan. However it was recognised that more work needed to be undertaken on the other plans for a focus on improvement. The documents will be approved at CGG in the next couple of months and the divisional presentations at the Committee will focus on these plans. We will invite corporate teams to the Committee to understand how they support the divisions. **Significant assurance**

CNST incentive scheme – Women & Children: We received a presentation from the Divisional Medical Director for Women and Children on the application for a discount in the clinical negligence scheme for trusts (CNST) subscription. This proposal needs to be approved by the Trust Board and will be presented at the next meeting. We recognised the focus on quality and safety and the need for the achievement of this. We support the initiative.

CQUIN (Commissioning for Quality): We fully achieved or partly achieved the CQUIN programme for 2017/18. Where we partly achieved, this was planned. Collaborative working has improved patient experience with respect to mental health and the sepsis nurse has also made a difference. **Moderate assurance**

Clinical Governance Group (CGG): This meeting was quorate (unlike the previous meeting). The QIS was a key feature within the meeting. There will be a change in the way of reporting into the Group to reflect the quality improvement plans.

Quality Impact Assessment – Acute Surgical Pathway: The Trust Leadership Group

approved the QIA at the beginning of the month and the changes took place on 9 April. We received the comprehensive assessment and were assured by the process and the content of the QIA. We would have preferred that the QIA had been undertaken at an earlier stage in the plans.

Quality Account: The Committee received the draft quality account. This will be presented to the trust board in June prior to publication on 30 June. **Substantive assurance**

Harm review process 2018/19: The Chief Nurse outlined the systems and processes around harm reviews. Further work is needed to refine the process and ensure that all the issues are identified and actioned. **Limited assurance (but increasing)**

Complaints update: It is very pleasing to note the improvement in complaint performance which almost met the 80% trajectory in March. 78.57% complaints were responded to within 25 working days in March. **Substantive assurance**

Board Assurance Framework: We received proposed changes to the BAF risks 1.1, 1.2, 1.3 and 2.1. We are recommending the following:

R1.1 – risk reduction from 16 to 12
R1.2 – risk reduction from 20 to 16
R1.2 and R2.1 – no risk reduction.

Other changes to the BAF will be within the BAF agenda item.

Received for information

- **Annual governance statement**
- **Compliance statement FT4**
- **QGC review of performance**
- **QGC work plan**

Items discussed at the March QGC meeting:

- **Looked after children:** The Committee expressed concern that not all looked after children were being identified within the A&E department. This will be a focus of the next report from safeguarding to the committee.
- **R&D Strategy:** The Committee did not approve this strategy as it needed to be more focussed on the quality improvement strategy.
- **Quality Improvement Strategy and associated plans**
- **Mandatory training compliance:** the Director of People and Culture attended to give a comprehensive update. We will review this again in four months.
- **Kirkup review** (circulated to NEDs)
- **Quality impact assessment – methodology** (circulated to NEDs)
- **Quality Assurance Visits**

Background

This report is the regular report to Trust Board from the QGC. It covers the meetings held in March and April 2018.

Recommendations

The board is requested

- Note the substantial improvement on complaints performance

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- Note that the Committee will receive another update on the never events action plans at its June meeting
- Note that the Committee reviewed the metrics associated with the divisional quality improvement plans and that the monitoring of these plans will be through the Clinical Governance Group (CGG)
- Note that the Committee received the quality impact assessment for the acute surgical pathway changes which were implemented on 9 April
- To receive this report for assurance.

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Financial Performance – Month 12 2017/18

For approval:		For assurance:	✓	To note:	

Accountable Director	Jill Robinson – Chief Finance Officer		
Presented by	Jill Robinson – Chief Finance Officer	**Author**	Jo Kirwan - Assistant Director of Finance Katie Osmond – Assistant Director of Finance

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
Finance & Performance Committee	23 April 2018	Noted

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R4.1

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☒	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is asked to: • Note the financial position at the end of Month 12 and 2017/18 Financial Year • Note the Month 12 and 2017/18 delivery to the revised

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	forecast. • Note the continued requirement for access to interim revenue support (cash) in line with the planned 2018/19 I&E deficit position.

Executive Summary

The purpose of this paper is to update the Board on the financial performance of the Trust.

This paper summarises the Trust's financial performance for months 1 to 12 and includes information on healthcare activity, expenditure variances and cost improvement plan (CIP) delivery. This paper also provides an update on delivery against the financial recovery plan (FRP) for month 12 and the 2017/18 year end position.

I&E Summary

For 2017/18 the Trust committed to delivering a deficit of £42.7m before receipt of Sustainability and Transformation Funding (STF) amounting to £12.7m, giving a Control Total deficit of £30m.

The Trust has recorded a **pre audited** deficit of £57.9m before STF for the 2017/18 financial year which is £15.2m worse than the original operating plan submitted to NHSI. However, this out turn position is consistent with the revised forecast agreed with NHSI in December 2017, and the Trust has managed and mitigated the risks which were previously outlined to meet this revised full year forecast.

The Trust earned £1.6m of STF in Q1 as a result of delivering its financial target for the quarter (£1.3m) and achieving the A&E front door GP streaming milestone (£0.3m). In addition, the Trust received a further £3.2m from the NHSI STF incentive and bonus scheme at the end of the financial year. The Trust received the 'general distribution' element of the scheme as a result of signing up to the £42.7m pre STF control total.

This reduces the **pre audited** YTD deficit to £53.0m against this agreed plan of £30.0m resulting in a £23.0m adverse variance to post STF plan.

This adverse position is largely driven by non-delivery of CIP, the provision of additional operational capacity (including RTT business case investment), workforce pressures and non receipt of STF.

Cash

As a result of the revised I&E forecast to £57.9m deficit, the Trust required additional interim revenue support in 2017/18. This requirement for revenue support in line with the planned deficit continues into 2018/19. During quarter 1 of 2018/19, the Trust requires £7.033m of cash support to maintain payments to creditors. Requests will be made for access to support on a month by month basis.

The timeliness of payments to creditors has improved in March, however it remains below the national target. The overall payment position continues to be challenging, with insufficient cash available to pay creditors at the rate required. Work to improve the debtors' position has shown some improvement, with a reduction in March of £0.7m of debt over 90

days, however there remains further scope to improve this metric.

CIP

The Trust has achieved £9.5m of CIP against its £20.9m annual target as at the end of March 2018. This position is consistent with the forecast

Agency Ceiling

At the end of March the Trust's annual spend on agency staffing is £20.9m, this is £2m lower than the agency ceiling of £22.9m.

Financial Duties

On the three key financial duties, the Trust has:

- **Not achieved** its Breakeven Duty
- **Achieved** the External Financing Limit
- **Met** its Capital Resource Limit

Background

The projected pre mitigation full year forecast deficit of £64.9m refreshed at M7, demonstrated the size of the financial challenge for the Trust to deliver its pre STF financial plan of £42.7m in 2017/18. As a result the Trust developed a financial recovery plan.

In implementing the financial recovery plan (FRP), this position could be mitigated to deliver a £57.9m deficit. This revised forecast out turn position (£57.9m) was agreed with NHSI and was submitted at Month 9.

The Trust's FRP was focused on a limited number of key projects to ensure capacity and capability is targeted at those schemes with the greatest potential to reduce the impact of the drivers of the deficit. Key projects included theatre productivity, use of temporary staffing, rostering, recruitment & retention, procurement and grip and control measures.

Delivery of the FRP/CIP actions and overall performance against Divisional control totals was monitored through fortnightly Confirm & Challenge meetings with each of the Divisions. Where a Division fell behind the agreed recovery plan, the monitoring escalated to weekly. Confirm and challenge sessions will continue into 2018/19.

Issues and options

Income and Expenditure

Overall the Trust delivered the Month 12 control total of £3m deficit, increasing the full year deficit to £57.9m.

It is positive that for the fifth consecutive and final month of the 2017/18 financial year, the Trust has delivered against its forecast position with both CIP and FRP delivering to plan.

This level of focus on financial delivery must continue into 2018/19 embedding these actions as 'business as usual' across the Trust. As a result, the fortnightly Divisional confirm and challenge sessions will continue.

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There were a number of financial risks that the Trust has actively managed in order to achieve the revised forecast out turn position of £57.9m deficit.

Financial Special Measures / Enhanced Oversight Regime

The Trust continues to be managed by NHSI via the enhanced oversight regime. Weekly status updates continue to be provided to NHSI including performance against forecast for key expenditure lines such as temporary staffing (bank and agency) and discretionary expenditure. Outputs from the Divisional confirm and challenge meetings are also forwarded and discussed.

NHSI continue to assess the robustness of the 2018/19 plan, particularly the readiness and deliverability of the CIP.

2018/19 Financial plan

The Trust submitted its 2018/19 Financial plan as part of its Operational plan to NHSI on 30 April 2018, which is described in more detail under the separate agenda item for the Operational Plan

The Trust has signed up to its 2018/19 Financial Control Total of a £40m deficit which entitles receipt of the Provider Sustainability Fund (PSF – previously STF) of £17.8m. The financial plan is based on agreed and signed contracts with clinical commissioners, and agreed divisional budgets. The plan includes a CIP requirement £23.9m, or 6% of turnover, of which £10.1m is currently fully identified. The remainder is being identified through a recovery programme supported by a Turnaround Director and the PMO. Key areas of opportunity are being prioritised for conversion into specific schemes, including theatre productivity and repatriation.

It is estimated that financial risk exists of between £10-15m which will require robust mitigation to ensure delivery of the 2018/19 Control Total.

The Capital Plan assumes that the Trust's internally generated resources will be principally committed to essential works and equipment replacement which will not be sufficient. The Trust submitted a revised urgent capital loan request in January 2018 which was successful and resulted in an additional £2.4m in 2017/18 and £2.6m in 2018/19. A further loan application will be required for outstanding schemes in 2018/19, estimated to be for £15m.

Recommendations

The Board is asked to:

- Note the financial position at the end of Month 12 and 2017/18 Financial Year
- Note the Month 12 and 2017/18 delivery to the revised forecast.
- Note the continued requirement for access to interim revenue support (cash) in line with the planned 2018/19 I&E deficit position.

Appendices:
Finance Report – Month 12

Worcestershire Acute Hospitals NHS Trust

Finance Report

Jill Robinson

Chief Finance Officer

23rd April 2018

March 2018

Month 12

Use of Resources Risk Rating Summary

Worcestershire Acute Hospitals NHS Trust

	Metric Definition	How we did YTD at M11	Risk Rating		Previous Month YTD	Full Year Plan (Forecast)
I&E margin rating	I&E surplus or deficit / total revenue.	(14.16%)	4	Adjusted financial performance deficit of **£56,272k** (£56,272k exc 16/17 STF allocation of £419k) / total operating income (exc impact of 1617 STF allocation of **£397,405k** = **(14.76%).**	4	4
I&E margin: distance from financial plan	YTD actual I&E surplus/deficit in comparison to YTD plan I&E surplus/deficit.	(6.78%)	4	I&E margin YTD actual of **(14.16%)** less I&E margin YTD plan of **(7.38%)** = **(6.78%)**.	4	4
Liquidity rating (days)	Measures the days of operating costs held in cash, cash-equivalent and liquid working capital forms.	(52.978)	4	Working Capital of (£62,207) / YTD Operating Expenditure of £428,585 multiplied by the number of YTD days (334) = (52.978).	4	4
Capital service cover rating	Degree to which the organisation's generated income covers its financing obligations.	(2.123)	4	Revenue available for service capital (£30,713k)/ capital service **£14,469k** = **(2.123)**	4	4
Agency rating	Total agency spend compared to the agency ceiling.	(9.05%)	1	Total agency spend of **£20,864k** less agency ceiling of **£22,940k** / divided by agency ceiling of **£22,940k** = **(9.05%).**	1	1

Income & Expenditure Overview – M12

Worcestershire Acute Hospitals NHS Trust

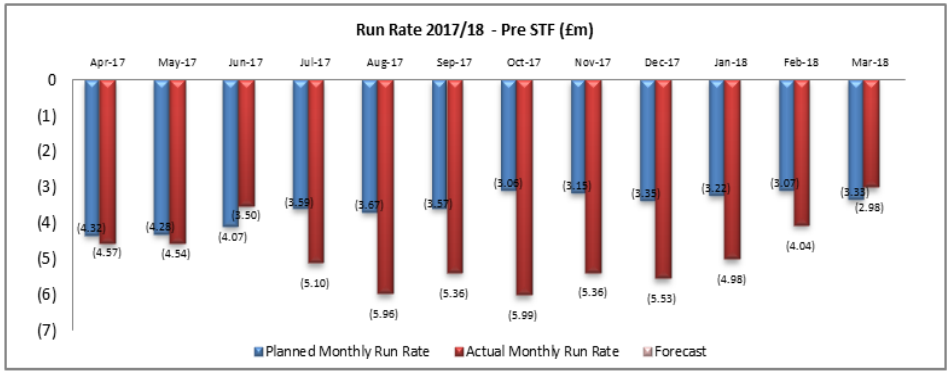
At the end of March the Trust is reporting a pre audited pre Sustainability and Transformational Fund (STF) deficit of £57.9m, which is £15.2m worse than plan. This out turn position is consistent with the revised forecast agreed with NHSI in December 2017

Inclusion of the STF (relating to Q1 and the STF incentive and bonus schemes) reduces the YTD deficit to £53mm against a plan of £30.0m resulting in a £23m adverse variance to plan.

A breakdown of the key variances to plan at the end of March are detailed on page 4.

Income & Expenditure	Year to Date		
	Plan £000s	Actual £000s	Var £000s
Operating Revenue & Income			
Patient Care Revenue (pre STF)	321,113	326,779	5,666
Other Operating Income	26,655	29,361	2,706
Non PBR Drugs	37,705	36,075	(1,630)
Non PBR Devices	3,184	3,604	420
Total Operating Revenue pre STF	**388,657**	**395,819**	**7,162**
Operating Expenses			
Pay	(253,626)	(267,502)	(13,876)
Non Pay	(112,428)	(119,519)	(7,090)
Non PBR Drugs	(37,945)	(36,176)	1,769
Non PBR Devices	(3,180)	(4,194)	(1,014)
Total Operating Expenses	**(407,179)**	**(427,391)**	**(20,212)**
EBITDA *	**(18,522)**	**(31,572)**	**(13,050)**
EBITDA %	-4.8%	-8.0%	
Depreciation	(9,881)	(10,668)	(787)
Net Interest, Dividends & Gain/(Loss) on asset disposal	(14,292)	(14,048)	244
Impairment Loss	0	(1,717)	(1,717)
Reported Total Surplus / (Deficit)	**(42,695)**	**(58,005)**	**(15,310)**
Less Impact of Donated Asset Accounting	44	121	77
Surplus / (Deficit) against Control Total pre STF	**(42,651)**	**(57,884)**	**(15,233)**
STF	12,663	5,322	(7,341)
Surplus / (Deficit) against Control Total inc STF	**(29,988)**	**(52,562)**	**(22,574)**
* EBITDA = earnings before interest, tax, depreciation and amortisation			

Monthly (Deficit) / Surplus Run Rate



At the end of March the Trust is reporting a pre audited pre Sustainability and Transformational Fund (STF) deficit of £57.9m, which is £15.2m worse than plan. However, this out turn position is consistent with the revised forecast agreed with NHSI in December 2017

Inclusion of the STF (relating to Q1 and the STF incentive and bonus schemes) reduces the YTD deficit to £53m against a plan of £30.0m resulting in a £23m adverse variance to plan.

The actual run rate deficit improved from February to March. This is largely due to an increase in patient care income.

Overall the Trust delivered the required monthly run rate of £3m and as a result delivered the revised FOT of £57.9m for the year as agreed with NHSI.

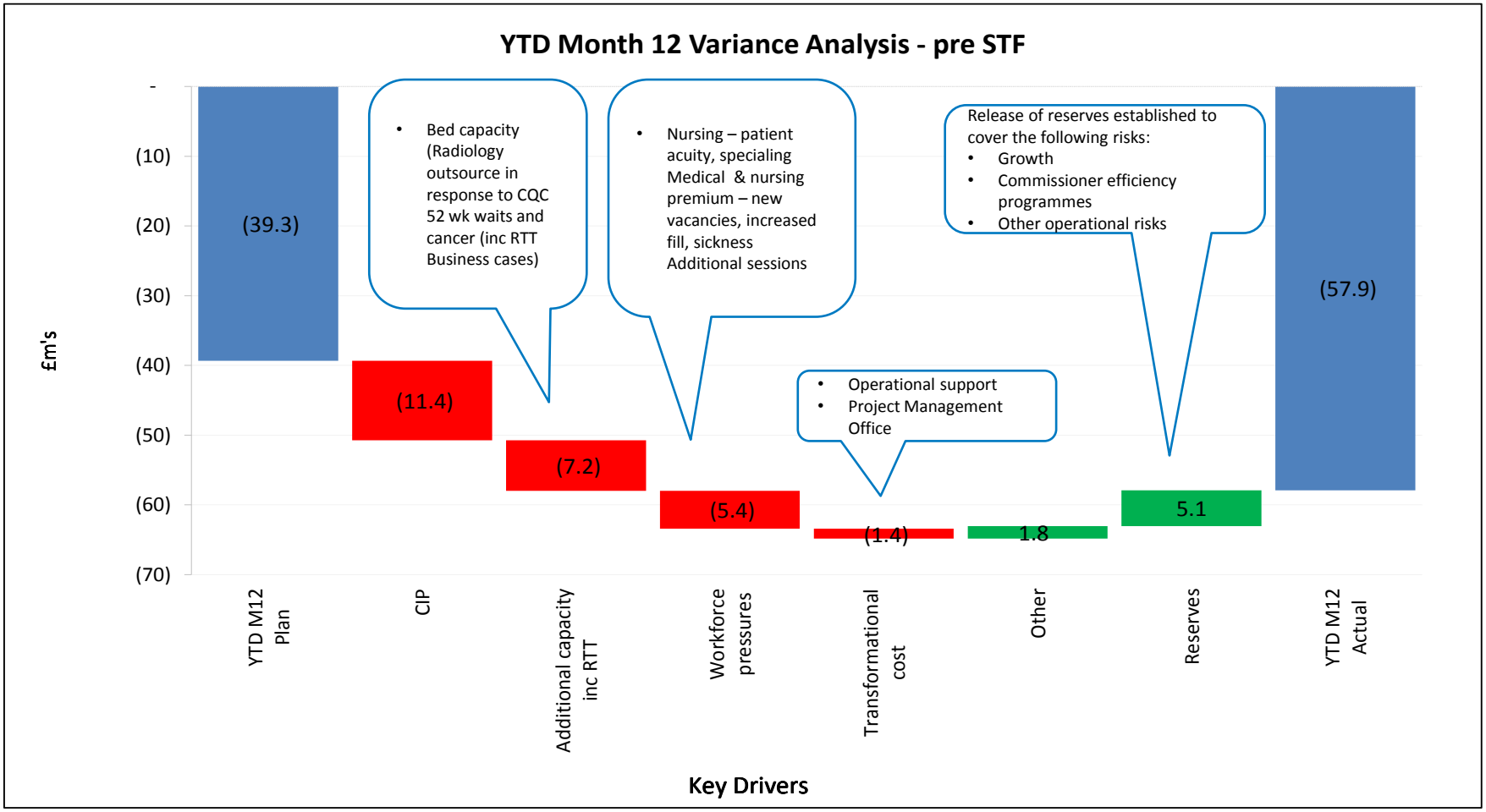
A breakdown of the financial recovery performance is detailed on page 5.

Note – this is the pre audited financial position.

2017/18 – YTD Key Variances pre STF

Worcestershire Acute Hospitals NHS Trust

At the end of month 12, the Trust is reporting a year end deficit of £57.9m. This position is £15.2m adverse to plan, the key variances are presented below.



Run Rate & FRP Performance March 2018 – M12

Worcestershire Acute Hospitals NHS Trust

- The original Trust profile (with the £2m NR FRP phased in M12) required a M12 run rate of £2.0m. The £2m NR target has since been profiled to reflect agreed plans. This resulted in a required run rate of £3m in M12.
- Overall, the March position has delivered to forecast – and the Trust has delivered its revised FOT of £57.9m deficit

Total I&E Run Rate

I&E Run Rate with Original FRP Plan	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	FY Forecast
Run Rate - Baseline (£m)	(4.6)	(4.5)	(3.5)	(5.1)	(6.0)	(5.4)	(6.0)	(5.7)	(6.6)	(6.6)	(5.6)	(5.4)	**(64.9)**
FRP (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.7	1.2	1.4	1.4	**5.0**
Non Recurrent	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	**2.0**
Forecast inc FRP	**(4.6)**	**(4.5)**	**(3.5)**	**(5.1)**	**(6.0)**	**(5.4)**	**(6.0)**	**(5.4)**	**(5.8)**	**(5.5)**	**(4.2)**	**(2.0)**	**(57.9)**

Reprofiled Forecast inc FRP following £2m identification	**(4.6)**	**(4.5)**	**(3.5)**	**(5.1)**	**(6.0)**	**(5.4)**	**(6.0)**	**(5.4)**	**(5.5)**	**(5.0)**	**(4.0)**	**(3.0)**	**(57.9)**
Actual run rate	**(4.6)**	**(4.5)**	**(3.5)**	**(5.1)**	**(6.0)**	**(5.4)**	**(6.0)**	**(5.4)**	**(5.5)**	**(5.0)**	**(4.0)**	**(3.0)**	**(57.9)**

- The original Trust profile (with the £2m NR FRP phased in M12) required a M12 run rate of £2.0m. The £2m NR target has since been profiled to reflect agreed plans. This resulted in a required run rate of £3m in M12.
- Overall, the March position has delivered to forecast – and the Trust has delivered its revised FOT of £57.9m deficit

Income Summary
Month 12 – March 2018

Worcestershire Acute Hospitals NHS Trust

Income including STF was £2.5m above plan in March. Excluding STF £4m favourable.

Inpatients was £1.1m favourable in March:

- Day case activity 4% above plan
- Elective activity 8% below plan
- Emergency activity 10% above plan - winter pressures.

ED/MIU £0.1m and Other Income £2.5m is favourable, Maternity £0.1m and Outpatients £0.1m are adverse.

Other Operating Income is £0.4m favourable

STF £1.5m adverse; Trust has not achieved the financial control and performance targets.

Income – The combined total reported income (including STF) **is £3.4m below the YTD plan**. Prior to STF funding there was an over performance of **£7.2m at the end of March**. In month there was an favourable variance of **£2.6m** to plan (pre STF **£4m** favourable).

Key movements in March:
Inpatients £1.1m favourable – Emergencies £1.1m and Day cases £0.1m were favourable and Electives £0.1m adverse.
Emergency activity 10% above plan – Medicine £0.9m, Oncology/Haematology £0.1m (new ward) and General Surgery £0.1m.
Day case activity was 4% above plan; surgical areas were down -£292k (General Surgery - £118k, T&O -£110k and Oral Surgery -£45k) offset by Cardiology £58k, Acute Medicine £138k (endoscopies insourcing) and Ophthalmology £185k (Outsourcing).
Elective activity 8% below plan; T&O -£154k offset by Gynaecology £60k (additional activity to reduce backlog).
Other Income £2.5m; Winter Monies £1.7m, Breast Screening business case approved by NHS England £309k and Cancer Transformational monies for diagnostics £148k.
STF Funding £1.5m adverse – Both the financial control(70%) and performance element(30% - Emergency Access Standard) targets have not been met in month.

CQUINs – Total CQUIN is worth £7.5m; Worcestershire CCGs £6.2m; Associate CCGs £0.5m and NHS England £0.8m. The £6.2m for the Worcestershire CCGs is mitigated through the cap/collar arrangement. NHS England and NHSI have confirmed the Trust can account for the £1.3m (0.5% CQUIN Risk Reserve) towards the 2017/18 control total. Quarter 4 CQUIN returns will be submitted to commissioners at the end of April 2018.

	In Month				YTD			
	Plan £'000	Actual £'000	Var £'000	% £'000	Plan £'000	Actual £'000	Var £'000	% £'000
Inpatient	12,100	13,227	1,127	9%	148,739	155,754	7,016	5%
Outpatient	3,603	3,485	(118)	(3%)	43,635	43,800	165	%
ED/MIU	1,695	1,842	146	9%	20,861	20,821	(40)	(%)
Maternity	2,089	1,976	(113)	(5%)	26,024	23,906	(2,119)	(8%)
Paediatrics	1,196	1,226	30	3%	14,852	14,183	(669)	(5%)
Other	9,537	12,060	2,523	26%	107,891	107,995	103	%
Patient Care Income	**30,220**	**33,817**	**3,597**	**12%**	**362,002**	**366,458**	**4,456**	**1%**
Other Operating Income	**2,155**	**2,594**	**439**	**20%**	**26,638**	**29,361**	**2,723**	**10%**
Patient Care & Other Operating Income	**32,375**	**36,411**	**4,036**	12%	**388,640**	**395,819**	**7,179**	2%
STF	**1,478**	**0**	**(1,478)**	**(100%)**	**12,663**	**2,034**	**(10,629)**	**(84%)**
Total Income	**33,853**	**36,411**	**2,558**	**8%**	**401,303**	**397,853**	**(3,450)**	**-1%**

Note the table above reflects the adjusted Cap/Collar position based on the annual phased limits - Collar £264.4m and Cap £271.4m .

Pay Expenditure
Month 12 – March 2018

Worcestershire Acute Hospitals NHS Trust

Pay expenditure in 2017/18 was £267.5m, an over spend against plan of £13.8m.

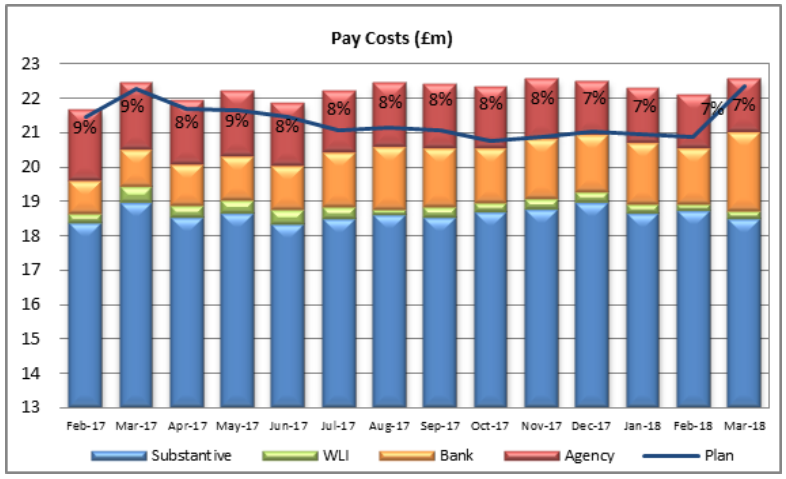
- Substantive pay spend was £227.1m (inc additional sessions).
- Bank pay spend was £19.5m.
- Agency pay spend was £20.9m.

The overall pay run rate increased in month by £0.46m. There has been an increase of £0.66m within bank staffing and a reduction of £0.20m within substantive staffing.

The majority of the increase is as a result of back dated WTD payments for medics and normalisation from February due to number of working days and sickness.

At year end the Trust is reporting a pay position of £267.5m, a £13.8m over spend against plan.

FT Subjective	Year to Date		
	Budget £000s	Actual £000s	Variance £000s
Medics - Consultants	(44,972)	(41,047)	3,925
Medics - Other	(27,465)	(21,238)	6,227
Medics - Agency / Bank	(2,517)	(21,511)	(18,994)
Total Medics Pay	**(74,954)**	**(83,796)**	**(8,842)**
Non Clinical	(40,677)	(38,804)	1,873
Non Clinical - Agency / Bank	(349)	(1,455)	(1,106)
Total Non Clinical Pay	**(41,027)**	**(40,259)**	**767**
Nursing & Midwifery	(98,969)	(92,045)	6,924
Nursing & Midwifery - Agency / Bank	(930)	(15,714)	(14,784)
Total Nursing Pay	**(99,900)**	**(107,760)**	**(7,860)**
ST&T	(34,555)	(33,481)	1,074
ST&T - Agency / Bank	641	(1,770)	(2,411)
Total ST&T Pay	**(33,914)**	**(35,251)**	**(1,336)**
Other	(3,832)	(437)	3,395
Total Other Pay	**(3,832)**	**(437)**	**3,395**
TOTAL PAY	**(253,626)**	**(267,502)**	**(13,876)**



Key YTD Variances:

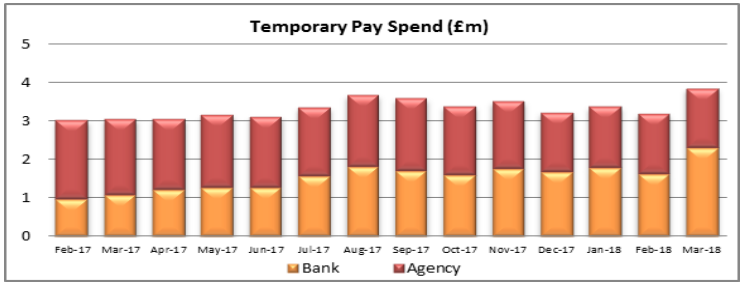
Medics – At month 12 the Trust reports 131.15 wte medical vacancies. The overall medics position is an adverse variance of £8.8m YTD and is driven by the premium costs incurred to cover vacant posts.

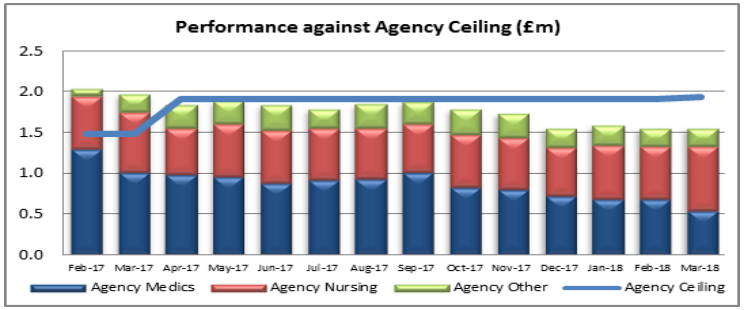
Nursing – Nursing continues to over spend overall, YTD (£7.9m). The key drivers of the nursing variance include;

- Additional Bed Capacity - £3.8m
- Patient acuity / specialing - £1.6m
- Slippage against CIP schemes - £1.8m

Agency

Agency staffing costs of £1.56m in month is an increase of £6k compared to last month. This is £374k under the monthly NHSI agency ceiling. The full year spend on agency totals £20.9m – £2m lower than the agency ceiling of £22.9m.





Non Pay Expenditure
Month 12 – March 2018

Worcestershire Acute Hospitals NHS Trust

In 2017/18 non pay expenditure was £186.3m, an over spend against plan of £8.6m.

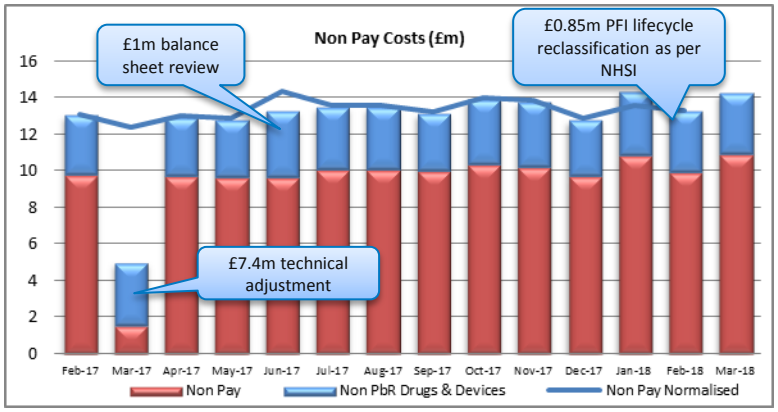
Overall the key drivers of the adverse position YTD is within Clinical Supplies and Services and this is largely driven by the cost of outsourcing activity in support of delivering RTT and supporting flow.

The Trust has undertaken a major reclassification of expenditure in line with NHSI coding. This has resulted in a disparity of budgets against actual spend but does not affect the bottom line position at cost centre level. Budgets are being realigned as part of the 2018/19 budget setting process.

In 2017/18 total non pay expenditure, excluding depreciation, PDC, interest payable and impairment losses was £159.9m. Including these items total non pay expenditure is £186.3m.

FT Subjective	Year to Date		
	Budget £000s	Actual £000s	Variance £000s
Clinical Supplies & Services	(41,741)	(46,002)	(4,261)
Drugs	(8,275)	(8,726)	(451)
Non PbR Drugs	(3,180)	(4,194)	(1,014)
Non PbR Devices	(37,945)	(36,176)	1,769
Establishment Expenses	(4,374)	(4,138)	236
General Supplies & Services	(7,364)	(6,993)	371
Other	(50,674)	(53,689)	(3,015)
TOTAL NON PAY	**(153,553)**	**(159,919)**	**(6,366)**
Depreciation	(9,881)	(10,668)	(787)
PDC - Dividend	0	(19)	(19)
Interest Payable	(14,292)	(14,000)	292
Impairment Losses	0	(1,716)	(1,716)
GRAND TOTAL	**(177,726)**	**(186,322)**	**(8,596)**

As part of the FRP plan authorisation levels were reduced in Sept. In Oct non-clinical items were removed from the iProc catalogue and a process established for requesting non-clinical items deemed essential.



Run Rate Changes

Non pay expenditure increased in month driven by the following key items:

- Normalisation of run rate - allowance for a 31 day month.
- Reduced levels of stock – particularly in prosthesis resulting in a lower closing stock balance.
- Bad debt provision.

Non PbR drugs expenditure remains static in month and is offset through income.

Key YTD Variances:

Clinical Supplies & Services

The key drivers of the YTD adverse variance are:

- Radiology increase in outsourced reporting following the switch of the 2nd CT scanner to support in patient flow - £0.6m.
- Outsourced T&O activity - £0.5m (outside RTT business case).
- Pathology are currently outsourcing a significant volume of tests due to consultant vacancies in Histopathology - £0.4m.
- Dermatology start point activity reduction - £0.42m.

Other

Contained within the "Other" line is Reserves, which contains CIP and phasing adjustments reconciling the overall Trust budget to the plan submitted to NHSI.

The £3.2m YTD adverse variance on this line is predominantly due to unidentified CIP schemes against the original plan, offset by Reserves phasing, as well as the impact of the £850k for PFI lifecycle credits.

CIP Performance
Month 12 – March 2018

Worcestershire Acute Hospitals NHS Trust

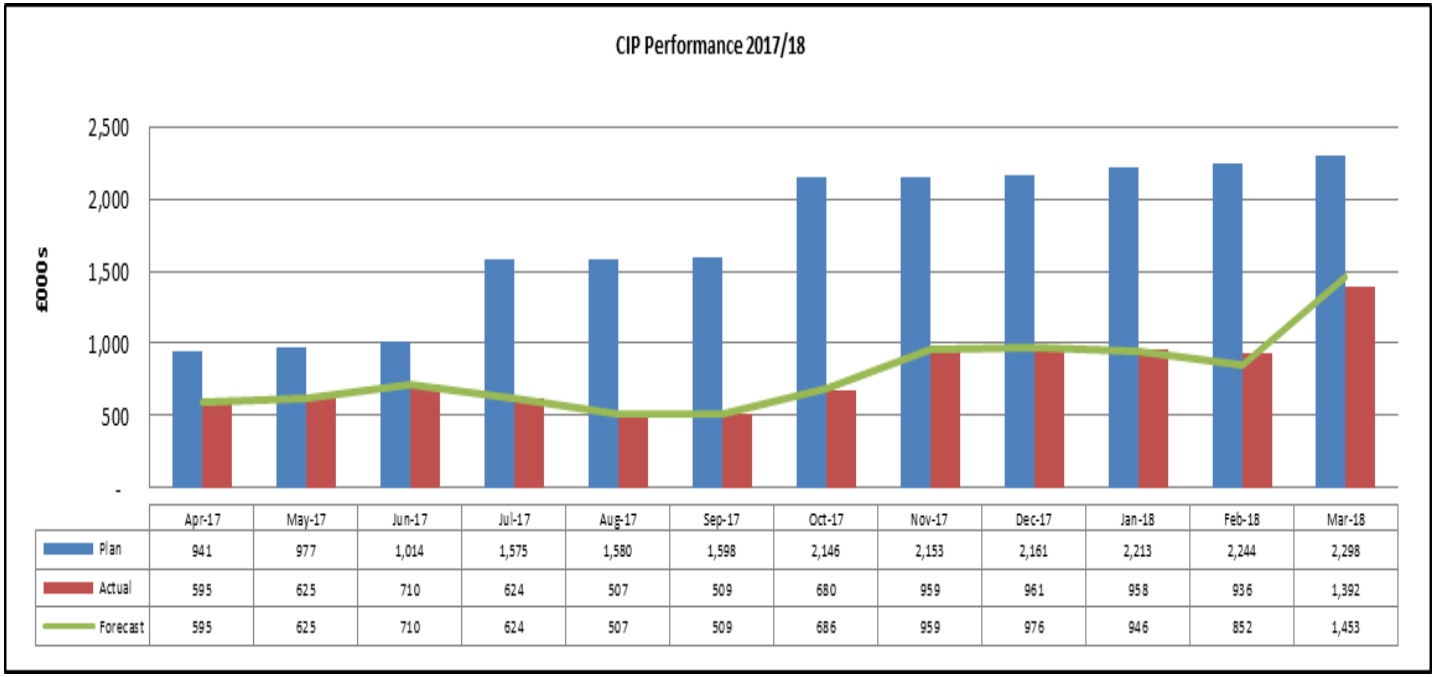
The financial plan assumed efficiency savings of £20.9m (5.3% turnover) were delivered in 2017/18.

In March the Trust had a plan to deliver £2.3m of savings and has achieved £1.4m of savings. This is a £0.9m adverse variance against plan.

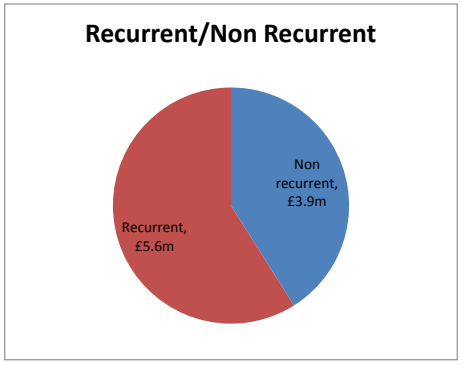
YTD the Trust had a plan to deliver £20.9m of savings and has achieved £9.5m of savings resulting in an £11.4m adverse variance against plan.

£3.9m of the 2017/18 savings were classified as non recurrent.

The full year effect of recurrent schemes provides an additional £1.5m in 2018/19.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Plan	941	977	1,014	1,575	1,580	1,598	2,146	2,153	2,161	2,213	2,244	2,298
Actual	595	625	710	624	507	509	680	959	961	958	936	1,392
Forecast	595	625	710	624	507	509	686	959	976	946	852	1,453



- The Trust delivered £9.5m of CIP in 2017/18
- £3.9m of the 2017/18 savings were classified as non recurrent.
- The full year effect of recurrent schemes provides an additional £1.5m in 2018/19.

Balance Sheet

Worcestershire Acute Hospitals NHS Trust

March

In March the Balance Sheet is ahead of the plan by £0.7m

There is an increase in value of the Trust's estate (£12.9m) following the result of the revaluation completed in March . This has changed Balance Sheet performance against the plan this month.

Other variances are on stock value which is higher than plan (£4.4m), mainly due to a decline in elective activity and purchase of a large quantity of implants stock to receive bulk discount. Trade and Other Payables are higher than plan by £15m, mainly due to the tight cash flow this year.

Private Finance Initiative (PFI) borrowings differ from the plan by £7.3m due to PFI availability credit received at the end of 2016/17 financial year resulting in reduction of the long-term liability.

	Budget	Actual	Fav/(Adv)
	£000s	£000s	£000s
Assets			
Property, Plant and Equipment, non current	177,152	180,105	2,953
PFI Property, plant & equipment, non current	77,316	87,787	10,471
Intangible Assets, non current	3,768	2,531	(1,237)
Trade and Other Receivables, non current	2,204	2,725	521
Total Non Current Assets	**260,440**	**273,149**	**12,709**
Inventories	5,625	10,119	4,494
Trade and Other Receivables, current	9,463	20,783	11,320
Other Assets, Current	3,316		(3,316)
Cash and Cash Equivalents	1,900	2,107	207
Assets Held for Sale	0	400	400
Total Current Assets	**20,304**	**33,409**	**13,105**
Total Assets	**280,744**	**306,557**	**25,813**
Current Liabilities			
Trade and Other Payables	(20,054)	(34,932)	(14,878)
Borrowings PFI	(2,106)	(2,105)	1
DH Revenue Support Loan	(39,506)	(39,506)	(0)
DH Capital Loan	(2,689)	(2,904)	(215)
Interest payable on DH Loans	0	(961)	(961)
Provisions	(618)	(772)	(154)
Other Liabilities	(494)	(640)	(146)
Total Current Liabilities	**(65,467)**	**(81,821)**	**(16,354)**
Net Current Assets/(Liabilities)	**(45,163)**	**(48,412)**	**(3,249)**
Non Current Liabilities			
Borrowings PFI	(68,008)	(60,704)	7,304
DH Revenue Support Loan	(102,344)	(128,092)	(25,748)
DH Capital Loan	(35,532)	(24,294)	11,238
Provisions	(1,653)	(3,013)	(1,360)
Other Liabilities	(3,011)	(3,224)	(213)
Total Non-Current Liabilities	**(210,548)**	**(219,327)**	**(8,779)**
Total Assets Employed	**4,729**	**5,410**	**681**
Financed by Taxpayers Equity:			
Public Dividend Capital	185,017	187,347	2,330
Revaluation reserve	54,320	69,238	14,918
Other reserves	(861)	(861)	0
I&E Reserve - Breakeven Performance	(196,439)	(213,006)	(16,567)
I&E Reserve - IFRS Transition and non breakeven	(37,308)	(37,308)	0
Total Taxpayers Equity	**4,729**	**5,410**	**681**

Cash

At the end of March the cash balance was £2.1m, £0.2m higher than minimum balance required by the DH due to a contingency allowed for emergency payments.

Interim Support/Borrowings

The Trust has received £57.070m additional revenue loan support in line with the revised I&E deficit forecast. In addition, emergency capital loan funding of £2.4m was received in March. Total current and non-current borrowings as at March are summarised in the table below.

	Capital	Revenue	Total
	£000s	£000s	£000s
Radiotherapy Loan	17,336		17,336
IT Infrastructure Loan	1,980		1,980
Emergency Department Loan	3,169		3,169
Capital Emergency Loan	4,713		4,713
Revenue Support Loan		167,598	167,598
	27,198	167,598	194,796

The Trust will continue to require revenue support in 2018/19 in line with its planned deficit. The expected requirement over quarter 1 is £7.033m.

Working Capital

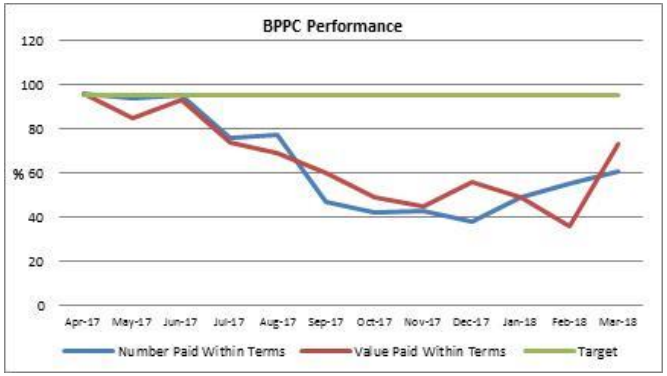
Worcestershire Acute Hospitals NHS Trust

The working capital balance remains negative in March (£62m).

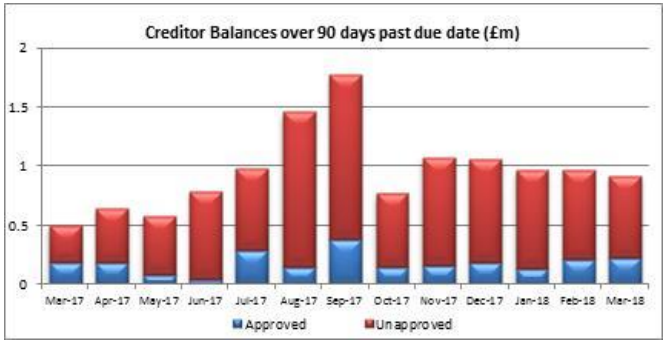
This means that the Trust has greater difficulty in covering its operating costs.

DH loan repayments in current liabilities are part of the working capital. A principal revenue loan repayment of £39.5m is due next year for which the Trust will need to agree either further borrowing or a revision to repayment terms.

The liquidity ratio has a direct impact on the Trust's ability to pay creditors within their agreed credit terms.



Better Payment Practice Code (BPPC) performance has improved this month, however is still below the national target of 95%. Only 61%, 7,956 invoices out of 13,027, and 73% value , £24.2m worth of invoices out of £33.2m were paid on time this month. The additional cash support received from the DH helped to clear the backlog of unpaid invoices and has improved BPPC performance for invoices that were due for payment in March.

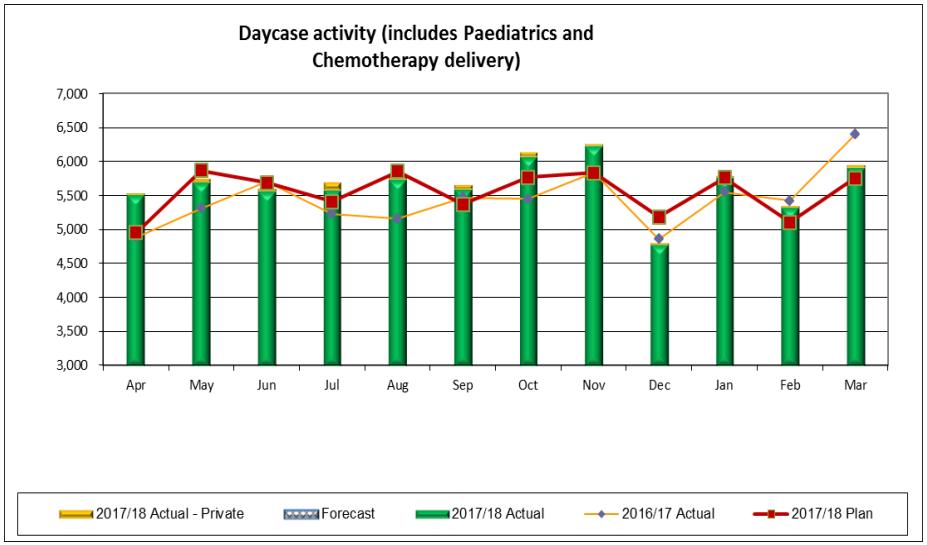


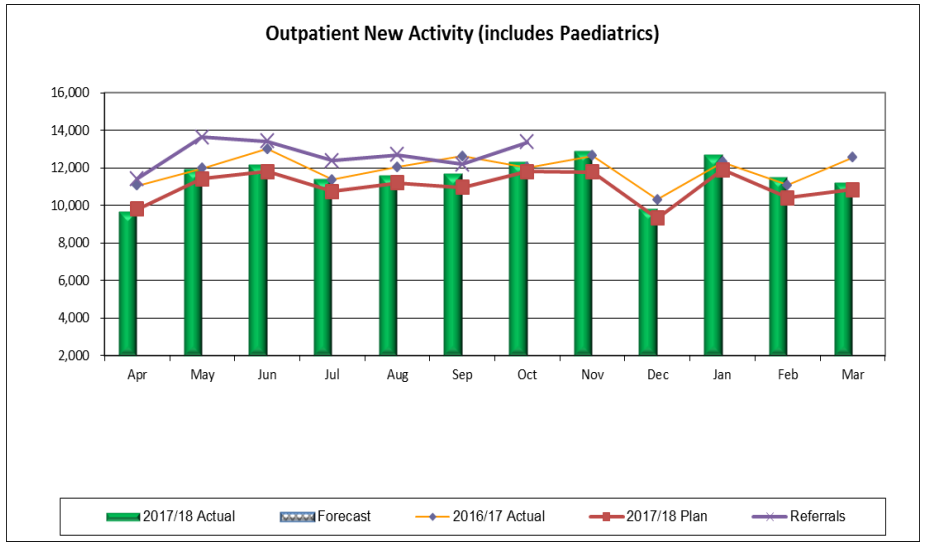
Outstanding creditors over 90 days past due date have marginally decreased in March. Unapproved invoices over 90 days of £691k remains high mainly due to disputed charges. The most significant aged creditors over 90 days overdue are Worcester SPC £290k, Birmingham W&C NHST £182k, Heart of England NHSFT £91k, SWFT £40k.

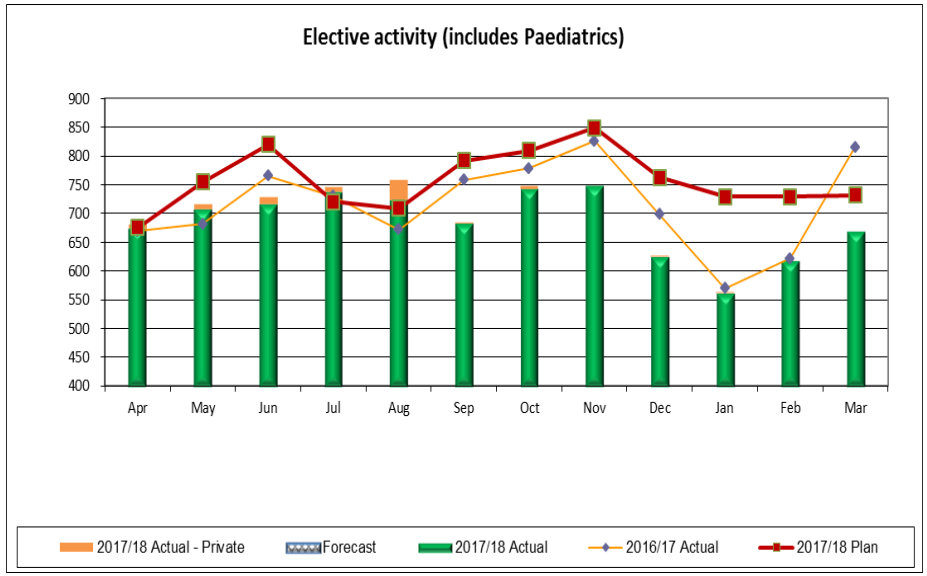
The debt over 90 days overdue has decreased by £0.7m in March with the value at the end of the month being £3.623m. The invoices for IT services provided to the three main Worcestershire CCG's to a value of £771k, for pharmacy gain share £317k, for various projects with South Worcs CCG £221k remain unpaid. The other significant debtors are NHS England £289k for CDF drugs, Birmingham W&C NHSFT £150k, UHCW £142k for antenatal and other SLA's.

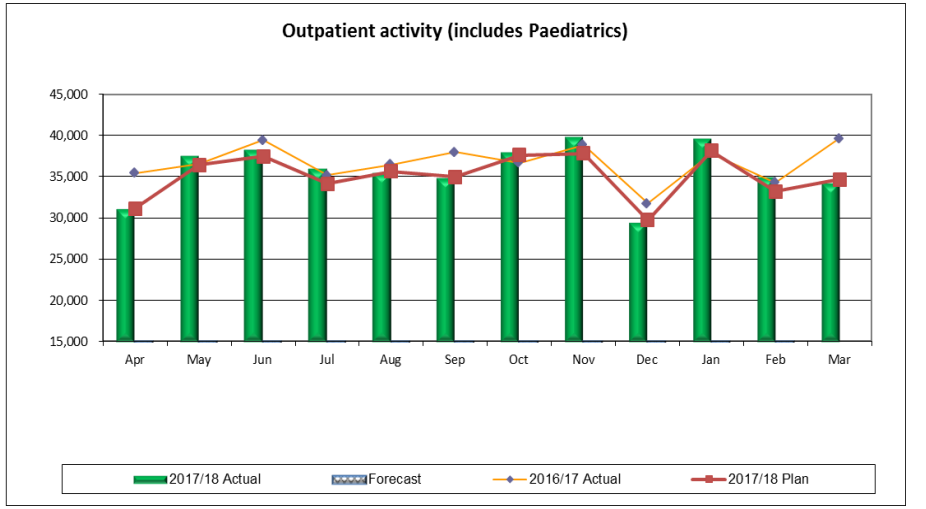
Activity – Elective, Day Cases and Outpatients New

Worcestershire Acute Hospitals NHS Trust



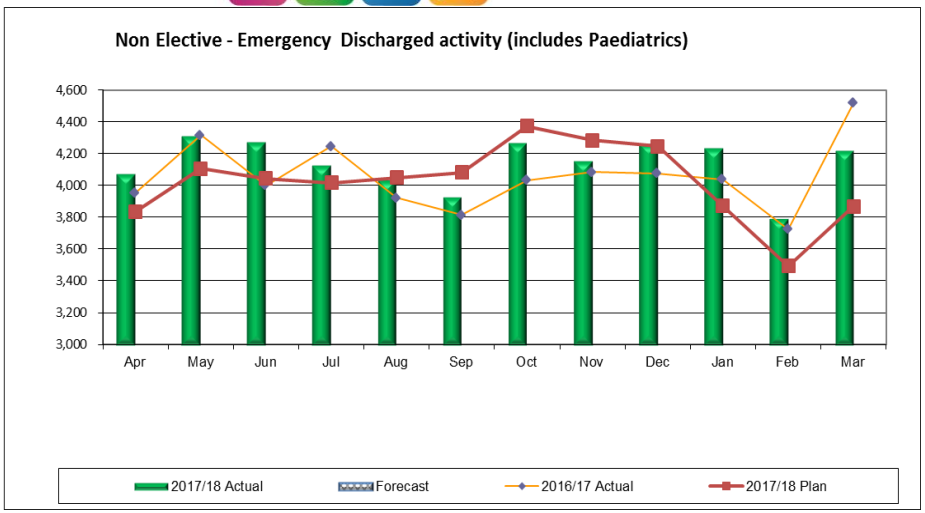


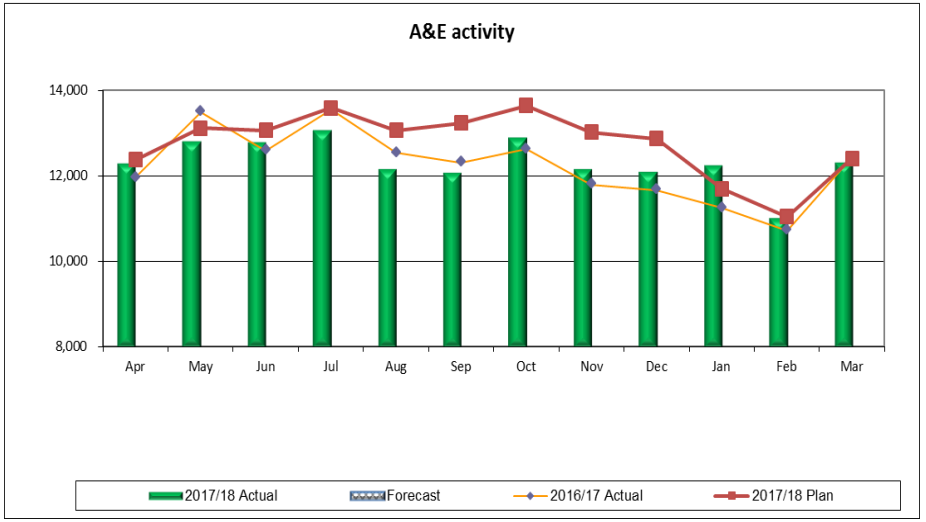




Activity – Outpatients, Non Elective and A&E

Worcestershire Acute Hospitals NHS Trust





NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	08 May 2018
Paper number	E2

2018/19 Operational Plan Refresh

For approval:	x	For assurance:		To note:	

Accountable Director	Michelle McKay, CEO		
Presented by	Sarah Smith, Director or Strategy and Planning	**Author**	Sarah Smith

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**
Strategy and Planning Group	20 April 2018	Draft narrative reviewed
Finance and Performance Committee (financial plan only)	23 April 2018	Approved the 2018/19 budgets prior to the transaction of CIP

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

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☒	**No assurance** *No confidence in delivery*	☐

Recommendations	Trust Board is asked to approve the 2018/19 Operational Plan refresh in line with joint NHSI/NHSE planning guidance issued in February 2018.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	08 May 2018
Paper number	E2

Executive Summary

The Trust has updated its two – year operational plan 2017 to 2019 following the Autumn budget statement, and in line with joint planning guidance issued for the year 2018/19 that was issued in February 2018.

The Trust intends to sign up to the revised 2018/19 financial control total of £22.2m deficit and to access the Provider Sustainability Fund.

This places an efficiency requirement of £23.9m on the Trust, which is c6% of turnover. A robust financial recovery programme is underway, led by a dedicated Turnaround Director with support from a strengthened corporate PMO, to identify and ensure delivery of the appropriate financial efficiencies.

The narrative plan has been updated to reflect other significant developments in the approach to improvement at the Trust, which include the Quality Improvement Strategy and the People and Culture Strategy.

The Trust plan is appropriately aligned with the current STP plans and the activity, financial and capacity assumptions should triangulate internally and with partner organisations plans.

The Trust has developed a three year plan (2018/19 to 2020/21) to set out the medium term plans and priorities for the organisation, which is informed in year one by this operational plan.

Background

The NHS has two-year contracts and improvement priorities set for the period 2017/19. Worcestershire Acute Hospitals NHS Trust (WAHT) submitted a two year operational plan (2017-2019) at the end of the 2016/17 financial year in line with joint planning guidance issued in December 2016.

New guidance *Refreshing NHS Plans for 2018/19* was issued in February 2018. Detailed planning templates have been issued via the usual portal and plan submissions should include a short narrative plan providing an overview and explanation of changes to the plan for 2018/19 in terms of activity, quality, workforce and finance.

Key areas from the 2018/19 guidance include

Resources available to CCGs have increased by £1.4 billion, principally to fund realistic levels of activity in emergency and elective care and ongoing investment and transformation in in mental health services, cancer and primary care. This also includes a new £400 million Commissioner Sustainability Fund (CSF) partly mirroring the financial framework for providers, to enable CCGs to return to in-year financial balance.

£650 million has been added to the £1.8 billion Sustainability and Transformation Fund to create an enhanced £2.45 billion Provider Sustainability Fund (PSF). As in 2017/18, 30% of the total £2.45 billion fund will be linked to A&E performance. Providers who accept their control totals will have access to the PSF for 2018/19 and will continue to be exempt from the application of an agreed range of contractual performance sanctions, as set out in the existing NHS Standard Contract.

Date of meeting	08 May 2018
Paper number	E2

The expectation is that the Government will roll forward the goal of ensuring that aggregate performance against the four-hour A&E standard is above 90% for the month of September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019, and that the NHS returns to 95% overall performance within the course of 2019.

The 2018/19 allocations allow for improvements in the volume of elective surgery being funded, and improvements in the number of patients waiting over 52 weeks. Commissioners and providers should plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018 and, where possible, they should aim for it to be reduced.

The 2017 Autumn Budget provided an extra £354 million of public capital in 2018/19. In updating 2018/19 operational plans, STPs and providers should not assume any capital resource above the level in the current 2018/19 operating plans unless NHS England and NHS Improvement have given written confirmation of additional resource

Local systems are expected to continue to implement the priority efficiency programmes. This includes taking every opportunity to maximise provider operational productivity, guided by the Model Hospital portal; the implementation of *Getting It Right First Time* recommendations; participation in networked arrangements for procurement; reducing agency staff usage; and improving the safety and efficiency of estate and facilities.

For STPs that are not yet integrated care systems, there is the requirement to ensure alignment in activity, income and expenditure assumptions across constituent commissioner and provider organisations and broader alignment in the plans across the STP geography.

There will be no additional winter funding in 2018/19. To ensure that winter preparation has been undertaken well in advance and using existing funds, systems will need to demonstrate that winter plans are embedded both in their system plans and in individual organisations' operating plans, including realistic phasing of non-elective and elective activity across the year. To support this there is a requirement for each system to produce a separate winter demand and capacity plan, triangulating the finance and activity implications along with the actions and proposed outcomes.

A general letter was issued following the submission of draft provider plans highlighting that not all plans were sufficiently robust and there was the need for further work to ensure sufficient read-across between activity plans, financial plans and performance trajectories, and capacity and / or workforce assumptions.

Issues and Options

The Trust continues to experience significant challenges to its quality, operational and financial performance and is pursuing more strategic solutions to these issues in 2018/19 as well as focussing on operational delivery.

Recommendations

Trust Board is asked to approve the 2018/19 Operational Plan refresh in line with joint

Date of meeting	08 May 2018
Paper number	E2

NHSI/NHSE planning guidance issued in February 2018.
Attachment: Update to two year operational plan. Focus on 2018/19

Worcestershire Acute Hospitals NHS Trust
Update to Two – Year Operational Plan 2017/18 – 2018/19
Focus on 2018/19

Introduction

Worcestershire Acute Hospitals NHS Trust (WAHT) submitted a two year Operational plan (2017-2019) at the end of the 2016/17 financial year in line with joint planning guidance issued in December 2016. New guidance *Refreshing NHS Plans for 2018/19* was issued in February 2018. Plan submissions include a short narrative plan providing an overview and explanation of changes to the plan for 2018/19 in terms of activity, quality, workforce and finance.

Background

During 2017/18 the Trust faced the dual challenge of needing to continue to address fundamental quality issues following the CQC Inspection report published in December 2015 (that led to an overall rating of inadequate) and major challenge around its financial position.

Despite some good improvements in core services that have been recognised by the CQC, the Trust has not yet been able to yet to demonstrate sufficient inroads through the new inspection process and is still, at the time of writing, rated as inadequate overall by the CQC.

The Trust has been under NHSI enhanced financial oversight as a result of the 2017/18 in - year position deteriorating from the agreed control total plan. A robust financial recovery programme was implemented which stabilised the financial position (albeit an ongoing deficit position) resulting in a 2017/18 financial outturn of £57.9m deficit which is £15.2m worse than the pre STF plan.

High levels of bed occupancy and chronically poor patient flow continue to represent the biggest risks to patient safety at the Trust. And, although the Trust has done significant work (led by the Chief Nurse and the Chief Medical Officer) to strengthen quality and safety systems and governance arrangements from floor to board, there is more to do embed these changes to fully develop a culture of safety and improvement.

The Trust entered 2017/18 with a new, largely substantive Board, having for the previous 18 months relied on a series of acting and interim executive and non - executive leadership arrangements. This has been a very positive development and critical to the Trust's ability to turnaround performance and rebuild confidence. Developing our clinical workforce and re-engaging our clinical leaders needs to run alongside our new Board leadership arrangements if we are to be assured of success.

The Future of Acute Hospital Services in Worcestershire (FoAHSW) programme concluded in 2017/8 following public consultation on the service reconfiguration proposals and approval of the clinical model. The programme had been in place for a number of years and through the programme, a number of the target services had been temporarily centralised on the Worcestershire Royal Hospital (WRH) site due to safety and sustainability concerns. These changes have now been made permanent and in 2017/18, the Trust was also successful in its bid for STP capital to enable much needed capacity development to fully support the delivery of the clinical model and the reconfigured services, subject to an approved full business case. The outline business case was approved in December 2017 and the full business case will be submitted in summer 2018.

2018/19 Operational Plan

The Operational Plan refresh for 2018/19 is set out under the following headings:

1. Activity plan
2. Quality plan
3. Workforce plan
4. Financial plan
5. Hereford and Worcestershire Sustainability and Transformation Plan (STP)

1. Activity Plan

1.1 Planning assumptions

The Trust and commissioners have worked on an 'open book' basis, and the projected 2018-19 activity levels have been agreed with commissioners, aligned to the STP planning assumptions.

The activity plan for 2018-19 is based on:

- A projected 12 months actual activity (April 17– August 17 actuals projected forward), adjusted for known changes to the baseline and capacity shortfalls addressed non recurrently in 2017/18;
- An average 2% demographic / non demographic growth in core points of delivery (PODs) and more tailored growth levels for other PODs; and
- Commissioner QIPP; contract agreement is a continuation of 2017/18 cap collar arrangements – Contract Value net of CCG QIPP is £272.8m, cap is £277.3m so Trust at risk for first £3m of CCG QIPP. See Appendix One.

High level activity assumptions are summarised below.

Activity	FOT 17/18	FY 18/19
Consultant led First Outpatient attendances	129,504	131,277
Consultant led follow up outpatient attendances	191,008	198,434
Total elective admissions spells (ordinary and day case admissions)	83,727	87,756
Total non-elective admissions	50,682	50,993
Total A&E attendances excluding planned follow ups	188,292	188,787

1.2 Demand and Capacity

Emergency care

Throughout 2017/18, the Trust experienced significant levels of stranded patients (defined as any patient, regardless of age, who has been in a 'therapeutic/assessment bed' for 7 days or more). Across the Trust, an average of 44% of beds are occupied by stranded patients, which is higher than the target, resulting in high bed occupancy and creating challenges in achieving flow, the emergency access standard and maintaining elective throughput. Worcestershire Royal Hospital has been operating consistently at or above 100% occupancy and, since Dec 2017, a similar upwards trend is starting to emerge at Alexandra Hospital (AH). In addition, there has been a gradual but constant centralisation of services at Worcestershire Royal Hospital without the planned additional bed capacity at this site.

High occupancy rates contribute to deterioration in ED performance. Overall, ED attendances have been relatively flat over the past three years, despite short-term fluctuations. However, the shape of the ED attendances has changed, with a marked increase (28%) in the proportion arriving by ambulance, putting additional pressure on the Trust's ability to meet the emergency access standard, and keep ambulance handover times within acceptable limits.

A number of best practice initiatives continue to be implemented to improve flow and reduce bed occupancy through the external support the Trust has received and through local schemes. Ambulatory emergency care has been further developed at both acute sites resulting in more non elective patients following ambulatory / same day pathways. A frailty assessment service for the county has been implemented based at the Redditch hospital site focussing on comprehensive geriatric assessment and admission avoidance to support more appropriate management of these patients. Average length of stay (LoS) for non-elective admissions at WRH is 5.2 days whereas at AH it is 7.1 days and in line with the average LoS with Right Care peers.

Following OBC approval in December 2017, a final business case is in development for £29.6m capital to support the acute services reconfiguration programme, and the Trust has received early support for the £3m link bridge element of the scheme at WRH in order to make the adjacent Aconbury campus and 3-4 wards therein part of the main site infrastructure from winter 2018.

Elective care

To support delivery of the elective programme, the Trust has, where clinically appropriate, moved inpatient elective work from WRH site to AH and outsourced activity to the independent sector. Improved productivity and efficiency and enhanced clinical service planning is a core part of the Trust 2018/19 financial recovery programme (FRP), and the Trust has engaged external support to maximise this opportunity. The activity levels modelled in this plan are achievable, subject to the modelled efficiency and productivity improvements, and the Trust has not assumed any material use of outsourcing during 2018/19.

Diagnostic services remain a specific challenge, where demand, particularly for endoscopy, currently outstrips capacity by some margin. A business case to substantively fund endoscopy capacity has recently been agreed, and the additional productivity and efficiency work is also focused on maximising opportunities in endoscopy. The Trust has plans in place for an expansion in ambulatory endoscopy capacity at the AH and at the Kidderminster Treatment Centre (KTC).

1.3 Delivery of operational performance standards

The Trust agreed challenging 2017/18 trajectories to recover RTT, diagnostics and 62 day cancer performance. Cancer performance continues to recover well despite a very poor start to 2017/18 and work on the cancer improvement plan and NHSI IST support will continue into 2018/19 with a specific focus on 62 day cancer performance. Based on unvalidated figures, the Trust was achieving 4 of the 8 operational standards for cancer waiting times in March 2018, and although the 62 day cancer target was not met, the trajectory of 80% is expected to be achieved, the first time since February 2016, with 82.07% of patients treated within 62 days.

RTT performance for March 2018 indicates that there are 4 patients waiting for 52 or more weeks and the percentage of patients who have been waiting less than 18 weeks is currently 82.34%.

Following the elective pause, RTT performance in February and March was slightly below trajectory but recovering, and this position should be maintained/ improved during 2018/19 with further reduction /elimination of over 52 week waits.

EAS performance remains extremely challenging and deteriorated further towards the end of 2017/18 despite ongoing initiatives to improve flow. The situation is exacerbated by a disproportionate rise in ambulance conveyances at the Trust. The Trust through its revitalised flow programme will seek to ensure that EAS performance improves across each quarter of the year compared to the same quarter in 2017/18 and that the Trust contributes appropriately, with a realistic EAS trajectory, to the goal of 90% aggregate performance for the month of September 2018 and a return to 95% performance nationally during the course of 2019.

Diagnostics performance recovered well during 2017/18 but performance deteriorated in March 2018 (3.80%) and did not achieve trajectory or operational standard. This was a result of ongoing 'winter' pressures and particularly the use of endoscopy beds as surge capacity.

Draft 2018/19 performance trajectories have been submitted to NHSI and for diagnostics and 62 day cancer performance, the operational standard for 62 day cancer of 85% is anticipated to be achieved from September 2018 onwards and no more than 1% of patients waiting for a diagnostic test from June 2018, with an anticipated decline in performance between December 2018 and February 2019.

2. Quality plans

2.1 Approach to quality

Quality Improvement

WAHT has developed a Quality improvement Strategy (QIS) which has evolved from the Quality Improvement Plan (QIP) operationalised during 2017/18.

The Quality Improvement Plan was generated following the Care Quality Commission (CQC) ratings of services from the inspections undertaken from July 2015 to November 2016 and the section 29A notice received in January 2017. Their findings and our improvements were categorised into the areas of: improving patient outcomes; patient experience and engagement; safe care; governance; operational flow and culture and workforce.

In November 2017 an inspection focused on urgent and medical care found that improvements were made in a significant number of areas that lifted the previous ratings in these core services. Due to a change in the process of CQC inspections, this did not however change the overall trust rating.

The Trust is committed to providing highest possible standards of compassionate care and the very best patient and staff experience. The Quality Improvement Strategy has been devised to ensure a structured approach. The aim of the strategy is to create a culture of continuous improvement and learning which is both patient centred and safety focused.

The Quality Improvement Strategy has been developed across three key domains (see Figure One) each with associated implementation plans and quality metrics to measure progress. Delivery of the strategy will be managed through the Quality Improvement and Governance Group reporting into Trust Leadership Group and the Quality Governance Board sub - committee.

Figure 1 - WAHT Quality Improvement Strategy

Quality improvement plans to deliver the Quality Improvement Strategy will also be outlined in divisional and directorate annual plans.

The Trust has other supporting quality improvement programmes in 2018/19 reflecting the national priorities e.g. through CQUINs. All but two of the 2017/18 national CQUINs are applicable across 2018/19 and an assessment of the anticipated 2017/18 year end performance shows full or partial achievement of all 13 CQUINs. 2017/18 performance against the sepsis standards is at the highest level since the trust originally participated in this CQUIN. Reflection on the 2017/18 approach to delivery of the CQUIN objectives demonstrates that consistent leadership, organisational commitment, effective governance structure and appropriate transformation team project support all led to the success of the programme.

Quality governance

The Chief Nursing Officer is the lead for quality governance. The Trust has rebuilt its governance structure to ensure that there is effective oversight and assurance of all aspects of clinical governance from floor to Board, supported by a safety and quality information dashboard (SQUID).

The principles of good governance have resulted in standardised terms of reference, reviewed membership of each group in the new governance structure and workshops to ensure group members are clear about their role and purpose.

With the scale of the financial challenge facing the Trust and the need to transform service delivery on multiple, levels, the Trust has recently enhanced the corporate PMO function to strengthen and support the financial recovery plans and the underpinning elements such as robust project and programme management, standardised documentation and processes, benefits realisation and tracking (financial and non-financial) and the QIA process. The Chief Medical Office and the Chief Nursing Officer meet weekly with the Head of PMO to review/approve the PIDs and associated QIAs for the financial recovery plans and any other major service change initiatives. A QIA report is included as part of the reporting structure from the Recovery Steering Group and separately through the quality governance structures. The Corporate PMO with support from the 4ward programme will be running engagement session with the wider organisation on the role and function of the corporate PMO, and gateway processes for scheme development, approval and implementation, including QIA.

Other key actions to improve quality

Ward based patient quality checks were rolled out across the Trust in July 2017. Questions relate to key areas for development highlighted from previous CQC inspections under the key lines of enquiry. Three weekly audits of patient notes on each ward are undertaken by matrons and the development of a dashboard has driven improvement of the quality of care for patients. Trust Executives undertake weekly quality check visits. The development of a ward based accreditation programme and an earned autonomy from sustained performance on quality indicators is currently in development

The Trust 4Ward programme links culture change through behaviour change with process improvement through the process flow conversations. It provides a framework for delivering our quality improvement aims. The programme includes four signature behaviours which underpin our intentions and action in the quality agenda for 2018/19.

These signature behaviours are:

- *We listen, we learn, we lead*
- *Do what we say we will do*
- *No delays, every day*
- *Work together, celebrate together*

Our action for quality related to the signature behaviours are:

- Listening to staff and patients views, understand where we can improve quality and safety for patients and experience for staff.
- Making the working environment conducive to continuous learning and improvement
- Actively engaging staff in continuous improvement through the development of divisional improvement plans and action plans
- Focusing on the human factors to ensure support and development of self- management and team working
- Being open and honest with people when things go wrong
- Sharing lessons learnt from incidents and improvements
- Creating a culture of openness and candour in line with the Learning not to Blame report, the Freedom to Speak up Report and other publications supporting incident reporting and learning

Quality improvement capability

It has been recognised that to create a sustainable safety and improvement culture, the Trust needs to build the skills and capability of staff at every level in a range of improvement techniques. Through the STP, staff have access to NHS Improvement's Quality Service Improvement and Redesign (QSIR) programme, and at the Trust we are creating an internal CPD programme that will have a suite of programmes ranging from basic skills to advanced improvement skills including Human Factors.

3. Workforce plans

3.1 Planning assumptions

The Trust's workforce plan has been completed in conjunction with the service and financial plans for 2018/19, the STP, and in line with internal CIP/FRP schemes.

3.2 Workforce Changes

The Trust's plan includes workforce changes due to additional staff required for agreed service developments. The additionality is relatively small compared to the workforce change required to wherever possible to address longstanding clinical staff vacancies and appoint substantively to vacant posts that are currently filled by ad hoc, premium cost temporary staff. The latter will result in substitution of substantive staff over temporary/agency as well as overall reduction in temporary/agency staffing expenditure. During the 2017/18 the Trust made significant inroads with the net result that over the period Feb 2017 to March 2018 medical staffing vacancies reduced by 44.02wte from 161.22wte to 117.20wte. As at 31st January 2018 the Trust had 141.06 wte budgeted registered nurse vacancies however taking into account roles appointed but not yet started, this reduces to 103.45 wte (excluding further attrition). Registered Nursing turnover at the end of March 2018 was 10.47% reduced from 11.17% in December. This is within Trust target of 10-12%.

Expenditure assumptions related to growth in activity are marginal and 'winter monies have been assumed for additional temporary capacity and to manage the period of transition to full acute services reconfiguration.

Summary proposed workforce changes for 2018/19 are presented below:

Trust Staff (WTE)	As at 31/3/2018	As at 31/3/2019
Bank	332.1	248.1
Agency staff (including, Agency, Contract and Locum)	204.4	138.8
Total temporary staff	**536.5**	**386.9**
Total Non-Medical: Clinical Staff	4062.3	4152.1
Total Non-Medical: Non-Clinical Staff	555.7	445.8
Total Medical and Dental Staff	581.9	590.3
Total substantive staff	**5199.9**	**5188.2**
Total staff	**5736.4**	**5575.1**

3.3 Workforce Challenges

The Trust continues to experience difficulties in recruiting to some key clinical posts and this presents one of the major risks to the Trust's operational performance. There are chronic recruitment hotspots in Medicine and in other areas due to national shortages and/or changes in specialty training numbers impacting both consultant and junior doctor recruitment. The Trust will continue with its recruitment and retention plan as part of the People and Culture Strategy and will also look at emerging workforce models locally and nationally through the STP and other local networks.

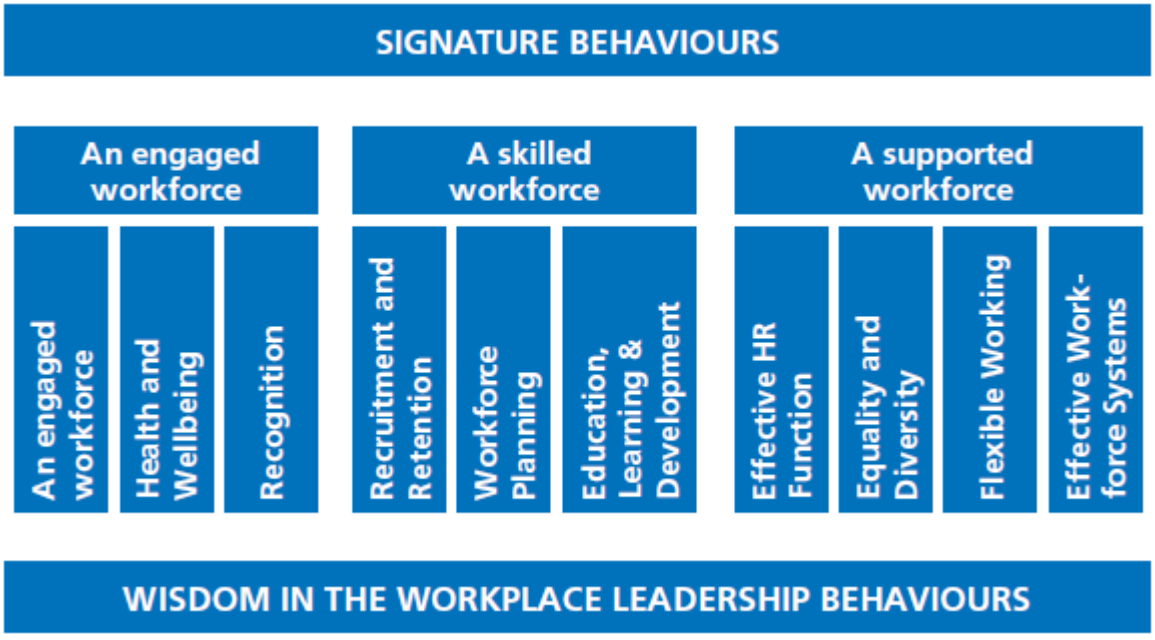
NHSI Model Hospital benchmarking from January 2018 (which is the latest information available) indicates that our retention rate for Registered Nurses, Midwives and Healthcare Support Workers is better than the national average for peer Trusts which correlates with our reducing turnover since July 2016 and puts us in the 4th (best) quartile for retention for Nurses, Midwives and Healthcare Support Workers. Our position has improved since October 2017 Model Hospital benchmark from 3rd quartile.

Our retention of healthcare support workers is worse than average but we do not have difficulty recruiting to these posts so this is not of particular concern. Vacancies and recruitment to areas with high vacancies are managed by Ward Managers, Matrons and Divisional Directors of Nursing and reviewed at the Nursing and AHP Workforce Assurance Group. Our new People and Culture Strategy was launched on 9th February 2018 and is underpinned by a Nursing and Midwifery Retention Strategy (January 2018)
The centralisation of some Women and Children's services to the Worcester site has enabled the Trust to better balance workforce supply and demand, both medical and nursing, which has helped with our vacancy position.

3.5 Governance and workforce key performance indicators (KPIs)

The Trust launched a new People and Culture Strategy in February 2018 (see figure two below)

Figure 2 People and Culture Model



Enabling strategies have been developed for each of the key headings in the workforce model supported by an implemention plan and a people and cuture scorecard, with key performance indicators that are reviewed and monitored at the monthly Finance and Performance Board Sub Committee and the bi-monthly People and Culture Board Sub Committee. All workforce plans and action plans are assured at the People and Culture Committee.

4. Financial Plans

4.1 Financial forecasts and modelling

The operating plan for 2018-19 is necessarily focused on driving out excess costs, mitigating capacity constraints and stabilising the workforce to support the organisation in terms of quality, patient safety and financial stability.

4.2 Control total delivery

The Trust has delivered, subject to audit, its revised 2017/18 forecast outturn of a £57.9m deficit, which is a greater deficit than the 2017/18 financial control total. For 2018/19 the Trust has been notified of a small change to the control total. The Trust Board has reviewed the financial plans and deliverability of the control total as part of the budget sign off process.

4.3 Planning assumptions

The financial plan for 2018/19 has been developed using the following key assumptions:

Income

Contract income changes are driven by national assumptions and local planning assumptions as agreed through the STP. The key income change assumptions are:

- 2017/18 projected outturn adjusted for non-recurrent items
- Application of tariff inflator per national tariff prices
- Application of national efficiency requirement in tariff
- Activity growth (demographic and non-demographic) assumed to be an average of 2% (core PODs) in line with STP assumption (based on specialty sense check exercise)
- CQUIN remains at 2.5%
- CCG QIPP assumed to be at £7.5m in 2018/19. This level of demand reductions will be challenging to achieve in year. CCGs have shared QIPP PIDs demonstrating the schemes being developed to support an activity / cost reduction of this magnitude.
- Given the financial positions of both commissioner and provider, a cap/collar contract model has been agreed to more equitably share risk and support implementation of CIP/ QIPP schemes.

Expenditure

The key expenditure change assumptions are:

- 2017/18 outturn underlying run rate
- Inflation assumptions are based on national assumed levels, plus an allowance for local cost pressures in line with historic levels seen.
- CIP assumptions as described in the section 4.6 below. Effectively 6% CIP to deliver the control total.
- An assumed marginal expenditure adjustment of 70% where activity rises or falls. This assumption does represent a risk, particularly when activity volumes are falling but not at a level to support step changes in the cost base, e.g. small reductions to outpatient activity across a number of specialties.

- Agency ceiling for 2018/19 will not exceed the published level of £17.29m. Expenditure will need to be significantly below this level to deliver the I&E control total.
- Growth has been assumed at 2%, with a higher rate for drugs and CNST based on notified increases in premiums.
- No impact of service developments is included within the position, other than those already being implemented, or the targeted winter cost reserve.

4.4 Cash position

The trust continues to forecast deficits through to 2018/19. These deficits require support in the form of loans from the DH to ensure the trust can meet its ongoing financial commitments. The post STF deficit position of £22.2m in 2018/19 would need to be mitigated through revenue support loans, less any movements in working capital. There is the need for investment in capital over the planning period to support the ASR reconfiguration programme, estates backlog maintenance and IM&T due to the requirement to repay the PFI and loan principal repayments from internally generated depreciation.

4.5 Sustainability and Transformation Fund (STF)

In signing up to the 2018/19 control total and associated conditions, the Trust will access the STF general funding of £12.663m plus the additional STF of £5.144m. This is reflected within the financial plans.

Summary

The table below shows the impact of the assumptions in arriving at the 2018/19 planned deficit of £22.2m, after receiving £17.8m from the Sustainability and Transformation Fund.

STATEMENT OF COMPREHENSIVE INCOME	Unaudited Out-turn 31/03/2018 £'000	Plan 31/03/2019 £'000
Operating income from patient care activities	369,226	381,756
Other operating income	31,692	45,173
Employee expenses	(267,417)	(271,699)
Operating expenses excluding employee expenses	(170,317)	(162,345)
OPERATING SURPLUS / (DEFICIT)	**(36,816)**	**(7,115)**
Finance Costs	(14,026)	(15,174)
Other gains/(losses) including disposal of assets	(124)	0
Surplus/(deficit) for the period/year including STF	**(50,966)**	**(22,289)**
Add back all I&E impairments/(reversals)	(1,717)	0
Remove capital donations/grants I&E impact	121	90
Remove impact of 1617 STF post accounts reallocation	(419)	0
Adjusted financial performance surplus/(deficit) including STF	**(52,981)**	**(22,199)**
*Control totals including STF **	*(29,988)*	*(23,704)*

** 2018/19 Control Total includes flexibility element of £1.5m, not available to the Trust as 2017/18 Control Total not delivered*

4.6 Outline CIP programme

The Trust has developed a financial recovery programme for 2018/19, which reflects a CIP of c.6% of turnover (£23.9m) to mitigate the impact of national and local cost pressures. The table below shows the current overview of the targeted recovery programme.

Bottom up development of schemes is being progressed by the new Turnaround Director, through the strengthened corporate PMO, a robust recovery programme structure and within the overall Trust governance arrangements. At the time of writing £10.072m is identified in the plan, with the remaining £13.8m being developed into schemes through the recovery programme.

Ref	Description	2018/19 £000's
1.2	STP Extraction	250
1.3	Joint CCG / WAHT …. Health System Collaboration	500
2.3	Estates & Facilities (inc. PFI) Review	1,035
2.4	Additional Divisional / Directorate Work Streams	2,262
2.6	Procurement	2,344
3.2	Clinical Coding Data Quality	75
3.5	Outpatients	300
3.8	Workforce Enablers	1,750
3.9	Workforce (Non Frontline / Management Stucture)	1,400
3.11	Training Apprenticeship Levy	156
	Total Identified Schemes	**10,072**
	Unidentified at plan	13,828
	Total CIP in 2018/19	**23,900**

4.7 Procurement

The CIP includes £2.4m of contract renegotiation and procurement savings in 2018/19. The Trust Procurement Team Strategy is already aligned with the Lord Carter report into provider efficiency:

- Spend analytics and electronic catalogue systems have been implemented.
- Inventory management systems and other back office saving opportunities are being explored.
- Department strategy aligned to the NHS Standards of Procurement

The team is now part of a Midlands collaborative exploring saving opportunities with other medium/large acute trusts as well as supporting the STP.

4.8 Agency expenditure

The Trust is committed to reducing agency expenditure, has demonstrated increased grip and is currently within the agency ceiling set by NHSI.

The Trust has taken the following actions to significantly reduce the pay run rate and continues to push hard for further reductions:

- Strengthened controls on vacancy management
- Improved direct engagement fill rates
- Implemented a theatres 'bank' and introduced recruitment and retention premia
- Developed medical workforce plans to address the significant levels of medical vacancies.

The agency expenditure cap for the Trust in 2018/19 is £17.29m.

4.9 Capital planning

In order to ensure that the Trust can maintain its estate, IT and clinical equipment to required standards, the capital planning strategy will continue to be to use depreciation as the sinking fund for asset renewal and replacement. From 2017/18 there is now a requirement to repay the PFI capital from capital resources whereas previously this was funded from revenue. The impact of all of these charges to capital has reduced the available funding for the capital programme.

The strategy for financing new investments will continue to be to borrow but only where there is a clear return on investment. However, the planned deficit position means the Trust cannot generate sufficient cash to repay the principals on existing loans let alone service additional borrowing making it increasingly difficult to obtain loan funding for investments

The expectation is that the Trust's internally generated resource will be principally committed to essential works and equipment replacement but this will not be sufficient. The Trust submitted a revised urgent capital loan request in January 2018 which was successful and resulted in an additional £2.4m in 2017/18 and £2.6m in 2018/19. A further loan application will be required for outstanding schemes in 2018/19. The original capital requests for 2018/19 totalled £58m and the final submitted plan includes a loan application value for 2018/19 of £15m, to manage the highest risk schemes.

The DH has now approved the £29.6m capital requirement for the acute services reconfiguration business case and also agreed that funding for the WRH link bridge element can be accessed now, to ensure some additional bed capacity is available for winter 2018. The remainder of the funding should be released upon completion and approval of the full business case during 2018.

The outline capital plan for 2018/19, based on known available funding is included below:

Capital Scheme	Details	2018/19 £'000
Internally Funded	IFRIC 12	2,113
	Contingency	2,112
	Developments	1,650
Sub Total Internally Funded		**5,875**
Loans (Interim)- approved	Property and Works	2,600
	ED	631
Sub Total - Loans (Interim)- approved		**3,231**
PDC - Approved in principle	ASR Scheme (incl Link Bridge)	16,889
Sub Total - PDC		**16,889**
Loans (Normal)- to be approved	Equipment	1,000
	Property and Works	7,000
	ICT	7,000
Sub Total - Loans (Normal)- to be approved		**15,000**
Total Capital Programme 2018/19		**40,995**

5. Herefordshire and Worcestershire's Sustainability and Transformation Partnership (STP)

The Trust remains and active partner in the Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP) and Trust Executives are the Senior Responsible Officer (SRO) for three of the key STP work streams; Clinical Services Strategy, Back Office and Infrastructure and Clinical Support Services and Diagnostics.

The STP Clinical Reference Group has been undertaking clinical pathway reviews during 2017/18, during this process the challenges around fragility and quality of services; and available workforce has identified the need for a holistic review of acute capacity and capability now and in the future, to support sustainable service planning. Thus the STP clinical services strategy is being developed to support:

- Our need to provide high quality acute services across 7 days
- Our ability to provide a sustainable clinical workforce

- A care model for an Integrated Care System (ICS) across the STP
- Sustaining appropriate access to specialised care within the STP footprint

The STP Finance and Efficiency work stream has refreshed the STP financial model and aligned CIP and QIPP programmes with the STP work streams. In parallel with this, there is a much more robust joint programme of CIP/QIPP schemes in 2018/19, the delivery of which is being managed through a Joint CIP/QIPP Group which meets monthly. CCG QIPP schemes to the value of £7.5m have been included in the 2018/19 Trust contract under the cap and collar agreement and there are joint CIP/QIPP schemes to deliver in relation to elective care, primary care and medicines and urgent care.

See appendix one.

Appendix One

2018/19 - Worcs Acute - QIPP schemes

CCG FRP Programme	Scheme Outline	QIPP Value £k	Responsibility for delivery
Primary Care & Prescribing			
PCE - referral optimisation	Builds on 17/18 PCE group practice work - incl top tips; advice & guidance, education and peer review; 18/19 target based on residual clinical variation opportunity + maintenace of reductions achieved in 17/18	900	CCGs
PbR - high cost drugs	Assumes value achieved in 17/18 can at least be achieved again - incl Bio-similar switches	450	WAT
	Total	**1,350**	
Elective Care			
End to end pathway - Ophthal	Part a: Community based triage of referrals - target 10% reduction	152	CCGs
	Part b: Joint working to identify and move appropriate activity from WAT to community and create capacity for repatriation of cataract activity to WAT	Assumed neutral or positive to WAT	Joint
End to end pathway - Urology	Revised pathways for LUTS and Haematuria - spec currently being finalised with consultants	133	Joint
OP f/up	Target 10% reduction in acute f/up activity - with promotion of self-care / self help / non face to face alternatives. Facilitated by GP review of f/up waiting lists and development of plans for alternative care	1,350	Joint
TLCB & Prior Authorisation	FYE of 17/18 intiatiated procedures + further procedures	877	CCGs
	Total	**2,888**	
Urgent Care			
Frailty	Optimisation of Frailty Assessment Unit to achieve at least 4 same day discharges per day for patients previously admitted	490	WAT
AEC	Optimisation of AEC capacity to achieve at least 15 same day discharges per day for patients previously admitted	1,103	WAT
End to end pathway - Urology	Impact of revised UTI pathway already in place - impact now being evidenced	375	CCGs
Stroke	New primary care test re unstable AF - builds on positive reduction in strokes	100	CCGs
	Total	**1,693**	
Neighbourhood Teams			
Focused admission avoidance	For each of 16 Neighbourhood teams - GPs working with enhanced care teams + utilising consultant connect - to avoid 1 admission per NBT per working day (potentially + weekends)	1,757	CCGs
	Total	**1,757**	
	TOTAL	**7,688**	

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	E3

Operational Performance Report

For approval:		For assurance:	√	To note:	

Accountable Director	Inese Robotham, Interim Chief Operating Officer		
Presented by	Inese Robotham, Interim Chief Operating Officer	**Author**	Inese Robotham, Interim Chief Operating Officer

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
F&P Committee	23 April 2018	Received the IPR for assurance

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R2.1

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☒	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is asked to: • Review operational performance against the four main operational standards • Seek assurance that robust remedial actions are in place to sustain/improve performance against the four main operational standards

Date of meeting	8 May 2018
Paper number	E3

Executive Summary

This paper provides the Trust Board with an update on the Trust's performance at month 12 against the four main operational standards:

- Emergency Access Standard (EAS)
- Cancer 62 day referral to treatment standard
- Referral to Treatment (RTT) standard and
- 6 week diagnostic wait standard.

This paper should be considered in conjunction with the Integrated Performance Report.

Background

NHS Improvement monitors performance of NHS trusts through the Single Oversight Framework. A series of metrics are used to assess a provider's performance against the themes of the framework.

The Trust has not been meeting the four main operational performance standards throughout 2017/18.

Issues and options

Emergency Access Standard (EAS)

The Trust experienced a very challenging Quarter 4 with a month on month decline in EAS performance to 71.28% in March 2018. There were 75 twelve hour trolley wait breaches during March taking the total for 2017/18 to 140. This is still a considerable reduction on 2016/17 when there were 396 twelve hour trolley wait breaches.

April 2018 to date shows signs of recovery with performance month to date at 75.22% (as at 26/04/18). Notably the Alexandra Hospital achieved performance above 90% on five days during the month of April. To date there have been 29 twelve hour trolley breaches in April on Worcestershire Royal Hospital site due to peaks in demand of high acuity patients.

The main driver for the underperformance against EAS remains a significant underlying deficit of acute beds on Worcestershire Royal Hospital site. Whilst this is partially mitigated by escalation capacity and deflects to Alexandra Hospital, the Emergency Department on Worcester site remains overcrowded and the inpatient wards continuously operate above 100% occupancy.

The first phase of works to address the capacity deficit commenced on Monday 30 April 2018 by the start of construction of the link bridge between Aconbury East building and the main hospital site. In line with the construction schedule, Evergreen 2 ward on Aconbury East was closed as planned on Thursday 26 April resulting in net reduction of 28 therapy led enablement beds.

The reduction was achieved by freeing up capacity across all three Aconbury wards (Evergreen 1, Evergreen 2 and Avon 4) through following collaborative actions involving all Local Health Economy partners:

- Maximised capacity at Worcester Stepdown Unit and Astley Hall (specialised dementia beds).
- Five additional discharges per day across all complex pathways during the week commencing 23 April.

- Frequent managed deflects to Alexandra Hospital with particular focus on conveying frail elderly patients directly to the Frailty Assessment Unit.
- Unblocking of a number of complex out of area discharges.
- Daily patient by patient review of all patients across the three wards to unblock any other delays preventing patients returning back to their usual place of residence.

The next phase of works to empty Aconbury East building involves relocation of Evergreen 1 ward to Aconbury North building in the middle of May 2018.

Improvement work on patient flow is on-going under the leadership of the newly appointed deputy Chief Operating Officer for Urgent Care. Additional programme support for the work streams is being finalised with NHSI and the Trust's Turnaround Director to build on Carnall Farrar recommendations. The programme consists of five distinct work streams: front, middle, back, frailty and bed management. Each work stream has named senior operational and clinical leadership in place and has a set of associated performance metrics.

Emergency Surgery Triage Clinic (ESTC) commenced on the 9th of April 2018. During the first two weeks of the clinic being operational there have been 173 calls to the ESTC consultant mobile and 49 attendances to the clinic with only two admissions directly from the clinic to surgical inpatient beds.

The planning guidance for 2018/19 mandates achievement of 90% by September 2018 and 95% by March 2019.

Cancer 62 day referral to treatment standard

There has been a significant improvement in Quarter 4 against the 62 day referral to treatment standard with March 2018 performance peaking at 82.07%. This is the highest performance against this standard since February 2016. The marked increase in performance is a direct result of consistent reduction of backlog of patients waiting over 62 days during Quarter 3 and Quarter 4 with added benefit of higher than usual conversion rate in March 2018. The current 62 day backlog is 73 patients (compared to 160 in September 2017); equally the number of patients waiting over 104 days has reduced to 17 (compared to 35 in September 2017).

The improvement in performance is driven by successful implementation of a recovery plan focused on seven key priority areas:

- Earlier first appointments
- Streamlined clinical pathways
- Faster diagnostic turnaround times
- Robust governance and operational scrutiny
- Timely access to treatment
- Reduced impact of patient choice
- Enhanced reporting suite

The Trust continues to receive intensive support engagement from NHSI and Cancer Alliance.

In order to achieve the 85% standard, further reduction of the backlog is required to below 50. The Trust and commissioners have agreed a recovery trajectory for 2018/19 achieving

the standard from September 2018 onwards.

Referral to Treatment (RTT)

The Trust's performance against the RTT standard was below trajectory in both February and March 2018 due to the impact of the national mandate to cease non-urgent and non-cancer elective activity during January 2018, the impact of on-going emergency pressures and patient cancellations due to inclement weather. The final validated position in March is 83.24% (March 2017 was 83.52%) and the total waiting list has reduced from 37,655 in March 2017 to 35,677 in March 2018. 52 week breaches have reduced to single figures to 4 as at the end of March 2018 (compared to 21 as at the end of March 2017).

Major improvements in performance for RTT have been seen in the Specialty Medicine division, for example

- Thoracic Medicine has improved from 63.13% in April 2017 to 74.72% in March 2018 and
- Neurology has improved from 75.36% in March 2017 to 90.92% in March 2018).

Within the Women and Children Division Gynaecology has improved from 72.48% in April 2017 to 90.92% in March 2018.

The specialties of concern remain Ophthalmology, General Surgery, Urology, Maxillofacial surgery, Trauma and Orthopaedics, ENT and Dermatology. The work is on-going with Four Eyes to maximise productivity and increase throughput on Kidderminster and Alexandra Hospital sites.

The trajectory for RTT performance in 2018/19 is still in discussion with the commissioners. The NHS planning guidance mandates a reduction of the waiting list at the end of March 2019 compared to March 2018 and zero 52+ week waiters throughout the year.

6 week diagnostic wait standard

Following a good recovery in Quarter 3 of 2017/18 against a challenging trajectory which was met for 6 consecutive months from August 2017 to January 2018, performance has been off trajectory and deteriorating since February 2018 (2.54% versus trajectory of 1.58%) and during March the figure was 3.8%, compared to the trajectory of 0.99%. The March 2017 performance was 3.73%. The main areas requiring improvement are endoscopy due to underlying capacity deficit exacerbated by winter pressures and use of the Worcestershire Royal Endoscopy suite as an inpatient escalation area, imaging due to increased demand including significant increase in 2 week wait referrals and urodynamics due to increased demand and equipment capacity.

The Trust and the commissioners are currently undertaking a joint deep dive analysis of the significant increase in demand for radiology diagnostic procedures. Despite capacity constraints radiology have achieved "carve out" of capacity for all cancer patients resulting in reduction in time from referral to report to 9 days. This work is been supported by Siemens Health who facilitated an intensive improvement week which led to improved referral vetting and appointment allocation system in radiology. This improvement work has significantly contributed to the recovery of the 62 day cancer referral to treatment standard.

The trajectory for the recovery of the 6 week diagnostic standard is currently still in

discussion with the commissioners.

Recommendations

The Board is asked to:

- Review operational performance against the four main operational standards
- Seek assurance that robust remedial actions are in place to sustain/improve performance against the four main operational standards

Appendices

None

NHS
Worcestershire
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NHS Trust

Date of meeting	8 May 2018
Paper number	E4

Finance & Performance Committee Assurance Report– MONTH 12

For approval:		For assurance:	✓	To note:	

Accountable Director	Phil Mayhew – Chairman of FPC/Non-Executive Director		
Presented by	Phil Mayhew – Chairman of FPC/Non-Executive Director	**Author**	Jill Robinson – Chief Finance Officer Thekla Goodman – FPC Committee Administrator

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
N/A		

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

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☒	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is asked to confirm it is assured that: - A revised Patient Flow Programme is in place.

	- A full-time Turnaround Director is in place to support delivery of the Trust's Recovery Programme and strengthen governance around CIP. - The Trust delivered its revised pre STF deficit of £57.9m (pre-audited). - The Trust met its Capital Resource Limit.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	E4

Executive Summary

The Finance & Performance Committee (FPC) focuses the agenda on three main priorities:

- Flow
- Cancer Performance
- Financial Performance

Background

The Finance & Performance Committee (FPC) meets on a monthly basis to gain assurance that plans are in place to achieve the Trust's agreed Operational Performance Targets, Financial Control Total, its Cost Improvement and Financial Recovery Plans.

The Committee met on 26 March 2018 (Month 11) and on 23 April 2018 (Month 12).

At each of its meetings the Committee reflects on a 'Wisdom in the Workplace' to encourage participation of the signature behaviours, the one for the April meeting centred around taking the learnings forward from past projects/schemes for the greater good of the Trust.

Highlights from the Meetings

In-Depth Reviews

At its meeting in April the FPC took an in-depth review of patient flow and Emergency Department process improvements and also in depth review of the Medium Term Financial Plan.

Patient Flow/A & E Improvements

The Divisional Medical Director for Urgent Care and Deputy Chief Operating Officer attended the meeting to give a progress update explaining that a number of work streams defined by key metrics, clinically led and with staff engagement, fed into the Patient Flow Programme. Each work stream consisted of key projects to ensure focus in targeted areas to drive through the improvements needed for sustainable flow throughout the organisation;

Front door/Admissions- key projects include the development of new pathways and with the aid of GPs, patients are being assessed and streamed to a specific ambulatory pathway to lessen the pressure in A & E.

In addition, the recruitment process has been re-invigorated to attract more physicians to Worcestershire and the Trust has also set up a working group with its Commissioners to tackle and refine the ambulance handover process.

In-patients – the Trust continues to review and refine processes to ensure staff adhere to its Internal Professional Standards ensuring that patients experience as little delay as possible with treatment pathways.

Discharge – work is ongoing to improve discharge processes to avoid lengthy exit waits, an integrated Discharge Team consisting of health economy colleagues has been established to support the implementation of national projects designed to help patients get home as quickly as possible. In addition, a daily review is held both at Worcestershire Royal Hospital

(WRH) and the Alexandra Hospital to expedite the transfer of patients no longer requiring acute medical care.

Bed Management – the Committee was advised that the bed management policy was constantly reviewed to ensure staff fully understood the available bed capacity at any point in time and an 'app' that would give a live bed state was being developed.

The Divisional Medical Director referred to the hard work and efforts undertaken by the Emergency Department in the face of ever mounting pressures and challenges, the FPC praised the staff for their unwavering commitment that had resulted in achieving a significantly improved performance during 'winter' compared to last year and would be visiting the department to convey the Board's appreciation.

Medium Term Financial Plan

The budget setting process for 2018/19 has been completed and Healthcare income contracts agreed and signed. Further work is on-going to finalise the plans for the Cost Improvement Programme (CIP) and turn the identified ideas into robust schemes, mainly around theatre efficiency improvements, workforce review/re-design and repatriation of activity (income) by end of April.

The Committee members noted that the Trust is required to submit its final operational plan to the NHSI on 30 April which will include details on revenue, CIP and capital together with activity plans/trajectories and workforce plans.

The 2018/19 underlying financial run rate is £53.9m which is an improvement from 2017/18 primarily driven by the recurrent effect of the 2017/18 Financial Recovery Programme (FRP) schemes.

The Trust's Financial Control Total of £40m deficit will require a CIP of £23.9m which is 6% of turnover; the achievement of a sustainable savings target of this magnitude is a major challenge to the Trust. A full-time Turnaround Director, reporting to the Chief Executive, has been engaged to support delivery of the Trust's Recovery Programme and strengthen the governance around the 2018/19 CIP programme and then develop a longer 3 year plan over the next few months. Some of the 2018/19 schemes have been held centrally so far and once validated will be devolved to specialties for delivery and transacted against their budgets.

The Trust continues to be under enhanced NHSI oversight, meeting on a weekly basis.

Standard Agenda Items

Financial Performance

The Director of Finance was pleased to confirm that the Trust had delivered its revised pre Sustainability & Transformational Funding (STF) deficit of £57.9m (pre-audited) for 2017/18.

In order to deliver £57.9m the Trust had developed a £7m Financial Recovery Plan (focussed on a limited amount of key projects) that was delivered during Q4 of the financial year. This same level of focus on financial delivery must continue into 2018/19.

Cash - As a result of the revised I&E forecast of £57.9m the Trust required additional interim revenue support in 2017/18 and this requirement will continue for 2018/19.

Procurement – the Committee noted the ambition to achieve an increased target of £3m (from £2m) in year through continued engagement with the Surgery Division and Theatres to identify additional credible schemes to deliver a bigger contribution to the FRP.

Capital – through the close monitoring of changing priorities the Trust met its Capital Resource Limit (CRL) with a small underspend of £189k under-spend due to the PFI programmed spend not being fully committed as per the planned expenditure. The urgent capital loan application for £2.4m in 2017/18 and £2.6m in 2018/19 has been approved and the £2.4m fully drawn down.

The schemes for 2018/19 have been agreed and submitted to the NHSI on 30 April as part of the final operational plan. This also includes a capital loan requirement for 2018/19.

Integrated Performance Report

Integrated Performance is reported elsewhere on the agenda and provides fuller detail of the Trust's operational performance. Due to Cancer being an area of enhanced focus the Committee particularly noted the following:

Cancer – the Trust is achieving 4 out of the 8 operational standards for waiting times in month 12. In brief:

- **62 day treatment**- the focus on reducing the backlog of patients waiting 62 days or more for their first treatment continues to impact the achievement of the trajectory and operational standard but due to an increase in focus a steady improvement has been noted with 82% achievement in March.
- **2 week wait** – performance has deteriorated in month - the introduction of a 'one stop clinic' in gynaecology and also an increase in referrals are the main contributors to this position.
- **Breast Symptomatic** – performance has significantly deteriorated in March owing to failure of equipment.

Emergency Access Standard (EAS) – a decline in performance was noted and the Health Economy and Trust have been identified as a National EAS performance outlier.

Winter Plan Evaluation

The winter plan was agreed by the Trust Leadership Group and many of the actions therein have the requirement for on-going development.

There were some very positive improvements in clinical pathways and patient pathways, one key indicator was the number of 12 hour breaches that occurred at WRH this year which was significantly reduced from the previous year and a reduction in the number of patients spending time in corridors. However, the Trust's Emergency Departments remain severely overcrowded and both sites operate at bed occupancy close to 100% or above.

Due to increased emergency demand a number of surge areas have been used as additional inpatient areas and whilst this has alleviated the immediate pressures it has had a detrimental impact on patient flow. A number of key actions were taken such as developing a frailty model at the Alexandra Hospital, expanding the Ambulatory Emergency Care model at WRH, GP streaming at the front door, additional bed capacity on Evergreen 2 ward at WRH and stranded patient reviews.

Whilst some of the schemes did not deliver the benefits expected, mainly due to recruitment issues, there were successes where many of the actions taken have shown clear benefits for patient flow and the quality of patient care. Next steps include a winter planning evaluation meeting with the senior divisional teams in April to assess what did not work and what could be done differently - this will form the first phase of winter planning for 2018/19.

Recommendations

The Board is asked to confirm it is assured that:

- A revised Patient Flow Programme is in place.
- A full-time Turnaround Director is in place to support delivery of the Trust's Recovery Programme and strengthen governance around CIP.
- The Trust delivered its revised pre STF deficit of £57.9m (pre-audited).
- The Trust met its Capital Resource Limit.

NHS
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Date of meeting	8th May 2018
Paper number	F1

People and Culture Report

For approval:		For assurance:	x	To note:	x

Accountable Director	Tina Ricketts, Director of People and Culture		
Presented by	Tina Ricketts	**Author**	Tina Ricketts

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	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	x	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)	R3.1 R3.2 R4.2 R4.3

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☒	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is asked to note the report which is provided for information and assurance.

NHS
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Date of meeting	8th May 2018
Paper number	F1

Executive Summary

This report provides an overview of the progress made against the people and culture agenda for the period 1st April 2017 to 31st March 2018. It also highlights the areas where further development is required if the Trust is to be recognised as an employer of choice.

From the scorecard in appendix one and the information available in the body of the report it can be seen that the Trust has seen improvement in a number of workforce metrics when compared to March 2017. Of note, set against the national NHS context, is the following:

- 27% improvement in the net culture score
- reduction in medical vacancies from 20% to 16%
- reduction in registered nursing vacancies from 8.4% to 7.5% and
- reduction in the overall staff turnover rate from 12.57% to 11.04%.

Of concern is the deterioration in non-medical personal development review compliance which currently stands at 67%. In addition, whilst good progress has been made with recruitment, the Trust has seen an increase in medical vacancies since January 2018. The main factor impacting on this performance is a reduction in the number of visa applications being approved by the Home Office. A number of actions have been identified to improve performance and these are detailed later in the report.

A workforce transformation programme has been launched to further progress the people and culture strategy and as a key component of the Trust's recovery plan. The programme involves reviewing the organisational design of the Trust whilst ensuring systems and processes are in place to maximise our human resource. A steering group has been set up to oversee the delivery of the programme.

Background

The people and culture agenda is seen as a priority for the Board and as such the Trust undertook the following actions in 2017/18 to ensure progress was made in this area:

- External support was commissioned to develop a detailed recruitment and retention plan. The plan was approved by Board in September 2017
- Investment in a 3 year culture change programme which was launched in October 2017
- External support was commissioned to develop a 3 year people and culture strategy. The strategy was approved by Board in November 2017 and was formally launched in February 2018. The strategy is supported by a detailed implementation plan
- Recruitment of a Director of People and Culture who commenced on 29th January 2018
- A review of the terms of reference and supporting governance structure of the People and Culture Committee.

Date of meeting	8th May 2018
Paper number	F1

Issues and options

The Trust undertook a baseline assessment when developing the people and culture strategy, which identified that the Trust required improvement in the following areas:

Table 1: 2017 baseline

Culture	• Staff recommending the Trust as a place to work (50% compared to a national average of 61%) • NHS staff survey results (in bottom quartile)
Staff engagement	• Overall staff engagement score (3.66 compared to a national average of 3.81, scale 1 to 5 the higher the better)
Colleague health and wellbeing	• Rolling sickness absence rate (4.27% against an acute trust average of 4%) • Colleagues reporting feeling unwell due to work related stress (38% compared to a national average of 35%)
Staff recognition	• Colleagues feeling valued and recognised by managers and the organisation (3.28 compared to a national average of 3.45, scale 1 to 5 the higher the better)
Recruitment	• Medical vacancy rate of 20% • Registered nursing vacancy rate of 9.4%
Retention	• Overall turnover rate of 12.57% (against a recommended rate of 12%)
Workforce planning	• Cost per unit of activity of £1,947 which placed the Trust in the mid to high cost range under the model hospital
Bullying and harassment	• Colleagues reporting harassment, bullying or abuse from colleagues in the last 12 months (32% compared to a national average of 25%)

From the above table the Trust identified two key areas for initial improvement:

1. To embed an intentional culture where colleagues feel empowered to improve performance through collective achievement, are accountable for their actions and transform care at every opportunity
2. To reduce the number of medical and qualified nursing vacancies and improve retention in these areas

It was determined that, if improvements could be realised in these key areas, they would have a positive impact on other workforce metrics. Whilst the strategy was only approved by the board in November 2017, the Trust has been working on improving the people and culture agenda throughout the year. Actions undertaken in the two key areas include:

4ward culture change programme:

- Launch event across 3 hospital sites in October 2017 with over 500 staff attending
- Engagement sessions delivered to over 1,900 staff
- The recruitment of 440 staff advocates
- Improvement to clusters with over 680 changes being made between Checkpoint 1 and 2
- Development of 4Ward Steering Committee and 4Ward Project Team
- Wisdom in the Workplace program for Trust Leadership Group, Board and Executive

Recruitment and retention:

- Detailed analysis of the medical workforce establishment
- Review of hard to recruit roles to determine alternative solutions (e.g. conversion of unfilled junior doctor roles into advanced nurse practitioner roles)
- Overseas medical recruitment campaign
- Recruitment open days with on the day interview and conditional offer
- Centralised recruitment for qualified nurses and healthcare assistants
- The over recruitment of healthcare assistants
- Introduction of new roles such as Physician and Nursing Associates

Actions undertaken to date have resulted in the following progress:

Table 2: Progress made in the period 1st April 2017 to 31st March 2018

Culture	✓ The net culture score for the Trust has increased from 28% in November 2017 to 55% in March 2018 ✓ A participation rate of 45% for the second checkpoint meaning that 2,704 of 6,020 participants responded ✓ The Trust saw improvement in two thirds of the NHS staff survey results which is against the national trend
Staff engagement	✓ The overall staff engagement rate has increased from 3.66 to 3.70 against a national average of 3.79 (scale 1 to 5 the higher the better)
Health and wellbeing	✓ The overall sickness absence rate has reduced from 4.27% to 4.18% against a national average for acute trusts of 4.07% ✓ The Trust has reduced the number of staff days lost to back problems by 21%
Staff recognition	✓ Colleagues feeling valued and recognised by managers and the organisation improved from 3.28 to 3.35 against a national average of 3.45 (scale 1 to 5 the higher the better)
Recruitment	✓ Medical vacancy rates have reduced from 20% to16% ✓ Registered nursing vacancy rates have reduced from 8.4% to 7.5%
Retention	✓ The overall staff turnover rate has reduced from 12.57% to 11.04% ✓ The turnover rate for medical staff (consultant and middle grades) has reduced from 8.85% to 7.48% ✓ The turnover rate for registered nurses has reduced from 14.58% to 10.13%
Workforce planning	✓ The percentage of consultants with up to date job plans has increased from 40% to 71%
Bullying and harassment	✓ The percentage of colleagues reporting harassment, bullying or abuse from colleagues in the last 12 months has reduced from 32% to 28% (against a national average of 25%)

From the above table and the scorecard in **appendix one** it can be seen that whilst the Trust remains below average in a number of key workforce metrics, incremental progress has been made across a number of areas. Of note, set against the national NHS context, is the

27% improvement in the net culture score, reduction in medical vacancies from 20% to 16%, reduction in registered nursing vacancies from 8.4% to 7.5% and a reduction in the overall staff turnover rate from 12.57% to 11.04%.

Of concern is the deterioration in non-medical appraisal (personal development review) compliance. The NHS Constitution requires organisations to provide staff with clear roles and responsibilities, personal development and line management, to support them to succeed. The following actions will be taken to improve both the quality and completion rates of personal development reviews across the Trust:

Table 3: Actions to be taken to improve PDR compliance

Action	**Executive Lead**	**By when**
Fortnightly PDR compliance data to be issued to the Trust Leadership Group so that hotspots can be identified and managers held to account for improving performance	Director of People and Culture	From 1st May 2018 onwards
A review of the spans of control (under the workforce transformation programme) to ensure that the number of PDR's that managers are required to undertake are appropriate	Director of People and Culture	30th Sept 2018
All managers to be set an objective to achieve 100% PDR compliance for their direct reports	Trust Leadership Group	31st May 2018
A review of the Trust's PDR Policy and forms to simplify and embed the 4ward signature behaviours	Director of People and Culture	31st July 2018
Training delivered on induction and mandatory training for managers to understand the importance of completing PDR/appraisals and how to record them on ESR	Director of People and Culture	From 1st April 2018 onwards
Management development workshops to ensure appraisers have the necessary skills and confidence to undertake effective PDR's	Director of People and Culture	From 1st April 2018 onwards

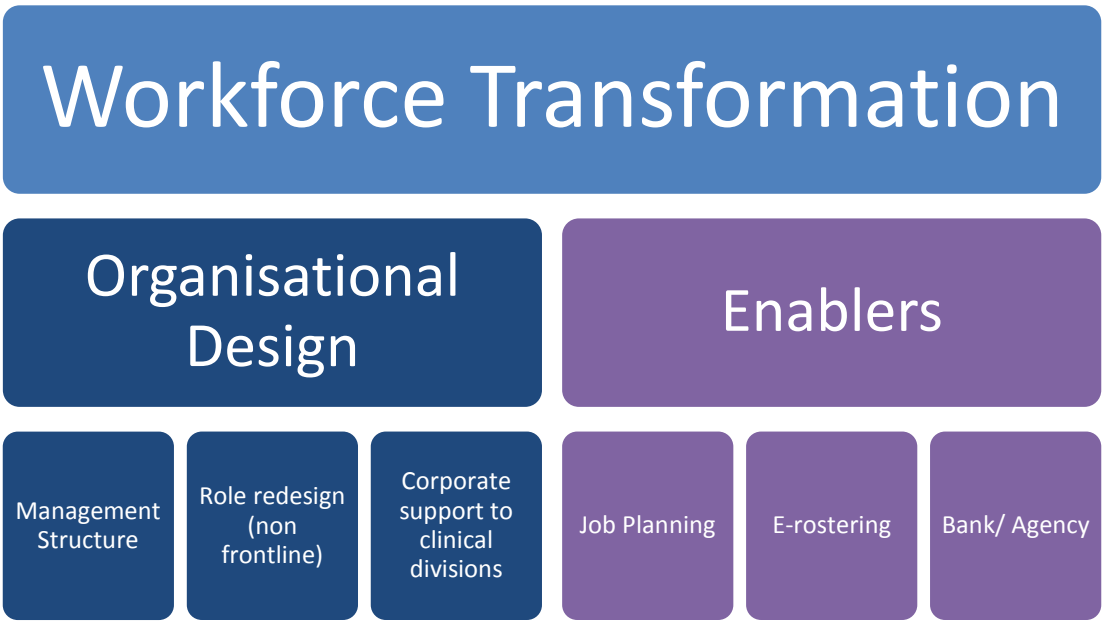
The Board is also asked to note the deterioration in the level of medical vacancies within the Trust which has seen an adverse trend since January 2018. A key factor is the decrease in visa applications that are being approved by the Home Office. This is impacting on the success of the overseas recruitment campaign to India and in particular the recruitment to middle grades. This is a national issue and the Trust has escalated its concerns to NHS Improvement and through the NHS Providers network.

The medical workforce group are currently working on the following actions to further reduce the number of medical vacancies within the Trust:

- Introduction of overseas rotational posts (MTI exchange scheme with Pakistan for clinical fellows in A&E and medicine)
- Rotational scheme for clinical fellows
- Alternative route for English assessment to support GMC registration
- Support for locum consultants to complete CERL enabling eligibility to apply for registration to the GMC specialist register
- Conversion of clinical fellow posts to specialty doctor posts to aid retention

Date of meeting	8th May 2018
Paper number	F1

A workforce transformation programme has been launched to further progress the people and culture strategy and as a key component of the Trust's recovery plan. There are six work streams to the programme which are outlined in the diagram below.



The following outcomes will be realised as a result of the programme:

Organisational design outcomes:

- Clear organisational design and structure
- Reduction in management layers (CIP savings)
- Clarity in roles and responsibilities
- Clear lines of accountability from board to ward
- Increased flexibility in tasks undertaken
- A workforce that can be flexed to meet demand
- Consistency in job banding
- Reduction in costs per unit of activity (CIP savings)
- Consistency in corporate service resource allocation to clinical divisions (CIP savings)
- Clarity in corporate support available/ provided to clinical divisions
- Increase in apprenticeships
- Full utilisation of the apprenticeship levy
- Improved career progression pathways

Enablers:

- Fit for purpose workforce IT systems (job planning and e-rostering)
- Ability to better plan demand versus capacity
- Reduction in variation of job plans
- Improved compliance with up to date job plans
- Reduction in the requirement for waiting list initiatives (CIP savings)
- Improved workforce planning (CIP savings)

- Trust level oversight of annual leave
- Reduction in variation of shift patterns
- Improved recording of absence
- Earlier notification of unfilled shifts
- Reduction in hours owed/ accrued by employees
- Achievement of NHS Improvement agency cap
- Improved bank fill rates
- Improved agency management
- Improved processes for high locum spend
- Reduction in agency spend (CIP savings)

The first phase of the programme is underway and includes benchmarking and the establishment of a baseline for each of the work streams. A steering group has been set up and additional resource identified to support delivery of the programme.

Recommendations

The Board is asked to note the report which is provided for information and assurance.

Appendices

1. People and Culture Scorecard as at 31st March 2018

ID CULTURE SCORECARD FOR TRUST BOARD - AS AT 31 MARCH 2018

Worcestershire Acute Hospitals NHS Trust

DATA FROM OLM BI/DISCOVERER - run 12 April 2018

Metric	Description	31/03/2016	31/03/2017	31/03/2018	Target	Trend from last month	Trendline for 3 years
Staff In Post (SIP)	**Contracted SIP (FTE)**	5,080.09	5,104.18	5,199.57	5672.36	3.37	
Staff FFT - Recommend Trust as a place to Work	2017 Staff Opinion Survey provisional results	51%	48%	50%	60 % QH average	0%	
PDR Compliance	Medical	82%	82%	89%	85%	-4%	
	Non Medical	80%	76%	66%	85%	-2%	
Up to date Job Plans	All Medical staff	68%	61%	67%	100%	0%	
	Consultants			72%	100%	1%	
	SAS Doctors			41%		1%	
	Information Governance	87%	90%	94%	95%	-1%	
	Fire	85%	82%	81%	90%	0%	
	Health & Safety	75%	85%	84%	90%	-1%	
	Conflict Resolution	81%	87%	88%	90%	-1%	
	Equality & Diversity	74%	69%	69%	90%	0%	
	Infection Control L1	85%	77%	89%	90%	1%	
	Infection Control L2			67%	90%	0%	
	Moving & Handling L1	90%	88%	88%	90%	0%	
	Moving and Handling L2			77%	90%	-1%	
	Safeguarding Children L1	88%	80%	99%	90%	0%	
	Safeguarding Children L2			63%	90%	0%	
	Safeguarding Children L3			59%	90%	0%	
	Safeguarding Children L4			100%	90%	0%	
	Safeguarding Children L5			100%	90%	0%	
	Safeguarding Adults L1	96%	96%	87%	90%	-1%	
	Safeguarding Adults L2			59%	90%	1%	
	Safeguarding Adults L3				90%	0%	
	Safeguarding Adults L4			100%	90%	0%	
	Safeguarding Adults L5			33%	90%	0%	
	Resuscitation L1			72%	90%	6%	
	Resuscitation L2 Basic Life Support	85%	85%	86%	90%	-1%	
	NLS L4 Newborn Life Support			58%	90%	2%	
	EPLS L4			74%	90%	6%	
	ALS L4 Advanced Life Support			63%	90%	3%	
	Preventing Radicalisation L1			86%	85%	0%	
	Preventing Radicalisation L2			89%	85%	-1%	
	Preventing Radicalisation L3 (WRAP)			52%	85%	7%	
	Preventing Radicalisation L4 (WRAP)			100%	85%	0%	
	Preventing Radicalisation L5 (WRAP)			100%	85%	0%	
	MCA and DoLS L1			64%	90%	1%	
	MCA and DoLS L2			47%	90%	9%	
Turnover	Annual Turnover	12.97%	12.57%	11.04%	10-12%	0.09%	
	Monthly Turnover			1.02%	0.95%	0.11%	
	Retention/stability index			90.08%	85.70%	0.21%	
Sickness Absence	Monthly sickness absence	4.06%	4.06%	3.84%	4.94%	-0.02%	
	Cumulative Sickness over 12 months			4.17%	4.34%	-0.01%	
	Medics Overall	16%	20%	16.23%	10%	0.27%	

ID CULTURE SCORECARD FOR TRUST BOARD - AS AT 31 MARCH 2018

Worcestershire Acute Hospitals NHS Trust

DATA FROM OLM BI/DISCOVERER - run 12 April 2018

Metric	Description	31/03/2016	31/03/2017	31/03/2018	Target	Trend from last month	Trendline for 3 years
Vacancy Rate	Consultant	11%	15%	14.13%	15%	1.18%	
	Other Medics	20%	24%	19.08%	10%	0.73%	
	Registered Nursing and Midwifery	7.13%	8.38%	7.46%	7%	-0.15%	
	Registered Nursing	7.83%	9.97%	6.94%	7%	0.16%	
	Registered Midwifery			13.59%	7%	-0.61%	
	AHP'S			4.69%	7%	-2.17%	
	Scientific, Therapeutic and Technical			4.16%	7%	1.23%	
	Ancillary			10.03%	7%	-0.05%	
	Senior Managers			9.37%	7%	0.85%	
	Administrative and Clerical			6.10%	7%	-0.02%	
*Agency as a % of Gross Cost**	All staff groups	13.12%	9.36%		7%	-7.01%	
*Bank as a % of Gross Cost *	All staff groups	3.56%	4.01%		7%	-7.37%	

**Vacancy rate is an in month value only*

Gross Pay Costs = Gross Staffing Costs

Registered nursing and midwifery vacancy rate includes Nurses & Midwives Band 5 and above

Agency as a % of gross pay cost = this is all agency for all staffing types

** No exclusions for sickness, maternity or career break which has marginally reduce compliance by around 0.2%*

KEY:			
	TARGET MET		PERFORMANCE IMPROVED
	WITHIN 3% OF TARGET		PERFORMANCE DETERIORATED
	TARGET NOT MET		PERFORMANCE UNCHANGED
			GREY BOXES ARE NOT APPLICABLE OR NOT AVAILABLE

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8th May 2018
Paper number	F2

Gender Pay Gap Report

For approval:		For assurance:		To note:	x

Accountable Director	Tina Ricketts, Director of People and Culture		
Presented by	Tina Ricketts	**Author**	Tina Ricketts

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		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
Trust Leadership Group	18th April 2018	Noted

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

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is asked to note the report which is provided for information.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8th May 2018
Paper number	F2

Executive Summary

From 6 April 2018 employers in Great Britain with more than 250 staff are required by law to publish their gender pay gap information, covering pay and bonuses.

The Trust's mean pay calculation indicates that there is a substantial difference between the average pay of male and female staff. However, this information is skewed by the numbers of male employees in senior Consultant posts and particularly bank/agency doctor posts. More than 69% of our consultant workforce are male. When we remove all doctors (including agency/bank doctors) from this calculation the gender pay gap reduces from 35.32% to 0.74% with an hourly rate difference of only 10 pence.

The Trust acknowledges that there could be greater female representation in its senior medical roles. However, in general the consultant workforce has a greater proportion of males to females across the NHS, which limits the pool of available applicants to these types of roles. The Trust is currently reviewing its leadership plan to strengthen the skills of its existing staff to support career development within the organisation. We have also publicised training which is specifically targeted at women and minority groups which should assist with the career development of female staff into more senior roles within the organisation and wider NHS.

The Trust recruits through NHS jobs and it is our policy to remove any personal information from applications which avoids gender or other bias at the shortlisting stage. We train our recruiting managers in equality and diversity to ensure that all applicants are recruited in a fair, open and transparent manner. We monitor our recruitment and other aspects of equality which form part of our equality and diversity annual report which is published on our website.

Background

In accordance with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), Worcestershire Acute Hospitals NHS Trust has undertaken a gender pay gap review as at 31 March 2017.

The Trust has calculated the following for its employees and workers:

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of males receiving a bonus payment
- The proportion of females receiving a bonus payment
- The proportion of males and females in each quartile pay band

Employees on full pay as a result of sickness are included in this analysis, however other full pay absences (such as maternity pay) are currently excluded from this report as the elements on our electronic staff records system return a cash value only and it is therefore not possible to identify an hourly rate.

The Trust will publish this information annually for all employees who are directly employed by the Trust.

The gender pay gap and equal pay are two distinct concepts:

- Equal pay is concerned with men and women earning equal pay for the same, or similar, work.
- The gender pay gap is about the difference between men and women's average pay within an organisation.

Generally, in Great Britain the average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions. Whilst a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower.

The Regulations have been brought in to highlight this imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take the appropriate steps to address them.

Issues and options

Workforce Composition

As at 31 March 2017, the Trust had 5,951 employees of which 4,936 (82.94%) were female and 1,015 (17.06%) were male. However, this ratio is almost reversed when we look at the composition of our medical workforce who are the most expensive staff group. Of the 583 doctors employed by the Trust at that point in time, 62.26% were male, with male consultants making up 69.78% of this staff group.

The trust's ratio of male to female staff is average for an acute Trust of this size. The greatest proportion of staff employed by the Trust, are in Nursing and Midwifery roles, which account for 47.10% of the total workforce. Of this staff group 93.19% are female with only 6.81% male. This is reflective of the number of registrants with the Nursing and Midwifery Council (NMC), who in their Equality and Diversity Report 2016-2017 reported that 89.2% of registrants were female compared to 10.8% of males.

NHS Agenda for Change (AfC) Pay Structure

The majority of staff employed by the Trust are on the national agenda for change terms and conditions of service. The basic pay structure for these staff is across 9 pay bands and staff are assigned to a band on the basis of job matching in line with the NHS Job Evaluation Scheme. Within each band there are a number of incremental pay progression points.

Medical and dental staff have separate national terms and conditions of service, depending on seniority. However, these too are set across a number of pay scales with varying numbers of spine points within them. There are separate national arrangements for Very Senior Managers (VSM pay scales), such as Chief Executives and Directors.

As an NHS acute sector organisation the majority of our services are on a 24/7 basis and staff who work unsocial hours or participate in on-call rotas may also receive pay enhancements. This mainly applies to clinical staff in ward areas, and non-clinical support services staff who work shifts. There are a number of clinical departments that do not provide 24/7 such as clinics and outpatient areas, and therefore do not attract enhancements.

Mean Gender Pay Gap

The Trust's average hourly rate of pay is £23.02 for males and £14.89 for females which

gives a Mean Gender Pay Gap of 35.32%:

Average & Median Hourly Rates as at 31 March 2017	
Gender	**Avg. Hourly Rate**
Male	23.02
Female	14.88
Difference	8.13
Pay Gap %	35.32

The mean pay calculation indicates that there is a substantial difference between the average pay of the Trust's male and female staff. However, it should be noted that this information is skewed by the numbers of male employees in senior consultant posts and particularly bank/agency doctor posts. More than 69% of our consultant workforce are male. When we remove all doctors (including agency/bank doctors) from the calculation the gender pay gap reduces from 35.32% to 0.74%, and the average hourly rate shows a difference of only 10p.

Average hourly rates as at 31st March 2017 (excluding doctors)	
Gender	**Avg. Hourly Rate**
Male	14.25
Female	14.14
Difference	0.10
Pay Gap %	0.74

The issue with doctors pay is exacerbated by the use of locum/agency contractors who will usually be on higher rates of pay due to the short term nature of the role. These roles are traditionally taken up by more men than women. At this point in time it was not possible to analyse the gender breakdown of contractors as they were paid through invoice. However, the changes to HMRC rules for public sector workers from April 2017 have led to more locums moving onto the payroll and we know that our current locum workforce (as at February 2018) is 297 with only 59 women (19.87%).

Clinical Excellence Awards

In addition, some senior medical and dental staff may be in receipt of clinical excellence awards which are consolidated into bonus rather than basic pay. At the time of the snapshot, 35.45% of male consultants were in receipt of a clinical excellence awards compared to 26.60% of our female consultants. We are mindful of the fact that not all roles within the Trust attract enhancements which can have an impact in distorting the mean hourly rate. In addition, flexible working opportunities are available for all staff to apply for, and some staff whose role would normally attract enhanced pay in addition to their basic pay may have requested to work set shifts, which do not attract the enhancements that their colleagues would be in receipt of and this again will have had an impact on the mean hourly rate.

We have also made comparisons of the hourly rates of some specific posts, examples of which are below:

COMPARISON OF HOURLY RATES						
Role	Number of Females	Average Hourly Rate	Number of Males	Average Hourly Rate	Diff	Gender Pay Gap
Senior Manager	27	£33.67	7	£37.19	£3.52	9.46%
Career grade Doctor	101	£23.39	127	£25.07	£1.68	6.70%
Matron	24	£23.40	2	£22.23	-£1.17	-5.26%
Physiotherapist	99	£17.73	10	£14.05	-£3.68	-26.19%
Staff Nurse	1567	£15.52	93	£15.77	£0.25	1.59%
Healthcare Assistant	730	£8.84	107	£8.79	-£0.05	-0.57%
Housekeeper	154	£8.26	8	£8.50	£0.24	2.82%

The above table demonstrates that for the majority of roles, the gap is considerably less than 35%. In some cases the average hourly rate for females, is greater than for male staff as depicted by the red text above.

Median Gender Pay Gap

The Trust's median hourly rate of pay is £17.16 for males and £13.87 for females which gives an overall median Gender Pay Gap of 19.15%.

Median Hourly Rates as at 31 March 2017		
Gender		**Median Hourly Rate**
Male		17.16
Female		13.87
Difference		3.28
Pay Gap %		19.15

The median gender pay calculation indicates that there is a difference between the average pay of the Trust's male and female staff. The Trust acknowledges this demonstrates that there is a gap that needs to be addressed. However it should be noted that the points raised above are contributing factors. The median hourly rate when we remove doctors shows that females are in fact in a more favorable position than males by 12.40%:

Median hourly rates as at 31st March 2017 (excluding doctors)		
Gender		**Median Hourly Rate**
Male		12.07
Female		13.57
Difference		-1.49
Pay Gap %		-12.40

Mean Bonus Gender Pay Gap

The mean bonus gender pay calculation indicates a £7,495.27 difference between the average bonus pay of the Trust's male and female staff which represents a mean bonus gender pay gap of 47.64%.

Difference between mean and median bonus pay for male and female employees	
Gender	**Avg. Pay**
Male	15,733.58
Female	8,238.31
Difference	7,495.27
Pay Gap %	47.64

The Trust does not as a rule pay bonuses. In this period 103 consultants were paid a bonus in the form of a clinical excellence award. Of these 25 were female (24% of all awards paid). This may indicate that more needs to be done to encourage clinical excellence award applications from female consultants.

Median Bonus Gender Pay Gap

The median bonus gender pay calculation indicates that there is 50% difference between the average bonus pay of the Trust's male and female staff.

Difference between mean and median bonus pay for male and female employees	
Gender	**Median Pay**
Male	11,934.30
Female	5,967.20
Difference	5,967.10
Pay Gap %	50.00

Proportion of Males and Females Receiving a Bonus Payment

Proportions of male and female staff paid bonus			
Gender	**Employees Paid Bonus**	**Total Relevant Employees**	**%**
Female	25.00	5,177	0.48%
Male	78.00	1,190	6.55%

As stated above the only bonus paid is consultant clinical excellence awards. Of the total workforce 0.48% of females received bonuses compared to 6.55% of males. However, when we look at this a percentage of our Consultant workforce it shows that 32.80% of all consultants were in receipt of Awards. Of these 26.6% female consultants received clinical excellence awards compared to 35.45% male consultants:

Consultant Clinical Excellence Awards by Gender as at 31 March 2017				
Gender	Role	Total Consultants	Clinical Excellence Awards	% of consultants
Female	Consultant	94	25	26.60%
Male	Consultant	220	78	35.45%
Grand Total		**314**	**103**	**32.80%**

This indicates a potential problem in the way the Trust offers the opportunity to apply for or receive clinical excellence awards by female staff.

Proportion of Males and Females in Each Quartile Pay Band

Number of employees as at 31 March 2017 Quartile 1 = Low, Quartile 4 = High				
Quartile	**Female**	**Male**	**Female %**	**Male %**
1	1,226	214	85.14%	14.86%
2	1,250	191	86.75%	13.25%
3	1,284	156	89.17%	10.83%
4	989	452	68.63%	31.37%

At the time the snapshot was taken the percentage of female staff was 82.94%. As shown in the table above this split is mirrored in the lower two quartiles, with a slight increase to 89.17% in quartile 3 which is primarily registered nurses. However, the percentage of women in quartile 4 drops significantly to 68.63%. This demonstrates the points raised earlier in this report that male staff are concentrated in the top quartile, primarily in medical roles.

If we remove all doctors from the numbers we find a more even spread across all 4 quartiles in both genders as can be seen below:

Number of employees (excluding doctors) Quartile 1 = Low, Quartile 4 = High				
Quartile	**Female**	**Male**	**Female %**	**Male %**
1	1098.00	196.00	84.85%	15.15%
2	1128.00	166.00	87.17%	12.83%
3	1168.00	126.00	90.26%	9.74%
4	1135.00	160.00	87.64%	12.36%

Based on the above findings the Trust will undertake a review of the clinical excellence award policy and associated equality impact assessment.

Recommendations
The Board is asked to note the report which is provided for information.

NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	8 May 2018
Paper number	F3

Safer Nurse Staffing – January and February 2018

For approval:		For assurance:	√	To note:	

Accountable Director	Vicky Morris- CNO		
Presented by	Jackie Edwards- Deputy Director of Nursing	**Author**	Sarah Needham – Associate Director of Nursing

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
People and Culture	23/03/18	Reported noted – limited assurance

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

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☒	**No assurance** *No confidence in delivery*	☐

Recommendations	The board is requested to: note the data for January and February 2018 regarding levels of nursing and midwifery staffing across the 42 inpatient ward areas of the Trust. Note for assurance the mitigations put into place to ensure patients' care needs are met.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	F3

Executive Summary

This paper provides an account of nursing and midwifery staffing levels on inpatient ward areas for January and February 2018, the average fill rate per ward and the care hours per patient per day. This data is triangulated with incident reports from staff that highlight potential patient harm caused to patients as a result of staffing levels which fall below the safer staffing establishment template.

- The safer staffing App continues to provide a clear audit trail to enable a review of comments and narrative related to actions taken to mitigate the staffing levels.
- Escalation of staffing levels and risks where staffing levels fall below 80% takes place through to the Divisional Nurse Directors (DDN), in turn to Chief Nursing Officer. Senior Nurses review staffing levels which fall below the safe staffing establishment for the shift by reviewing the acuity and dependency scoring and utilising professional judgement in terms of what the safe staffing requirement and skill mix is for that shift and take action to address the staffing gap.

Headlines from January safer staffing data

- The Trust had 84 red flag shifts, which is 2% of our total shifts for the Trust. This was an increase from 1.4 % from December data. A number of these shifts have been recorded by staff as being related to sickness and opening additional bed areas which were required to meet extreme capacity surges the Trust experienced.
- Of the 84 red flag shifts only 31 incident reports were submitted, 30 reported minor harm (examples include late medications, delays in documentation etc, and 1 with no harm. A red flag shift occurs whereby staffing (which includes bank/agency staff) falls below 80% and DDNs and Matrons have not been able to add additional staff to increase the overall staffing levels. The Trusts Standard Operational Policy for Safer Staffing outlines the escalation process and is available on request.
- Escalations as required and mitigations were recorded to ensure assessment of patient acuity and patient needs for all of the 84 red flag shifts. The actions captured on the staffing app highlighted that staff from buddy wards were utilised to cover gaps on a shift by shift basis and includes moving our bank and agency staff if and when required.

Headlines from February safer staffing data

- The Trust had 179 red flag shifts which is 5% of our total shifts for the Trust, where qualified nurse staffing levels were documented as below the ward safer staffing establishment. Of the 179 red flag shifts there were 17 Incident reports. Only 1 incident reported moderate harm due to staffing pressures and overcrowding in ED and long waits for beds, 16 reported minor harm and the remainder were unreported.

- During February, staffing challenges were experienced which were attributed to extreme weather conditions (where staff were unable to get to work) and a significant number of times when additional bed capacity was required to be open due to the extreme capacity surges the Trust experienced.

- Escalation as required and mitigations were put in place to ensure assessment of patient acuity and patient needs on the 179 red flag shifts occurred. The actions captured on the staffing app highlighted that staff from buddy wards were utilised to cover gaps on a shift by shift basis.

Date of meeting	8 May 2018
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- The escalation areas which required staffing, over and above ward establishments needed daily coordination to ensure staffing met the requirements. Daily quality audits were put in place for all these additional inpatient areas to ensure adequate scrutiny and assurances given the constraint on staffing. Therefore all senior nurses were asked to undertake a Quality audit for each patient in these areas as well as engaging with staff, patients and relatives to understand the impact on their experience.

Background

Following the Francis Report (2014), all NHS Trusts are required to submit monthly data, detailing ward nursing and midwifery staffing fill rates against a benchmark of 80% fill rate. This information is required to be presented to a Board Committee and published on the Trust website.

The integrated score card (See Appendix 1) reports the January and February 2018 data. This data has also been reported in March 2017 to the People and culture committee.

The staffing level fill rates are RAG rated as Green above 90%, Amber 80-89% and Red 79% and below.

Issues and options

Assurance can be provided that overall staffing levels across the Trust for the months of February and January 18 were above the national requirement of 80%, however, some areas reported staff levels below 80% as referenced below and highlighted in appendix 2.

January data

- The average fill rate of planned hours for registered nurses and midwives were below the national requirement of 80% for some areas

The ward areas which did not achieve an overall fill rate of above 80% for the month of January were:

- AGH; Wards 2,5,11,16 and 18 and Critical care.
- Worcester site- Gynaecology and Lavender Suite.

Although only 2% of the wards were declared as red flag shifts.

- Trust wide fill rate for day shifts was 95.15%, and nights were 93.59% and non-registered nurses for days 118.10% with nights at 93.59%.
  - The Safer Staffing App was further improved in month by;
    - Adding a RAG rating dot which highlights whether acuity data has been completed.
    - Adding the detail of the ward acuity to the front page so that it is easier for senior nursing staff to determine where staffing can be flexed if required.
    - One to one meetings with ward managers has taken place when requested to support them in the completion and utilisation of the app.

Registered Nurse (RN)/Health care Assistant (HCA) fill rates for days and nights –

Overall Trust position (inpatient)

RN day	RN night	HCA day	HCA night	Red flag shifts	Trust Staff % fill
95.15 %	**93.59%**	**118.10%**	**93.59%**	**84 (2% of shifts)**	**86.33%**

February data

- The average fill rate of planned hours for registered nurses and midwives is above the national requirement of 80%. Day shifts were 93.66%, and nights were 94.89% and non-registered nurses for days 91.99% with nights at 182.82%.

Registered Nurse (RN)/Health care Assistant (HCA) fill rates for days and nights – Overall Trust position (inpatient)

RN day	RN night	HCA day	HCA night	Red flag shifts	Trust Staff % fill
93.66 %	**94.89%**	**91.99%**	**182.82%**	**179 (5%)**	**85.10%**

The table above demonstrates that the average of staffing across the Trust in the month of February is above 90%. Of note is that our HCA workforce is reporting as above 100% due to fact that band 4 nursing associate/practitioners do not report in to our qualified workforce and HCA's are utilised to backfill qualified staffing gaps. Our nursing associates/ practitioners support our qualified workforce in assessment, intervention and evaluation of patient care.

Although the above overall safer staffing data is above the 80 % staffing requirement across the Trust. We recognise that there are hot spot areas which needed additional support by:

- Moving staff from other areas to fill the staffing gaps,
- Redeploying bank/agency staff from other areas to ensure the site is safe.
- Matrons/ ward managers/ corporate nursing staff working clinically

It is also acknowledged that moving staff who are already stretched to support other areas is impacting on:

- Staff morale as staff are physically tired.
- Potential impact on patient care due to inconsistency of staff on shift.
- Potential impact on fill rates for bank/agency shifts as they don't like to be moved from their booked areas.

Significant work is underway to support staff with a range of work streams in progress, these being:

- Recruitment and retention (NHSI supported work stream) action plans,

- Introduction of 'allocate' soft wear to provide ,
- International nurse assessment and training packages,
- development of simulation laboratory at Kidderminster,
- Second cohort of Associate nurses.
- ACP fast-track programme (NHSI supported work stream)
- We have also begun work with University on development of a programme of step back into clinical practice following retirement.

Recommendations

The board is requested to: note the data for January and February 2018 regarding levels of nursing and midwifery staffing across the 42 inpatient ward areas of the Trust.
Note for assurance the mitigations put into place to ensure patients' care needs are met.

Appendices
1 – terminology used
2 – Jan/Feb data

Date of meeting	8 May 2018
Paper number	F3

Appendix 1

Terminology and explanatory terms

Shifts and Hours

- Early - 6 Hours
- Late - 6 Hours
- Night - 12 Hours
- Long Day (Early Without a Late) - 12 hours

Total Planned Hours - The amount of Planned Staff multiplied by shift hours

Note: See **Shifts and Hours** above.

Total Actual Hours - The amount of actual staff multiplied by shift hours

Note: See **Shifts and Hours** above.

Avg Fill Rate % - Percentage of the shift hours fill rate.

(Total Planned Hours / Total Actual Hours) * 100

Note: If a shift does not have any planned staff for that shift the number is defaulted to 1.

For Example: Ward A has 0 planned HCAs. If Ward A has covered a night shift with a HCA this will show up as 1200% because the default number is 1 hour but the night shift is 12 hours long.

Avg Care Hours Per Day - AVG Actual RN Hours + AVG Actual HCA Hours

AVG = Sum of the actual staff hours / Day Range input above.

Avg Care Hours Per Patient Per Day - AVG Care Hours Per Day / Number of Available Beds

Unsafe Shifts - Amount of unsafe shifts during the time period input above.

% Trust Staff - Percentage of staff that were trust staff and not bank.

Data Collection Method - This data is being collected by staff on the wards and manually inputted into the safer staffing application. If there is data missing this may be due to the shift not being filled by the ward staff.

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Appendix 2

January 18 Data

Please note that we had some data quality issues regarding the average care hours per patient per day, which were resolved for February reporting.

Site	Division	Ward	Avg Registered Nurse Day Fill Rate %	Avg Care Staff Day Fill Rate %	Avg Registered Nurse Night Fill Rate %	Avg Care Staff Night Fill Rate %	Avg Care Hours Per Day	Avg Care Hours Per Patient Per Day
AGH			93.35	298.08	91.80	1111.64	123.47	
	Medicine		97.06	414.61	92.17	1886.19	117.27	
		Alex Discharge	95.45	100			23	NO BED DATA
		Coronary Care	99.19	3600	93.55	3600	47	11.75
		Emergency Department	89.37	179.03	92.17	10800	192	NO BED DATA
		MAU	97.31	90.32	102.15	96.77	277	7.91
		Triage/AEC	159.52	0			25	NO BED DATA
		Ward 12	88.71	96.37	97.85	105.65	173	6.18
		Ward 14	102.69	104.84	100	112.9	124	6.53
		Ward 2	94.09	95.16	67.74	143.55	125	5.68
		Ward 5	82.58	100.54	77.42	125.81	161	7.32
		Ward 6	83.33	114.19	106.45	104.84	114	5.18
	SCSD		90.86	54.84	89.78	00.00	135.00	
		Critical Care	90.86	54.84	89.78	0	135	16.88
	Surgical		85.69	90.36	91.61	94.68	134.80	
		Ward 10	92.47	98.39	96.77	100	115	5.48
		Ward 11	72.9	85.48	100	100	132	6.00
		Ward 16	77.42	75.12	67.74	75.81	110	3.93
		Ward 17	106.45	95.56	100	95.97	178	6.36
		Ward 18	79.21	97.24	93.55	101.61	139	4.96
KTC			106.45	125.81	101.61	28800.00	73.00	
	SCSD		106.45	125.81	101.61	28800.00	73.00	
		Ward 1	106.45	125.81	101.61	28800	73	NO BED DATA
WRH			98.18	150.13	95.78	93.18	156.19	
	Maternity		86.91	80.47	87.69	82.92	300.67	
		EGAU/ANW Gynaecology	91.13	85.48	79.03	70.97	76	NO BED DATA

		Lavender Suites	80.52	75.27	89.42	74.55	631	NO BED DATA
		Riverbank	89.07	80.65	94.62	103.23	195	6.29
	Medicine		94.76	224.39	90.76	88.97	162.38	
		Acute Stroke Unit	81.12	97.59	87.27	100.88	214	7.38
		Avon 2	100	87.1	67.74	98.39	124	5.64
		Avon 3	100	86.29	73.12	108.06	128	6.40
		Avon 4	97.85	109.68	100	101.61	172	7.17
		Emergency Department	92.51	97.1	94.24	100.81	419	NO BED DATA
		Evergreen	96.77	110.89	90.32	100	167	5.96
		Laurel 1	101.08	119.35	103.23	122.58	95	5.00
		Laurel 2	107.26	93.55	99.19	98.39	165	7.86
		Laurel CCU	93.55	1800	96.77	0	90	11.25
		Medical Assessment Unit	98.71	89.25	101.29	60.22	172	7.48
		Medical Day Case	90.32	62.37			43	NO BED DATA
		Medical Short Stay	87.74	78.41	91.04	83.19	188	NO BED DATA
		Silver Assessment Unit	84.95	85.48	84.95	93.55	134	6.70
	SCSD		86.05	55.38	82.18	51.62	166.50	
		Critical Care	91.45	35.48	89.35	0	220	22.00
		Laurel 3	80.65	75.27	75	103.23	113	7.53
	Surgical		109.56	87.13	108.20	111.44	96.78	
		Beech A	100	89.25	66.67	98.39	115	5.75
		Beech B	152.38	111.9	142.86	242.86	84	6.46
		Beech C	76.34	85.48	101.61	100	105	6.18
		Beech HDU	104.03	0	100	0	48	12.00
		Head and Neck	84.72	69.35	101.61	53.23	75	6.82
		SCDU	93.55	96.77	98.39	170.97	99	7.62
		Trauma and Orthopaedic A	124.6	153.57	135.71	147.62	100	5.88
		Trauma and Orthopaedic B	171.43	110.12	128.57	126.98	112	5.89
		Vascular Unit	79.03	67.74	98.39	62.9	133	8.87

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February 2018 Data

				Day		Night		Care Hours Per Patient Day (CHPPD)	
Hospital Site Name	Ward Name	Average Fill rate - Registered Nurses/Midwives (%)	Average Fill rate - care Staff (%)	Average Fill rate - Registered Nurses/Midwives (%)	Average Fill rate - care Staff (%)	Cumulative Count Over the month of patients at 23:59 each day	Registered Midwives/ Nurses	Care Staff	Overall
WRH	Acute Stroke Unit	86.9%	99.2%	87.2%	109.6%	863	3.9	3.4	7.3
WRH	Avon 2	90.5%	89.3%	78.6%	107.1%	615	2.8	3.1	5.9
WRH	Avon 3	94.0%	90.2%	73.8%	94.6%	553	3.1	3.3	6.4
WRH	Avon 4	95.8%	110.7%	108.9%	98.2%	664	2.6	4.8	7.3
WRH	Beech A	98.2%	93.5%	70.2%	107.1%	564	3.0	2.9	6.0
WRH	Beech B	98.8%	83.8%	92.5%	120.0%	247	3.7	2.8	6.5
WRH	Beech C	78.0%	81.5%	98.2%	98.2%	468	3.1	3.2	6.3
AGH	Coronary Care	100.0%	-	100.0%	-	106	12.7	0.0	12.7
AGH	Critical Care	82.4%	75.0%	81.5%	-	145	22.8	1.7	24.5
WRH	Critical Care	98.6%	82.1%	98.6%	-	314	21.1	0.9	22.0
WRH	EGAU/ANW Gynaecology	97.3%	79.5%	89.3%	78.6%	238	5.3	4.5	9.7
WRH	Evergreen	75.4%	90.2%	66.7%	120.2%	726	2.3	3.3	5.7
WRH	Evergreen 2	98.1%	113.8%	78.3%	136.7%	732	2.1	2.8	4.9
WRH	Head and Neck	86.7%	80.4%	98.2%	66.1%	298	4.4	3.3	7.8
WRH	Laurel 1	100.0%	128.6%	100.0%	128.6%	523	3.2	2.1	5.3
WRH	Laurel 2	99.1%	95.5%	95.5%	100.0%	593	4.4	3.3	7.7
WRH	Laurel 3	75.9%	75.6%	75.0%	100.0%	410	4.9	2.7	7.6
WRH	Laurel CCU	96.9%	-	96.4%	-	212	12.3	0.1	12.3
WRH	Lavender Suites	81.9%	71.0%	90.6%	73.4%	814	16.4	5.4	21.8
AGH	MAU	104.8%	97.9%	109.1%	95.5%	949	4.0	3.7	7.7
WRH	Medical Assessment Unit	97.9%	97.6%	90.0%	76.2%	644	4.9	2.7	7.6
WRH	Medical Short Stay	93.6%	71.3%	91.7%	79.0%	702	4.1	3.3	7.4

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				Day		Night		Care Hours Per Patient Day (CHPPD)	
Hospital Site Name	Ward Name	Average Fill rate - Registered Nurses/Midwives (%)	Average Fill rate - care Staff (%)	Average Fill rate - Registered Nurses/Midwives (%)	Average Fill rate - care Staff (%)	Cumulative Count Over the month of patients at 23:59 each day	Registered Midwives/ Nurses	Care Staff	Overall
WRH	Neonatal TCU	84.2%	139.5%	80.0%	140.0%	183	1.8	3.1	5.0
WRH	Neonatal Unit	126.1%	133.3%	144.4%	155.6%	392	7.5	1.6	9.0
WRH	Riverbank	87.5%	81.3%	95.2%	110.7%	491	9.3	1.9	11.2
WRH	SCDU	91.7%	90.2%	98.2%	189.3%	451	3.5	2.8	6.3
WRH	Silver AU	104.8%	86.6%	78.6%	95.2%	566	3.3	3.8	7.0
WRH	Surgical High Care Unit	90.8%	77.5%	88.2%	70.0%	201	8.1	1.8	9.9
WRH	Trauma and Orthopaedic A	88.3%	165.0%	137.5%	140.0%	480	2.7	3.1	5.8
WRH	Trauma and Orthopaedic B	146.3%	99.4%	135.0%	125.0%	508	2.7	3.6	6.3
WRH	Vascular Unit	84.3%	67.3%	98.2%	55.4%	519	5.3	2.0	7.3
KTC	Ward 1	104.5%	116.1%	100.0%	-	172	8.0	2.4	10.4
AGH	Ward 10	103.6%	86.9%	92.9%	98.2%	503	3.3	3.1	6.4
AGH	Ward 11	76.8%	89.7%	100.0%	100.0%	553	3.5	3.4	6.9
AGH	Ward 12	100.5%	119.0%	132.0%	122.0%	857	2.8	3.4	6.2
AGH	Ward 14	96.9%	106.2%	100.0%	131.5%	525	3.0	3.6	6.6
AGH	Ward 16	72.3%	81.1%	72.6%	82.1%	374	4.6	4.0	8.6
AGH	Ward 17	96.0%	104.9%	101.2%	102.7%	757	3.1	3.7	6.7
AGH	Ward 18	77.8%	99.5%	96.4%	151.8%	679	3.2	3.2	6.4
AGH	Ward 2	103.6%	100.0%	69.0%	157.1%	622	2.8	3.3	6.1
AGH	Ward 5	86.8%	95.8%	82.9%	125.0%	607	4.7	3.0	7.7
AGH	Ward 6	80.4%	117.6%	112.5%	137.5%	601	2.6	3.2	5.8

NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	8 May 2018
Paper number	F4

People and Culture Committee Assurance Report

For approval:		For assurance:	x	To note:	

Accountable Director	Mark Yates Acting Chair		
Presented by	Mark Yates Acting Chair	**Author**	Martin Wood Deputy 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		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		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)	R3.1 R3.2 R4.3

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Please see individual items within the report

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

Worcestershire Acute Hospitals NHS Trust

Date of meeting	8 May 2018
Paper number	F4

Executive Summary

Items discussed at the March 2018 meeting included:

- **People and Culture Strategy**: The Committee noted the planned revision of the terms of reference for the 4ward Steering Group and Recruitment and Retention Steering Group which support the Committee in its work. The revised terms of reference are to be presented to the Committee in May 2018. The results from the 2017 staff survey confirm that our Trust remains in the bottom 20% of all acute trusts for the overall staff survey results. However, there has been a slight improvement in two thirds of the questions when compared to the 2016 results which is against the national trend. For example, the overall staff engagement score has improved from 3.66 (2016) to 3.70 but is lower than the national average of 3.79. Of note is that our Trust is in the top 20% of acute trusts for reporting errors, near misses or incidents witnessed in the last month. All NHS Trusts have been invited to comment on the draft Health and Care Workforce Strategy for England which was subject to consultation until 23 March 2018**.** Feedback has been submitted to the West Midlands HR Directors network who will be submitting a response to the consultation on behalf of Trusts within the region. Limited assurance.

- **Flexible Working:** Following feedback received from colleagues it is evident that not all colleagues are aware of the services that can be accessed from our Trust's two on-site child care facilities (Worcester and Redditch). In response to this the Trust's website has been updated and a leaflet developed to provide information on the support available to colleagues for both childcare and eldercare. Limited assurance**.**

- **Medical Workforce Revalidation:** The appraisal rate for all medical staff is 89%, above the Trust board target and a slight increase since the last report with the rate of 82%. Corrective actions are in place for medical appraisal and revalidation to achieve Trust and national targets. Significant assurance.

- **Leadership Plan:** The Trust's People and Culture Strategy provides a framework to engage staff, support staff and develop a skilled workforce and bring about a new organisational culture which will equip our Trust to meet the opportunities and challenges it faces over the next 3 years. Leadership is a priority for our Trust. The Committee have asked for further development of the Leadership Plan which will help our Trust ensure that its current and future leaders are equipped to provide the best possible care and offer excellent employment opportunities to the community but also help leaders to fully understand the business of providing health care. The updated plan will be reviewed by the Committee in May.

- **Freedom To Speak Up (FTSUP) Guardian:** The Committee have supported the bi-annual FTSU participant's survey and the on-going communication of the FTSU programme to all staff. Revised Terms of Reference for the FTSU Working Group were approved. Moderate assurance.

- **Guardian for Safe Working (GSW) :** The Committee were disappointed to learn that the GSW cannot provide assurance at the present time that the junior doctors within our Trust are compliant with the new 2016 TCS for safe working hours. There is currently no benchmarking data available due to the recent introduction of the GSW. A further report is to be submitted to the Committee in May. No assurance.

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- **Communication and Engagement Action Plan:** This item is to be considered further at the next meeting.

- **People and Culture Scorecard/KPIs:** The Scorecard with Corrective Action Statements as appropriate was noted.

- **Apprenticeship Levy:** The Committee approved the apprenticeship plan which provides details of the actions that will be undertaken to ensure full utilisation of the levy in 2018/19. There is on-going work to provide both new apprenticeship roles across our Trust and advanced apprenticeships for the existing workforce. Moderate assurance.

- **Medical Vacancies Deep Dive:** In February 2017, the Trust vacancies were at 161.22. I am pleased to report that this number has reduced and there are currently 68.93 wte projected vacancies still to fill, 19.57 wte are not currently on the list to fill due to posts on hold pending service review. This leaves a potential vacancy position of 49.36 wte to fill, recognising that this may increase if applicants withdraw from current processes, visas not approved by the home office, further resignations, non-attendance at interview etc. Plans are in place with each division. Limited assurance.

- **Recruitment and Retention:** The Director of People and Culture provided an update on the work of the Medical Workforce Group and Nursing Midwifery and AHP Workforce Group and the work programme for each Group. Limited assurance.

- **Safer Staffing:** The Committee considered safer staffing data for December 2017 and January 2018. In January 2018 our Trust had 84 red flag shifts, which is 2% of our total shifts for the Trust and this has increased from 1.4 % from December data. Red flag shifts highlight areas whereby staffing has fallen below the ward safer staffing establishment. A number of these shifts have been attributed to staff sickness and opening additional capacity areas which were required to meet extreme capacity surges. Limited assurance.

  4WARD Steering Group: The Committee have noted the approach taken for the continued engagement programme and in particular that the overall response rate to the second checkpoint is just below 45%. Moderate assurance.

Other items presented:

- Board Assurance Framework – Risk 3.2 Culture Change – to remain at 15. Risk 4.2 Resourcing of Clinical Staff – to be reduced to 16 from 20.
- People and Culture Risk Register - Risk PC05 – Staff recognition linked to PDR compliance. The rating for this risk increased to 12.
- JNCC Minutes
- Work plan

Background

The People and Culture Committee is set up to ensure that the Trust develops and implements the People and Culture Strategy. This report covers items discussed at the March 2018 meeting.

Issues and options

Date of meeting	8 May 2018
Paper number	F4

None.
Recommendations
The Trust Board is requested to • Receive the report for assurance.
Appendix – None

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	G1

Board Assurance Framework

For approval:	x	For assurance:		To note:	

Accountable Director	Michelle McKay CEO		
Presented by	Michelle McKay CEO	**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	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	x	Quality of Care	x
Finance and use of resources	x	Strategic Change	x	Stakeholders	x

Report previously reviewed by		
Committee/Group	**Date**	**Outcome**
QGC	19 April 2018	Approved change in risk score R1.1, R1.2
People and Culture Committee	Virtual	Approved change in risk score R4.2, removal of risk R4.3
Finance and Performance Committee	23 April 2018	Recommended change to the risk score for R4.1 was not approved

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

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is recommended to approve the changes as detailed in the report.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	G1

Executive Summary

The Board Assurance Committee has been reviewed by each of the responsible committees and the changes recommended are as follows:

Quality Governance Committee (risks R1.1, R1.2, R1.3, R2.1)

BAF risk	Action	Decision
Risk 1.1	Change in risk score to 12 from 16. Removal of one metric relating to complaints with further concerns, amendment to metric relating to reduction in SIs, addition of controls and assurances and deletion of gaps in controls and gaps in assurances, addition of risks from corporate risk register	Agreed
Risk 1.2	Reduction in risk score to 16 from 20. Addition of controls and assurances and deletion of gaps in controls and gaps in assurances, addition of risks from corporate risk register	Agreed
Risk 1.3	Reduction in risk score to 16 from 20. Addition of controls and assurances and deletion of gaps in controls and gaps in assurances, addition of risks from corporate risk register	Not agreed Agreed
Risk 2.1	Addition of controls and assurances and deletion of gaps in controls and gaps in assurances, addition of risks from corporate risk register	Agreed

People and Culture Committee (risks R3.1, R3.2, R4.2, R4.3)

BAF risk	Action	Decision
Risk 3.1	No changes	Agreed
Risk 3.2	No changes	Agreed
Risk 4.2	Reduction in risk score from 16 to 12	Agreed
Risk 4.3	Removal of risk	Agreed

Finance and Performance Committee (risk R4.1)

BAF risk	Action	Decision
Risk 4.1	Reduction in risk score from 20 to 12	Not agreed

Risk R5 minor changes to the gaps in control and gaps in assurance are recommended.

The Audit and Assurance Committee were requested to approve the process of the changes to the BAF at its meeting on 4 May. The Audit and Assurance Committee Chairman will give a verbal update on the outcome of this meeting.

Next steps

The Board Assurance Framework has been in place since July 2017. At the time of development, it was agreed that an operational BAF was required. The BAF will be redeveloped once the overall long term strategic intent of the Trust is developed, which is programmed for 7 June.

Background

The Board agreed at its meeting in January 2018 that the BAF would be considered bimonthly by the board committees and the Trust Board.

Issues and options

N/A

Date of meeting	8 May 2018
Paper number	G1

Recommendations
The Board is recommended to approve the changes as detailed in the report.
Appendices The Board Assurance Framework, version 29

Enc G1 attachment

NHS
Worcestershire
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NHS Trust

Board Assurance Framework
May 2018
Version 29

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			**3x4** ↓					**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					**4x4** ↓			**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	4x4=16						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** ↔		**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	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	**5 x 4 = 20**			**3x4**					**3 x 3 = 9**

	roles	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. 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** ↔			**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**

NHS
Worcestershire Acute Hospitals NHS Trust

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**	**April 2018**	**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							
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Initial Risk Score	20						
Current Risk Score	12	16	16	16	16	20	20
Target Risk Score	8	8	8	8	8	8	8
Risk Appetite	Low						
Direction of travel	↓						

Relevant Key Performance Indicators		
Metric	**Trust compliance March 2018**	**Target**
Complaints responded to within 25 days	78.57%	80%
5% Reduction in Number of serious incidents each year over next 5 years	Baseline – 122 (2017/18)	116 (31.3.19)
P M Review completion	52.59% (Feb 2018)	>60%
HMSR (rolling 12 mths) SHMI (rolling 12 mths)	102.60 (Dec-16 to Nov-17)- Improving 1.0401 (July-16 to June-17) Band 2 As expected	Improving Band 3 better than expected
Compliance with NEWs Audit Compliance with Observations Accuracy (adult inpatient) NEWs Escalation (snap) % 2222- calls appropriately escalated % Unplanned admissions ICU with appropriate Escalation (adults only)	84% 98% 98% 88% 80% 93%	100% 95% 95% 95% 85% 90%
National Clinical Audits Audits with an action plan	100%	100%
Friends and Family Test A&E Score Acute Score Outpatients Score	73.38% 91.93% 92.39%	Top Quartile

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 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 Patient Carer and Community plan approved Risk maturity review undertaken NHS I improvement director finalising corporate governance systems Review of AMD structure undertaken	Review of KPIs at the following Divisional performance and Accountability meetings Quality Improvement Board Clinical Governance Group Quality Governance Committee Quality Improvement Review Group NHSI performance Review meetings Complaints targeted approach with Divisions SI performance monitoring Agreed proforma with KPIs to report through to CGG OU risk maturity review Governance support in place Sept 2017-Mar 2018
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Clinical governance review to be completed Gaps in associate medical director structure	Review Divisional Governance meetings to ensure capability exists within the Divisions and provide training as required.

Related High Risks (15 and above and DATIX ID)

2591	**Medicine Risk Register:** EDS not completed in a timely manner	20	2873	**Corporate Risk Register:** If staff do not receive appropriate safeguarding training there is a risk that patients at risk of harm may not be identified	12
3325	**Corporate Risk Register:** There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.	16	3650	**Corporate Risk Register:** There is a risk that the Trust is unable to deliver safe and effective care due to medical staff vacancies	12
3522	**Risk register:** There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes	16			

NHS
Worcestershire
Acute Hospitals
NHS Trust

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**	**April 2018**	**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							
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Initial Risk Score	20						
Current Risk Score	16	20	20	20	20	20	20
Target Risk Score	8						
Risk Appetite	Moderate						
Direction of travel	↓						

Relevant Key Performance Indicators		
Metric	**Trust compliance March 2018**	**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 collaborative improvement projects	TBD	TBD
QI Strategy in place Divisional Improvement plans in place	Approved In draft	Yes
Improvement methodology training plan in place	Yes	Yes

Rationale for current score

The Trust does not currently have an 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?**

Quality Improvement Plan and Quality Improvement Board in place to monitor progress. Quality Improvement Strategy approved by Trust Board Patient carer and community plan approved by Trust Board SQuID system in place Quality Improvement methodology training plan in place and being progressed Harm review panels chaired by CNO/CMO well established Medicines management summit held in November 2017 Medicines Management Audit Plan NED & Exec programme of Safety walkabouts Exec quality audit programme Quality Impact Assessment process in place Senior Nurse statement of intent in relation to Quality monitoring Improvement plan in place for staff survey Risk improvement plan to improve risk maturity score from 2 to 3 in place	KPI's for PMO projects KPIs for QIP projects Annual staff survey report. Monthly QIP exception reports Frailty Improvement 4ward programme Mandated professional standards Ward round/board round QIRG review of Improvement methodology NHS I review of IPC. Performance now green Oxford University Hospitals Trust Risk review report – progressed to Level 2 CQC report of visit in November 2018 shows improvement in 10 areas across Medical and Urgent & Emergency Care
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Divisional quality improvement plans in draft	Divisional Quality improvement plans in draft

Related High Risks (15 and above and DATIX ID)					
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
2976	**SCSD Risk Register:** Failure to achieve JAG Accreditation	16	3341	**Risk Register:** Risk of patient harm and potential catastrophic risk of death for vulnerable and frail patient caused by C.difficile	15

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**	**April 2018**	**Target Date**		**Dec 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								**Relevant Key Performance Indicators**		
								Metric	**Trust compliance April 2018**	**Target**
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017	Risk assessment of Clinical Information Systems Number of recommended actions completed	10 out of 41 actions complete	42
Initial Risk Score	16									
Current Risk Score	20	20	20	20	20	20	20			
Target Risk Score	9									
Risk Appetite	Low									
Direction of travel										

Rationale for current score
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. Internal audit report showed weaknesses in IT systems. Working group in place and actively undertaking the actions identified. SI incident resulted in no harm.

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 Staff training in place and on-going Reports via divisional governance reports to CCG on letters Task and finish group set up and meeting regularly Audit and Assurance Committee monitoring implementation of action plan	. Review undertaken by Internal audit Backlog cleared from Bluespier. Harm reviews completed. Staff training underway and on-going
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**

Related High Risks 15 and above 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	16

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 emergency access standard; RTT; Cancer 62 days and diagnostics.)						
Executive lead	**Chief Operating officer**	**Last Reviewed**	**April 2018**	**Target Date**	**Sept 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								**Relevant Key Performance Indicators**		
								Metric	**Trust compliance March 2018**	**Target**
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017			
Initial Risk Score	20							Emergency Access Standard	72.12%	92%
Current Risk Score	20	20	20	20	20	20	20	Non-elective stranded patients	44.30%	15%
Target Risk Score	9							12hour breaches	75	0
Risk Appetite	High							Number of DTOC patients	25 (Mar 2018) 38 (Jan 2018)	21 (Jan 2018)
Direction of travel	⟺							Referral to Treatment	84.46%	89%
								Cancer 62 day	74.06%	85%
								Diagnostics	2.54%	<1%

Rationale for current score	
The Trust is not currently meeting the four main 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?**

Patient Flow programme in place RTT Recovery Plan Cancer Plan Diagnostic Plan System Level Plan and Escalation Framework	Integrated Performance Report Weekly Urgent Care & Flow Dashboard Weekly Cancer Dashboard to Cancer & RTT PTL meetings Elective access Board Weekly RTT PLT meetings A&E Delivery Board Urgent care escalation Meeting with NHSI Weekly Cancer Assurance call (NHSI & CCG) Monthly Cancer Board
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 pathway capacity Insufficient workforce to deliver Plans	Ensure all internal processes are followed in line with internal policies. Continue to work with system partners to develop strategies to ensure patients receive care in the right place at the right time. Implement Performance Framework

Related High Risks (15 and above 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
3482	There is a risk that patient safety, effectiveness and management may be compromised in ED due to EXIT block.	20	3483	Patients may be harmed due to delays in treatment/waiting times	16
2981	**Medicine Risk Register:** Capacity	20	3637	There is a risk that inpatients cared for in Endoscopy recovery do not have adequate provisions & staffing to provide safe care	16
3482	**Corporate Risk Register:** There is a risk that patient safety, effectiveness and management may be compromised in ED.	20	2709	Risk of delayed admission to critical care as unit full	16
2689	Breaching national Emergency Access Standards	20	2858	15 minutes triage in ED - WRH	16
3361	**Medicine Risk Register:** SIAN area -ED WRH	20	2871	If RTT and non RTT reports are not consistently using new methodology, patients are not being managed through central WLs	16
2875	Co-horting patients under WMAS care	20	3483	**Corporate Risk Register:** Patients may be harmed due to delays in treatment/waiting times	16
3325	There is a risk that stroke patients may not get timely assessment, diagnosis and treatment.	16	3659	There is a risk of delay in diagnosis and treatment for elective endoscopy patients cancelled due to inpatient outliers	16
2299	**Corporate Risk Register:** Patients not receiving follow-ups within clinically stipulated timescale, may result in loss of vision	16	2634	Patients with Mental health illness in ED may have reduced quality of care and delay in assessment	**15**
3484	There is a risk of sub optimal patient care in surge areas	16	3363	Failure to deliver timely care to patients admitted for elective procedures and on an elective pathway	15

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	**Director People and Culture**	**Last Reviewed**	**April 2018**	**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							
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Initial Risk Score	16						
Current Risk Score	12	12	12	12	12	16	16
Target Risk Score	4						
Risk Appetite	High						
Direction of travel	↓						

Relevant Key Performance Indicators		
Metric	**Trust compliance April 2018**	**Target**
CQC well led domain rating	Inadequate	Requires Improvement
Fit and Proper Persons Test is completed for all of the leadership team	100%	100%
4Ward	Baseline N/A	Net Leadership score of 50% for EP2 Net Culture score of 45% for CP1
Staff survey	March 2018 – bottom quartile	Middle quartile (March 2019)

Rationale for current score
The Trust Board is complete with one interim position (being advertised in May 2018). Two interim posts at divisional level

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 (4Ward) including one-on-one coaching for TLG and Board Recruitment plan in place Span of control review being undertaken People and Culture strategy approved by Trust board	Staff survey results FFT CQC rating on Well Led domain Appraisal KPIs Net Leadership score Net culture score People and Culture sub-committee monitoring actions P&C Strategy in place 4ward culture programme fully supported
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Lack of Trust wide Training needs analysis	

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	

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	**Dir P&C**	**Last Reviewed**	**April 2018**	**Target Date**	**Sept 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							
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Target Risk Score	4						
Initial score	15						
Current score	15	15	15	15	15	15	15
Risk Appetite	Significant						
Direction of travel	⟺						

Relevant Key Performance Indicators		
Metric	**Trust compliance April 2018**	**Target**
4Ward Net leadership and culture scores		Net leaderships core for EP2- 50% Net culture score for CP1- 45%
Board leadership score		
NHS Staff Survey 2017 Staff Engagement Metrics Staff FFT – recommend as place to work	3.7 50%	national average 62%

Rationale for current score

There are significant cultural and behavioral 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?**
cultural change programme launched Oct 2017 Culture steering group in place. Board development Programme in place Wisdom in the workplace programme to support cultural change throughout the Trust 4ward programme in place	Staff survey results Staff FFT CQC rating on Well Led domain Appraisal KPI's Net Leadership scores

P&C strategy approved		Concerns raised via FTSU Guardian
Gaps in controls and assurances: what additional controls and assurances should we seek?		**Mitigating Actions: what more should we do?**
4Ward programme not fully rolled out Communications campaign re zero tolerance on bullying and harassment		Deliver cultural change programme.
Related High Risks (15 and above 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
2791	**Corporate Risk:** Inappropriate staffing levels	20

NHS
Worcestershire 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	R4.1
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	April 2018	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							
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Initial Risk Score	12						
Current Risk Score	20	20	20	20	20	20	20
Target Risk Score	6						
Risk Appetite	Moderate						
Direction of travel							

Relevant Key Performance Indicators		
Metric	Trust compliance March 2018	Target
Compliance with monthly control total	Not achieved	Per the financial plan
CIP delivery in Line with Plan	Not delivered	Per the financial plan
Operational Metrics linked to STF	Partially compliant at End of March	Per the agreed trajectories
Compliance with Capital Resource Limit (Forecast)	Compliant	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	Per operational plan
Better Payment practice Code	Stabilised in Q4. Not compliant	95%

Rationale for current score

There are risks to the control total in 2018/19 due to the scale of improvement required within the Trust. The Trust is in line with the 2018/19 medium term financial plan.

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. 2017/18 Financial Outturn revised to £57.9m pre STF has been approved by the Board in January 2018.
 	
Detailed Financial Recovery Plan is in place:
• Divisional plans focused 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
• Corporate led grip and control initiatives including implementation of financial recovery authorization limits as outlines in SFIs / SoD
• Finance training to be refreshed with all budget managers to ensure compliance with Trust procedures
• Identification of non-recurrent benefits to mitigate financial risks in 2017/18
 	
Strengthened Governance
• Fortnightly confirm and challenge sessions established with CFO (Clinical Divisions and Corporate Departments). Escalated to weekly where performance is not on track
• Increased frequency of meetings with NHSI regional team to oversee progress (Delivery Board / PRM)
• Meetings with NHSI national team
 	
CIP programme integrated with Model Hospital and focus on key projects with highest potential return
• Active engagement with national NHSI Model Hospital team to maximize results
• Acceleration of key projects (theatre productivity, E-Rostering etc) with support of 4Ward culture programme
• Turnaround Director in post and driving development of Medium Term Financial Strategy and Recovery Plan
 	
Close monitoring of performance against capital programme and strengthened capital expenditure controls. Any approved schemes not yet committed are being reviewed through Capital Prioritisation Group and reported to FPC. Schemes linked to loan funding are held until a decision on the Trust's Loan Application is received. The loan application has been resubmitted during January 2018 to request emergency release of £5m across Q4 2017/18 and Q1 2018/19 to progress critical schemes.
 	
Daily Cashflow forecasting and rephasing of cash draw down requirements in line with the operating plan.
	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
	Minimum cash balances against plan
	Monitoring of debt levels
	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 are timely and effective. Ensure all CIP projects and FRP actions have completed and signed off PIDs & QIAs. NHSI lead presented Model Hospital Opportunities to Trust in March 2018 and will do a follow up review of the 2018/19 plan. Key areas of opportunity to be converted into plans as part of medium term financial planning

Related High Risks (15 and above and DATIX ID)

3481	**Corporate Risk Register:** Lack of capital resources prevents the Trust from transforming operations	16
3291	**Corporate Risk:** there is a risk that the financial deficit is worse than planned	16

NHS
Worcestershire 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	People & Culture Director	Last Reviewed	April 2018	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							
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Initial Risk Score	20						
Current Risk Score	12	16	16	16	16	20	20
Target Risk Score	9						
Risk Appetite	Moderate						
Direction of travel	↓						

Relevant Key Performance Indicators		
Metric	Trust compliance February 2018	Target
Vacancies	7.00%	8% or less
Turnover rate	10.95%	10<>12%
Sickness absence rates	3.96%	
Compliance with Safer staffing	96.2% (day) 103% (night)	95%
% bank and agency spend (P&C scorecard)		

Rationale for current score

The Trust reputation is poor so will struggle to attract and retain staff. 40% reduction in medical vacancies in the last 9 months. Nurse turnover and vacancies in line with national average. Current vacancy rate for trained nurses reduced in last quarter.

Controls: what are we currently doing about the risk?	Assurances: how do we know if the things we are doing are having an impact?
Recruitment plan approved and in place. . Vacancy rates monitored through Performance and Accountability meetings Business cases agreed for new Consultant posts being recruited to. People and Culture strategy approved and being implemented	HR workforce reports & Score Card Agency use/ shift fill rate. Performance against recruitment trajectory Recruitment KPIs Turnover rate

Task and Finish group in place for medical and nursing staff to enhance recruitment and retention Overseas recruitment to India Raised trust profile with recruitment video	
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
Hard to recruit roles – not available in national market place Insufficient numbers of junior doctor placements Lack of development of new roles eg nurse practitioners	Strategic workforce plan in development

Related High Risks (15 and above and DATIX ID)

2791	**Corporate Risk Register:** Inappropriate staffing levels	20	3484	**Corporate Risk Register:** Potential sub optimal care in overflow wards due to staffing	16
3505	**Human Resources Risk:** Inability to recruit Clinical Staff	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
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	3170	**Medicine Risk Register:** Lack of seven day Consultant review in respiratory high care	15
3296	**Medicine Risk Register:** Gastroenterology cover at the Alexandra Hospital	16			

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 Planning and Development**	**Last Reviewed**	**April 2018**	**Target Date**	**3 years**	**Review Group**	**Strategy & Planning Group/Trust Board**
CQC Domain(s)	Safe	**Caring**		**Responsive**		**Effective**	**Well Led**
Corporate Objective(s)	1	2		3		4	**5**

Risk Rating: Likelihood x Severity							
	April 2018	Feb 2018	Jan 2018	Dec 2017	Nov 2017	Oct 2017	Sep 2017
Initial Risk Score	16						
Current Risk Score	16	16	16	16	16	16	16
Target Risk Score	9						
Risk Appetite	High						
Direction of travel	⟺						

Relevant Key Performance Indicators		
Metric	**Trust compliance April 2018**	**Target**
Board approved clinical strategy	In development	Approved strategy
Enabling strategies in place e.g. estates. workforce	In development	Approved strategies
Related medium term financial sustainability plan	In development	Approved plan
Achievement of Trust agreed financial control totals going forward	In plans	Trust meets agreed totals

Rationale for current score

The Trust has 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 also underdeveloped There is an issue 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 & Planning 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 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. (Financial) Recovery Steering Group in place Two year operating plan 2017-2019 (being refreshed Feb/Mar 2018) Risk based capital prioritisation plan Turnaround director in place FRP in place being monitored via F&P committee	Improvement in the clinical and financial sustainability of Trust services and the financial sustainability of the Trust overall. Operating plan 2017-19 reviewed by NHSI First high level draft in place. Enabling strategies – early drafts completed Plans on a page for the recovery plan in place
Gaps in controls and assurances: what additional controls and assurances should we seek?	**Mitigating Actions: what more should we do?**
No current overarching clinical strategy however development work has started Enabling strategies at varying degrees of completeness and progressing	Further develop enabling strategies to support implementation of clinical strategy 2017-19 operating plan to be refreshed based on revised NHSI Guidance issued in Feb 2018 due to be submitted 30 April Clinical engagement sessions to take place in May Second version of Strategy – June 2018 Further work needed on plans on a page for financial recovery.

Related High Risks (15 and above and DATIX ID)

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	8 May 2018
Paper number	G2

Cyber Security Assurance

For approval:	x	For assurance:	x	To note:	

Accountable Director	Jill Robinson, Chief Finance Officer		
Presented by	Jill Robinson – Chief Finance Officer	**Author**	Jas Cartwright, Head of Systems & Development

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		Develop and sustain our business			

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance		Quality of Care	X
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?*	N	BAF number(s)	

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☒	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is asked to: 1. Note the progress made around strengthening the Trust's data security and information requirements and the actions required to further mitigate the known risks. 2. Approve the submission of compliance with 17/18 Data Security Protection Requirements

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	8 May 2018
Paper number	G2

Executive Summary

Cyber security remains a top priority for the Trust and we remain focussed on strengthening our security position by addressing any known areas of vulnerabilities There is currently national concern that hospital systems are at threat from hacking groups and even countries. In light of this threat, NHS Improvement are seeking assurance from all trusts that we are taking the appropriate steps to implement the recommendations outlined in the guidance published by NHS Digital 'ten steps to data protection and data security' published in January 2018. All organisations are required to confirm compliance with 17/18 Data Security Protection Requirements (2017/18 DSPR) by 11 May 2018.

The Care Quality Commission (CQC) will be considering data security as part of the well-led elements of their inspection and NHS Improvement will also be ensuring that data security is included in their oversight arrangements.

This report sets out the progress that has been made concerning data security as well as the on-going work that may be required to address any known areas of vulnerability.

Through national security funding awarded in 17/18, we have been able to invest in security software that has helped us to improve our security position. During 2017/18, two external security assessments have been undertaken. Although the findings cannot be widely shared, given the risk that would present to the organisation should details of any vulnerabilities fall into the public domain, the Board can be assured that appropriate actions are being taken to address any identified vulnerabilities which are addressed in detail through the Information Governance Steering Group, which reports to the Trust Leadership Group.

Background

From April 2018 the new Data Security & Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit (IG Toolkit). This toolkit is part of a new framework for assuring that organisations are implementing the ten data security standards and meeting their statutory obligations on data protection and data security as recommended by Dame Fiona Caldicott, the National Data Guardian for Health and Care (see Appendix B for details of the 10 Steps to Cyber Security).

It is important to note that going forward, the Care Quality Commission, will consider data security as part of the well-led elements of their inspection and that NHS Improvement will also be ensuring that data security is included in their oversight arrangements.

The Trust shares its technical infrastructure with Worcestershire Health & Care Trust and the Worcestershire CCGs. There is therefore a joint responsibility, including financial, to address any shared vulnerabilities, as well as a need to understand what actions they will be taking to address any vulnerabilities that are specific to their own organisation.

The Trust has governance arrangements in place to work through the additional data security requirements. The Information Governance Steering Group, through the Information & Security Forum, oversees the implementation of and adherence to the 2017/18 DSPR.

Progress and Issues

Over the last 12 months, much work has been done to strengthen our security position. Through the national funding successfully secured in March 2018, we have been able to

procure software that will strengthen our security position. The programme of work will be completed by March 2019. Appendix A *(confidential, circulated to Trust Board members only)* provides an overview of the work being undertaken.

Having a shared network and server infrastructure with Worcestershire Health & Care Trust and the CCGs, the Trust's ICT team work with our partner organisations to ensure that their compliance to NHS Digital Standards is maintained and, where possible, the organisations work together and, where necessary, jointly fund security enhancements.

Our greatest risk, as with the vast majority of UK organisations, remains staff and their response to phishing emails, which we can mitigate through mandatory staff training and awareness.

To help us improve our security position further we will continue to:

- Raise staff awareness around data security in relation to phishing emails
- Promote and enforce the use of complex passwords with staff.
- Address the issues identified by the external ICT security assessments
- Implement the hardware and software solutions that we were able to purchase via national security national funding received in late March 2018.
- Complete the actions on the Cyber Security Risk ID: 3606. Further information on this is available on request.

In response to the 2017/18 DSPR, the Trust is required to confirm the following:

- **Senior Level Responsibility:** Our Senior Executive responsible for data and cyber security is Jill Robinson, Chief Finance Officer, who is also our SIRO and an executive member of the Board. **Status: Fully Implemented**.
- **Information Governance Toolkit v14.1**: this was submitted at the end of March 2018 to meet the end of year deadline requirements. All 45 standards were scored at a level 2, providing overall rating of satisfactory. **Status: Fully Implemented**
- **Preparation for General Data Protection Regulation (GDPR) in May 2018:** Kimara Sharpe, Company Secretary, has been appointed as the Data Protection Officer for the Trust and has completed the national Data Protection Officer training. A GDPR working group has been set up and is meeting on a regular basis. There is an action plan which is being worked through. A high level summary of the plan will be reviewed and discussed at the private session of the Board on 8 May 2018. **Status: fully implemented**
- **Training staff:** The current Information Governance staff training compliance is 95% (of staff completing training on an annual basis). **Status: Fully implemented**
- **Acting on CareCERT advisories:** The Trusts' ICT Outsourced Partner 'Computacenter' and the ICT Service Delivery Manager collectively review all CareCERT security advisories issued by NHS Digital and act upon those that are relevant to our organisation and update the CareCERT Collect portal within 48 hours. These alerts and these processes are overseen by the Information &

Security Forum **Status: Fully Implemented**

- **Business Continuity:** An ICT business continuity plan to support our response to data and cyber security incidents is being developed. This plan will be brought to TLG for approval in May 2018 and will be tested during 2018/19. **Status: Partially implemented**.
- **Reporting Incidents:** All data security incidents are reported on the Trust's reporting system Datix, any incidents that meet the national criteria for external reporting are reported via the Information Governance toolkit. **Status: Fully Implemented**
- **Unsupported systems:** An ICT project is in place to replace appropriate systems by the end of July 2018. Any unsupported systems have been identified and logged in the relevant risk register and there are appropriate plans in place to remove, replace or mitigate. **Status: Fully Implemented.**
- **On site cyber and data security assessments:** Two separate on-site cyber and data security assessments have been completed this year:
  - NHS Digital completed their security review in January 2018, the Information & Security Forum are currently overseeing the work to implement their recommendations.
  - Penetration testing of the environment was completed in early April 2018. The Information & Security Forum are currently overseeing implementation of the recommendations from this testing.

  Status: Fully Implemented
- **Supplier Certification:** For all new systems and major system changes the information governance pack is applied and this includes risk assessment, privacy impact assessment and confidentiality forms. If necessary, suppliers are asked to provide evidence of their toolkit compliance. The new data security & protection toolkit is based on the 10 data security standards and includes compliance with GDPR and Cyber Essentials. **Status: Fully Implemented**

The responses to the above areas are designed to test whether the organisation has implemented the 10 standards outlined in the 2017/18 DSPR. Based on the above responses, it is our intention to confirm that the Trust has **fully implemented** all aspects of the requirements with the exception of Business Continuity Planning, which has been **partially implemented**.

Recommendations

The Board is asked to:

1. Note the progress made around strengthening the Trust's data security and information requirements and the actions required to further mitigate the known risks.
2. Approve the submission of compliance with 17/18 Data Security Protection Requirements

Appendices

Appendix A: Cyber Security Framework Work Programme & Action Plan *circulated to board members only*
Appendix B: 10 Steps to Cyber Security

Date of meeting	8 May 2018
Paper number	G2

Appendix B: 10 Steps to Cyber Security

NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	4 May 2018
Paper number	Enc G3

Self-certification, Conditions G6 and FT4 as at 31 March 2018

For approval:	x	For assurance:		To note:	

Accountable Director	Michelle McKay CEO		
Presented by	Michelle McKay CEO	**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	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	X	Quality of Care	X
Finance and use of resources	X	Strategic Change	X	Stakeholders	x

Report previously reviewed by		
Committee/Group	Date	Outcome
QGC	19 April 2018	Approved (condition FT4)
Audit and Assurance Committee	4 May 2018	Verbal report at meeting

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

Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The Board is recommended to
	• Declare non-compliance with NHS Provider Licence Condition G6
	• Declare the following with respect to condition FT4:
	  ○ 1, 2, 5, 6 – confirmed
	  ○ 3&4 – not confirmed

Worcestershire Acute Hospitals NHS Trust

Date of meeting	4 May 2018
Paper number	Enc G3

Executive Summary

Condition G6 (3)
Condition G6 states:
Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

In full, the requirement is:
1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
(a) the Conditions of this Licence*,
(b) any requirements imposed on it under the NHS Acts, and
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence, and
(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

* NHS Provider licence

This means that a provider is required to have in place effective systems and processes to ensure compliance, identify risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

In 2017, the Trust declared not compliant with the condition.

It is proposed that the Trust declares not compliant with this condition.

Condition FT4 (8)

In summary the compliance is suggested as follows:

	Corporate Governance Statement	**2018**
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed
3	The Board is satisfied that the Licensee has established and implements:	Not confirmed

	(a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not Confirmed
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed

NHS
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Date of meeting	4 May 2018
Paper number	Enc G3

Background
NHS Trusts are required to make the following self-certified declarations, as at 31 March 2018: 1. Condition G6(3): Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution 2. Condition FT4(8): Providers must certify compliance with required governance standards and objectives. Whilst NHS Trusts are exempt from holding a provider licence, NHS Trusts are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate. This is then used as a basis for oversight. NHS trusts therefore are legally subject to the equivalent of certain licence conditions and in light of this now have to self-certify. There is no set process for assurance on how conditions are met which reflects the autonomy given to providers. Boards need to sign off on compliance and there are no returns or information submissions. Templates are provided to assist with the process but do not need to be returned. The compliance will be posted on the website.
Issues and options
None
Recommendations

The Board is recommended to
• Declare non-compliance with NHS Provider Licence Condition G6
• Declare the following with respect to condition FT4:
  ○ 1, 2, 5, 6 – confirmed
  ○ 3&4 – not confirmed

Appendices 1 Condition G6 2 Condition FT4

Date of meeting	4 May 2018
Paper number	Enc G3

Appendix 1
Condition G6
Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Proposed response: Not compliant

Evidence:

The Trust has remained in quality Special Measures throughout the year. In addition the Trust had the following conditions/warning notices in place:

- Section 31 Condition placed on registration (requirement to report 15 minute triage breaches and Harm Reviews) emergency department, Worcestershire Royal Hospital (30 March 2015)
- Section 31 Condition, Radiology, trust wide (16 August 2016) *The Trust has requested this to be lifted*
- Section 29A warning notice focussing on the systems, processes and the operation of the governance arrangements in place for identifying and mitigating risks to patients in relation to which significant improvement is required *superseded by the warning notice below*
- Section 29A warning notice focussing on the domains of Safe and Well Led (July 2017)

The Trust had an unannounced visit by the CQC on 11/12 April 2017 which resulted in the section 29A notice received by the Trust in July 2017 where concerns were outlined relating to the domains of safe and well led.

The Trust provided the CQC with the Quality Improvement Plan, comprising six domains of focus, following Board approval in July.

The Trust responded to the CQC as required by the section 29A notice on 5 September with a detailed narrative setting out the actions being taken by the Trust in respect of the concerns raised in the letter from the CQC including appendices which provided evidence relating to the actions taken.

There have been further visits by the CQC during the year. The November visit has reported with the improved ratings in several core areas. The reports from the visits in January and February (three in total) are awaited.

No further section 29A notice has been received by the Trust.

The Board Committees have met and reported to each Board meeting. All terms of reference have been revised and approved by the Board during the year. The relevant risks within the Board Assurance Framework is reviewed by each Committee bimonthly and changes approved by the Board at each meeting. The Audit and Assurance Committee reviews the processes for the management of the BAF. The Risk Management Strategy was approved by the Board in July 2017.

Governance below the level of Committees is currently being reviewed.

The Trust continues to have significant challenges in delivering key national standards as at 31 March 2018. These include the 4 hour Emergency Access Target, 18 weeks referral to treatment – incomplete pathways, 62 day cancer performance standard and the 6 week wait diagnostics standard.

Date of meeting	4 May 2018
Paper number	Enc G3

Appendix 2
Condition FT4
Appendix 2 – detail of compliance

	Corporate Governance Statement	2018	Evidence
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust has remained in quality Special Measures throughout the year. In addition the Trust had the following conditions/warning notices in place: • Section 31 Condition placed on registration (requirement to report 15 minute triage breaches and Harm Reviews) emergency department, Worcestershire Royal Hospital (30 March 2015) • Section 31 Condition, Radiology, trust wide (16 August 2016) *The Trust has requested this to be lifted* • Section 29A warning notice focussing on the systems, processes and the operation of the governance arrangements in place for identifying and mitigating risks to patients in relation to which significant improvement is required *superseded by the warning notice below* • Section 29A warning notice focussing on the domains of Safe and Well Led (July 2017) The Trust had an unannounced visit by the CQC on 11/12 April 2017 which resulted in the section 29A notice received by the Trust in July 2017 where concerns were outlined relating to the domains of safe and well led. The Trust provided the CQC with the Quality Improvement Plan, comprising six domains of focus, following Board approval in July. The Trust responded to the CQC as required by the section 29A notice on 5 September with a detailed narrative setting out the actions being taken by the Trust in respect of the concerns raised in the letter from the CQC including appendices which provided evidence relating to the actions taken. There have been further visits by the CQC during the year. The November visit has reported with the improved ratings in

			several core areas. The reports from the visits in January and February (three in total) are awaited. No further section 29A notice has been received by the Trust.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Executive team regularly receive communications from NHSI. All guidance is regarded by the executive team and where appropriate escalated to the Board. The Trust Leadership Group also receive all guidance.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Not confirmed	a&b. The Board Committees have met and reported to each Board meeting. All terms of reference have been revised and approved by the Board during the year. The relevant risks within the Board Assurance Framework is reviewed by each Committee bimonthly and changes approved by the Board at each meeting. The Audit and Assurance Committee reviews the processes for the management of the BAF. The Risk Management Strategy was approved by the Board in July 2017. c. Governance below the level of Committees is currently being reviewed.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	Not confirmed	a&b. The Trust Leadership Group (TLG) meets fortnightly to manage the operational business of the Trust. Board Committees meet monthly (Finance and Performance, Quality Governance) and People and Culture meets bimonthly. The Board meets bimonthly and has a forward plan for business. At each meeting reports are given on quality, financial and people management. c. The Quality Governance Committee meets monthly and holds the executive directors to account for quality standards. The Finance and Performance Committee meets monthly and holds the executive directors to account for performance standards. d. The Finance and Performance Committee meets monthly to scrutinise the financial performance and reports to each Board meeting. The financial recovery plan is reported to the F&P committee monthly. A turnaround director is in place. There was an agreed revised

	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		control total negotiated during the year in recognition of a deteriorating financial situation. e. The Quality Governance Committee uses real time information via the SQuID system to inform the decision making process. The backlog in complaint response and serious incident review has decreased significantly throughout the year. The F&P Committee scrutinise the performance dashboards and financial performance reports monthly. The board approved the Quality Improvement Strategy and associated plans at its March meeting. f. The Board Assurance Framework (BAF) has been in place and is considered at each Board meeting. The relevant risks are considered by Board Committees at each meeting. g. The Trust has a well embedded business case process in place. External consultation took place in relation to the Future of Acute hospital services in the summer, 2017. Divisions will be producing business plans for 2018/19. h. The Trust was registered with the CQC during the year 2017/18.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its	Confirmed	a. The Quality Governance Committee (QGC) oversees all aspects of quality within the trust. This meets monthly and escalates via a written report to each Board meeting. The Chief Nurse and Chief Medical Officer are responsible for quality of care at board level. A non-executive director has been identified to provide leadership with respect to learning from deaths. b. Each business case developed has an associated quality impact assessment (QIA) using methodology as suggested by NHS Providers. The QIAs are signed off by the Chief Nurse and Chief Medical Officer and are reported to the QGC. Any QIAs not signed off are escalated to the QGC and then to Trust board. d. QGC considers real time data via SQuID at each of its meetings. This is

	Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		then reported to the Board via the written report from QGC. The Board considers an integrated performance report at each meeting. e. The Board receives a patient story or equivalent at each Board meeting and approved the Quality Improvement Strategy and associated plans (including the Patient, Carer and Community Plan) at its March 2018 meeting. Patient representatives attend the QGC meeting and participate in ward visits. HealthWatch also attends QGC. f. Through TLG the divisions are held to account for the quality of care within the Trust. Each division reports monthly to the Clinical Governance Group which in turn provides a report to the QGC.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board has one vacancy which is filled with an interim position. All Board members have undertaken the Fit and Proper Person Test. A self assessment against the well-led domain has been undertaken and an action plan is in place. The outcome of the Well-Led inspection undertaken by the CQC in February 2018 is awaited.